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

Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Inadequate
End of life care	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in the county of Cornwall. The Trust is not a Foundation Trust and performance is monitored by NHS Improvement (NHSI). The Trust serves a population of around 415,783 people, a figure that can be doubled by holidaymakers during the busiest times of the year.

CQC has previously carried out two comprehensive inspections at Royal Cornwall Hospital NHS Trust. The first being in January 2014 when the Trust was rated as requires improvement. In June 2015, we carried out a follow up to the first inspection and found the trust had not made sufficient progress in all areas and a second comprehensive inspection was initiated, which we carried out in January 2016. At that time, the trust was rated as requires improvement overall. We rated safe, effective, responsive and well led as requires improvement and caring as good.

This inspection was a responsive, unannounced focused inspection and was conducted on 4 and 5 January 2017. We reviewed end of life and urgent care services to review progress against the inadequate ratings for those core services as identified on the previous inspection in January 2016. We reviewed medicine services as continued intelligence had raised concerns with regards to quality and safety of the service. We also looked at the governance and risk management support for the services we inspected.

Only those services provided at the main Royal Cornwall Hospital site in Treliske were inspected. We did not inspect:

- St Michaels Hospital
- West Cornwall hospital
- Penrice birthing unit

Key findings:

Safe:

- There was not a reliable or effective system in place to identify, capture, report or review incidents. Although staff did complete incident forms and they were encouraged to do so, there was little evidence of actions or learning resulting from these.
- The classification of incidents was not effective, for example, we found multiple examples of incidents (where harm had resulted) classified as 'no harm'. This meant not all incidents were investigated or escalated appropriately, and opportunities to learn and improve were missed. It also meant that the trust were not able to produce accurate reports for analysis or accurately identifying risks or trends.
- Not all incidents had action plans associated with them, and those that did, were not always robust or monitored to ensure they had been completed, and learning had taken place.
- As the level of harm had not always been correctly established or recorded, there was no assurance that duty of candour had always been applied appropriately.
- There was inconsistency with the quality of serious incident investigation reports and evidence of learning from patient deaths. There was no evidence to show actions identified following serious incidents were reviewed for progress and led to improvements. In addition, we found examples of serious incidents that had not been reported as such.
- There were delays in medicine administration in the emergency department, which had not been resolved. There were two incidents during our inspection of a lack of security with the drug cupboard keys. There were some issues with medicines' management and storage, although this was mostly well managed.
- There had not been a sustained or satisfactory improvement in the timeliness of observations, and management of sepsis in the emergency department.

Summary of findings

- There were frequent staff shortages across medical wards and the complicated systems to secure agency staff meant that staffing levels in areas fell below safe levels. Neurology did not have sufficient staffing capacity to provide a seven-day service.
- The number of consultants in the emergency department and the hours they worked were below recommended levels, although there was active recruitment, and good coverage from junior doctors. The overcrowding in the department meant there were times when the nursing staff levels were not adequate. Levels of nursing staff were rising towards planned numbers, but staff raised concerns about cover in the minor injuries' area at night being adequate.
- The specialist end of life team did not have enough medical or nursing staff to provide a service seven days a week and cover arrangements were limited.
- There was insufficient attention to safeguarding children. Staff did not receive sufficient training to adequately recognise or respond appropriately to the abuse of children. In some ward areas, less than 50% of the staff were sufficiently trained in children's safeguarding. Training for both adult and children's safeguarding was not meeting trust targets.
- Many consultants did not have the required levels of mandatory training to keep people safe. Very few consultants had training in infection control, manual handling, fire safety, health and safety or information governance. Nurse mandatory training was much improved in the emergency department and coming up towards targets.
- There was inconsistent understanding across wards regarding which nursing staff had in date syringe driver training and competency to safely set up and monitor equipment.
- There was no up-to-date record of review of equipment skills for staff in the emergency department, and a number of pieces of equipment were indicating they were overdue for servicing.
- Resuscitation trolley checks on the Medical Admissions Unit and Tintagel ward were frequently missed which meant that there was an increased risk to the patient if the equipment was needed.
- The overcrowding in the emergency department was causing reduced access to some areas, including the resuscitation room. Emergency evacuation may also be hindered.
- Not all patients were able to reach their call bells. These were not provided in some areas, or within patients' reach in others.
- We found that medicines were not stored securely in the Medical Assessment Unit and despite raising our concerns found that medicine security got worse as the inspection went on.
- Not all patients were receiving a timely electrocardiogram (ECG) test when presenting in the emergency department with chest pain.
- Improvements were required to how treatment escalation plans were completed by doctors to ensure compliance with policy.
- Infection control practices were unsafe on the Medical Admissions Unit and not all cleaning of equipment was recorded in the emergency department. We observed a lack of hand hygiene at times among the staff in the emergency department.
- There was a variable level of completion of emergency department patient records from comprehensive to poor, although audit work in the department demonstrated this was improving.
- On regular occasions on the medical wards, we found that records trolleys were left unlocked and unoccupied. We also found zip locked bags containing records left unattended by the ward entrances awaiting collection.

However:

- There was a much improved assessment and response to patient risk, triage and urgent treatment.
- There was an impressive length of time given over to nurse mandatory and continuous developmental training in the emergency department.
- Comprehensive risk assessments were undertaken, and risks to people were assessed, monitored and managed on a day-to-day basis, with good use of the National Early Warning System (NEWS).
- Infection control practices were generally good in most areas.

Summary of findings

Effective:

- The Royal College of Emergency Medicine (RCEM) audits were not given a satisfactory priority in the year in which they were to be undertaken. The results of the asthma audit were poor although they had used an insufficient dataset, and the audit was done outside of the required period.
- We asked for, but were not provided with up to date audit information for some national audits. The results of these in the previous inspection were worse than the national average.
- There was a lack of ongoing audit information to evidence quality and progress in the delivery of effective end of life services.
- During December 2016, a revised end of life strategy and patient care documents was launched based on national guidance. The strategy lacked accompanying training and emphasis to ensure all doctors understood what their roles and responsibilities would be.
- Whilst new end of life care plans were being rolled out across the trust, there remained a lack of recorded evidence to show end of life care provided was holistic and person centred. There was a reliance on the patient or relatives of the patient initiating and articulating any personalised wishes in order for any actions to be taken.
- A continuously funded secondment post for generic hospital staff to work with the specialist end of life team to increase their skills and knowledge was available but not fully utilised.
- There was little evidence of advance end of life care planning being undertaken. Most of the staff we spoke with did not recognise end of life as relevant during the last twelve months of life.
- Discharge was not done in a timely way. All patients were subject to standards set in the SAFER care bundle. Achievement in standards of discharge was significantly lower than the trusts target. Examples of these targets included the timeliness of discharge and discharge on the patient's clinically stable date.
- There was no seven-day consultant cover for neurology patients. This increased the risk to patients at weekends. The use of a consultant of the week model had an impact on the effectiveness of treatment. Staff were not supported well and patients were missing important medicines because of a lack of accountability under this model. The end of life service did not provide seven-day services, and there was limited out of hours cover. All services needed to provide effective care were available seven days a week in the emergency department.
- Appraisal rates in medicine were not meeting targets. Only two wards had appraisal rates higher than the 95% trust target. Some wards were significantly lower with Kerensa ward having 56% compliance and Tintagel ward having 65% compliance. In the emergency department, staff appraisals had improved and were heading towards target.

However:

- There was evidence that people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- In medicine, there was evidence people had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- The link end of life link meetings were a productive forum for learning and sharing clinical and policy updates and were valued by those staff who attended.
- Records maintained by the specialist end of life team showed they were prompt to respond to referrals. Staff throughout the hospital told us they understood how to contact the team and highly valued the expertise, guidance and support provided.
- There was a strong ethos in the hospital and the emergency department for multidisciplinary working and we saw some good examples of this. When people received care from a range of different staff, teams or services, it was coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment.

Summary of findings

- In the emergency department, staff had the right competencies, experience and skills and professional development and competency training had improved. There was an excellent range of training for medical staff, including outstanding simulation training and production of high-quality case studies, teaching materials, guidance and protocols.
- The emergency department had excelled in the timeliness, care and treatment of patients suffering a stroke or trauma.
- There had been improvement in the national stroke audit. The trust had gone from a level E to a level D.

Caring:

- Feedback from patients and those close to them was mostly very positive about the way staff treated people. People were treated with dignity, respect and kindness during their stay.
- People are involved and encouraged to be partners in their care and in making decisions. Staff spend time talking to people, or those close to them and we witnessed staff in the emergency department at a very busy time, taking care to help patients understand what was happening to them.
- Staff had the skills and compassion to communicate effectively to patients during times of distress. This was particularly apparent in the coronary care unit, and in the emergency department.
- Feedback was overwhelmingly positive on Wellington ward. Staff were enthusiastic about the care they were giving. Patients felt that staff went the extra mile and exceeded their expectations.
- Patients and their relatives told us they had been consulted about end of life treatment and care, this was also evidenced in some of the care plans we reviewed, although there was a lack of detailed written information in care records to show what had been discussed with patients and how they had been included and involved in treatment and care.
- The new cancer resource centre provided a wide range of resources, counselling and support to any person affected by cancer.

However:

- Friends and Family response rates were not good across the medicine directorate. For example on Carnkie ward, Tintagel ward and Kerensa ward response rates were below 10%. In the emergency department, although improving the response rate was also very low, but the trust was recommended, in those responses received, by a higher number of people than the England average.
- For end of life care, there was a lack of survey or other evidence to show patients' needs were being consistently met.
- Due to overcrowding in the emergency department, there were unintentional, but difficult to avoid breaches of privacy and dignity for some patients.

Responsive:

- Although processes were in place to support flow within the hospital there were not enough beds to meet the demand of the service. Bed capacity was full and escalation areas (such as theatres and day case surgery) were regularly being used. Additionally there were 40 medical outliers in surgical wards. This took up 16% of the surgical bed base.
- Demand on the emergency department and the way it had been required to operate meant too many patients were, at times, waiting on trolleys to be admitted to a ward, and flow was not timely; the department had not met the target to admit, discharge, or transfer 95% of patients within four hours for at least the last two years. At the time of our inspection, this was running at around 77%.
- People were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment and people experienced unacceptable waits for some services. During the inspection over 100 patients were delayed in hospital due to inability to access community services. Between April 2016 and December 2016 over 1700 bed days were lost because of inadequate hospital flow.

Summary of findings

- On average 97 patients a month were waiting longer than seven days for discharge. This increased the risks of patients deteriorating, prevented patients who required medical care accessing wards, and caused crowding in the emergency department.
- Senior staff told us that the GOLD calls with system partners were not effective; and the call we witnessed corroborated this on one of the busiest days on record. Some system partners did not attend the call, and others were not prepared with information to provide an overview of capacity in the system.
- Staff in the end of life service told us discharge delays were frequent and resulted from a lack of community resources. There was no information to fully evidence this and no plans in place to work with community services to address these issues, and in some areas there was confusion regarding who had overall responsibility for processing fast track patient discharges through to discharge.
- There was a lack of processes in place to evidence if the end of life care provided was responsive to patient's needs and wishes. Ward staff primarily relied on the patient or relatives to initiate and communicate any requests.
- There was inconsistent feedback and evidence to show if patients spiritual and cultural needs had been reviewed and any needs addressed, and each patient's personal choice as to where they preferred to receive their end of life care was not routinely monitored and reviewed.
- Complaints in medicine were not being handled in a timely way and in the emergency department, there was insufficient evidence to show complaints led to changes and improvements.
- A third of complaints in medicine were resolved beyond their timescales, and there was insufficient evidence that learning was shared across the trust.

However:

- The medicine and emergency department services were planned to meet the needs of local people. People using the service could all do so on an equal basis. We found that some reasonable adjustments had been made to manage individual patient vulnerabilities needs. This included patients living with dementia and patients with a learning disability. We found that there had been significant improvements in the stroke service, which ensured that the design of services were tailored to meet their needs.
- The emergency department had moved up the national rankings in terms of accident and emergency target waiting times, and the time taken to first treat patients was consistently better than the standard of 60 minutes, with care and treatment appropriately prioritised. People in the emergency department were kept informed about waiting times and alternative access to treatment in the county.
- The cancer resource centre provided a wide range of services, support, training and information based on the needs of patients and people close to patients. The centre also provided training information and information for trust staff and other professionals who provided any services to patients with cancer.
- We found that it was easy for patients to raise a concern or a complaint. There was openness, transparency, and a will to learn from complaints on the wards. We found examples where learning from complaints had resulted in changed practice locally.
- There had been a drive for the complaints team to hold early resolution meetings with complainants, and these had resulted in fewer complaints progressing through to formal complaints.

Well-led:

- Although staff understood what the vision and values were, they felt they were not able to fully live by them due to the pressures of the job. We were also given examples where senior staff had showed a lack of compassion to staff which was not in line with the trusts values.
- The strategy was clear and recognised the challenges the medicine division had. However, some of the objectives were unachievable considering the status of the wider health system.
- There was no effective assurance system in place for identifying, capturing and managing risks between ward and divisional level. There was no assurance that risks were being escalated and actioned appropriately. There was a lack of capacity to recognise and respond proactively to emerging risks given the focus on urgent priorities.

Summary of findings

- There was a disconnect between the local and divisional teams which meant there was limited openness, transparency, and a culture of helplessness from filling in incident forms or raising concerns as staff felt nothing would happen.
- The emergency department risk register had few clinical risks; concentrated on mostly potential environmental risks; and beyond the ongoing situation with crowding, did not address known or current concerns. The end of life service did not have a specific risk register.
- Safety and quality meetings at divisional level were of a variable standard. Whilst all departments indicated the occurrence of meetings, some departments demonstrated a lack of escalation. It was also reported by staff in some divisions that the escalation of issues was futile, with little recognition, feedback or action from executive level meetings.
- There was not a holistic approach to the monitoring of safety and performance data, supported and informed by robust, ongoing clinical audits in all services underpinned by robust action plans to drive improvements. There were a number of areas not being considered through this mechanism, or not demonstrating sufficient priority.
- There was a lack of audit and quality measures to fully evidence quality and risk management issues for end of life patients to maintain and make service improvements. There was no routine engagement with patients or those people close to them to gather feedback in order to make service improvements.
- Quality improvement was not embedded across the organisation.
- There was a conflict between delivering high quality patient care, and the time to commit to good governance and risk management.
- Available funds and training available for the development and sustainability of a skilled workforce throughout the trust had not been fully utilised.
- There was an established pattern of increased referrals to the specialist end of life team but there were no plans in place to ensure the team had the capacity to cope with this.
- Leaders did not have the capacity or capability to lead effectively. There was a lack of support from the wider system, which led to delays in the management of key risks, such as patient flow. Senior leadership of the end of life service was not fully effective and coordinated.
- In medicine, there were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported and appreciated. This was particularly apparent on Tintagel ward. More work was needed to improve the continuing poor staff engagement and staff survey results.
- All staff we met were focused to continually improve the care they were giving. This was particularly apparent on Wellington ward where innovate schemes had been introduced to develop skills further.

However:

- The specialist end of life team was held in high regard by staff we spoke with on the wards and other services we visited, and in the emergency department, there was experienced, committed, caring and strong leadership. The leaders understood the challenges they faced and had ambitions for improvements and innovation. Staff in the emergency department felt respected and valued. There was encouragement of openness, candour and collaborative working.
- Despite the pressure on the wards, there was a culture of openness and transparency between the team, which was cascaded from the ward manager, and matrons. All staff we spoke with were positive about the attitudes of the matrons and said that they led the service well.
- Staff were focused to continually improve the care they were giving. This was particularly apparent on Wellington ward where innovate schemes had been introduced to develop skills further.
- In the emergency department, there was experienced, committed, caring and strong leadership. The leaders understood the challenges they faced and had ambitions for improvements and innovation. Staff felt respected and valued. There was encouragement of openness, candour and collaborative working.
- There had been strong innovation and encouragement through professional development and acknowledgement of success and excellence in the emergency department.

Summary of findings

- The specialist end of life team were held in high regard by staff we spoke with on the wards and other services we visited.

We saw several areas of outstanding practice including:

- There was an outstanding commitment to medical simulation training in the emergency department and this extended to the production of detailed and valuable case studies. This provided education for staff, but also awareness of human factors in a busy environment, and how staff might react to those.
- There had been an outstanding response to trauma and stroke patients in the emergency department. The department was among the top hospitals in the country for providing timely and appropriate care.
- There was an outstanding commitment to mandatory training for the nursing staff in the emergency department with three-day sessions held to cover this and other key topics for continuous professional development.
- Despite unprecedented overcrowding, the emergency department was calm and professional during our unannounced inspection.
- MASH up Monday training on Wellington ward – small training sessions on the ward done by the ward sister and other relevant staff. Now extended to something each weekday. Ward sister won a trust pride and achievement award in November 2016 for this.
- Clinical Matron for the cardio-respiratory directorate was nominated for a Nursing Times award for 'Matrons Rounds' – promoting safe, effective, caring, responsive and well led care, January 2016.
- One of the respiratory doctors had organised a respiratory day, for staff, at a local pub that included training, lunch and discussion about respiratory care (there was a cost of £10). The matron said the doctor was very enthusiastic and staff were looking forward to the day.
- The use of an electronic pharmacy system to ensure detailed exchanges of communication to community GP's and pharmacists. This ensured that the community teams were up to date in dose changes, new medicines, discontinued medicines, and those that were to continue but were temporarily stopped.

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

Importantly, the trust must:

- Review, document and implement the governance processes, subcommittee structures and reporting lines to and from the board and ensure this is communicated to staff.
- Review the governance in the emergency department and across medicine to ensure it has evidence that recognises and addresses risks, safety, and quality of care. This needs to include actions from avoidable patient harm, progress with audits, and demonstrable learning and improvements when there are incidents, complaints, and other indications of emerging or existing risks.
- Review and improve governance processes to fully evidence all quality and risk management issues for end of life patients, and ensure these are reported in line with the risk management policy and processes.
- Review and implement the systems and processes for managing corporate, divisional and local risk registers and ensure that all staff are clear about their roles and responsibilities. The risk register must be improved to recognise all risks, particularly clinical risks, and consider where there are gaps in what is reported and how they are reviewed.
- Review the incident reporting systems and processes and provide assurance this is a fair reflection of the risks in the trust at all times. Ensure any categorisation of an incident is accurate in order to ensure learning and appropriate escalation from all incidents, including 'near miss' events. In addition, to ensure that duty of candour is correctly applied in all cases.
- Review how end of life patient care is captured within the trusts incident reporting system to ensure incidents reported in all categories can adequately identify if they also involve end of life patients, and improve and educate staff trust wide to recognise what end of life issues could or should be reported as an incident.
- Present incident information with more prominence in safety reviews and governance committees with a responsibility for risk, and embed and demonstrate learning and improvement.

Summary of findings

- Address timeliness and inconsistencies in the quality of investigation reports for all serious incidents.
- Demonstrate learning across the trust from patient deaths, particularly, but not limited to, any that were unexpected or avoidable.
- Ensure that actions to improve on performance measures are robust, are actioned appropriately and are discussed at the relevant meetings to ensure senior level and board oversight as necessary.
- Ensure a holistic approach to the monitoring of safety and performance data, supported and informed by robust, ongoing clinical audits in all services underpinned by robust action plans to drive improvements.
- Ensure that staff receive appropriate safeguarding training to protect both adults and children.
- Ensure that both nursing and medical staff have appropriate mandatory training to keep people safe.
- Continue to review and put in place measures to address and manage patient access and flow, and ensure patients are appropriately discharged, working closely with system partners to achieve workable solutions to the current barriers, including a review of the effectiveness of system wide GOLD calls and the steps taken in advance of anticipated busy periods to plan for this.
- Ensure that designated leaders have the time and capacity to lead effectively and manage governance within their divisions, departments and teams.
- Review using the emergency department as an access point for medically expected and surgical patients to relieve pressure on the whole system, reduce breaches of patient privacy and dignity, and improve the response to patients.
- Ensure that there is appropriate medical oversight and accountability for neurology patients on Tintagel ward including at weekends.
- Find a workable solution to delays in the administration of medicines to patients in the emergency department, and ensure that medicines in the medical division are stored safely and securely.
- Ensure there is a sustained and effective improvement in the management of sepsis in the emergency department.
- Ensure there is evidence in the emergency department of governance for equipment and the environment, which includes staff competence, cleaning regimes, availability of call bells in all areas, and maintenance being undertaken when required.
- Ensure that resuscitation trolleys in medicine are checked appropriately so they are safe to use.
- Ensure that medical records remain secure and locked away throughout the medical division.

In addition the trust should:

- Ensure multidisciplinary processes improve to discharge patients at appropriate times of day.
- Ensure that complaints are managed in a timely way. Improve systems and processes to show how complaints have been scrutinised for themes and level of impact and what subsequent actions have been taken.
- Improve governance processes to fully evidence all quality and risk management issues for end of life patients, and ensure these are reported in line with the risk management policy and processes.
- Ensure plans are developed to support improvement in culture within the trust.
- Ensure there is sufficient oversight of outcomes for patients.
- In line with national guidance, routinely audit and evidence if patients are achieving their preferred place to receive their end of life care. Complete ongoing audit programme and deliver this to evidence quality and progress in of effective end of life services.
- Identify and evidence the cause of any fast track discharge delay of end of life patients from the hospital and complete appropriate action plans to evidence discharge delay improvements.
- Improve processes so all staff are clear who has overall responsibility for processing fast track patient discharges through to discharge.
- Ensure that staff have appraisals when they are due to meet the trusts target.
- Ensure that staffing levels throughout the medicine division keep people safe. Particularly within cardiology.
- Ensure senior staff on all wards know which nurses have in date syringe driver training and competency to safely set up and monitor equipment.

Summary of findings

- Have comprehensive action plans in place to ensure all medical staff have education to fully understand their roles and responsibilities with the end of life strategy and care planning documents.
- Improve staff training and records to show staff have initiated conversations regarding the personal wishes of end of life patients and those people close with them.
- Evidence how end of life patients spiritual and cultural needs have been reviewed and needs addressed.
- Ensure that standards of cleanliness and hygiene are maintained consistently throughout the medicine division. Address any shortcomings with hand hygiene in the emergency department.
- Ensure that work continues to improve the waiting lists in cardiology.
- Undertake a review of the time to carry out ECG tests for patients presenting in the emergency department with chest pain to determine whether improvements have been made.
- Remove any temporary congestion causing obstruction to entry to the resuscitation room in the emergency department, escape exits and to the mental health crisis room.
- Ensure there are no breaches in security of the drug cupboard keys in the emergency department.
- Resolve the issues in the emergency department's clinical decision unit around safe management of medicines.
- Look to introduce a risk matrix for the admission of patients with a mental health issue to the clinical decision unit in the emergency department.
- Consider how the nursing staff are placed when there are patients waiting in the corridor in the emergency department to ensure adequate clinical supervision.
- Consider how to get the best out of staff who are asked to help in the emergency department at short notice, and ensure they have good support and guidance.
- Review the nursing cover in the minors' area at night to ensure it is safe for both patients and staff.
- Improve cover arrangements for the specialist end of life consultant so this is sufficient at all times with a consultant with a similar level of expertise.
- Review the electronic alert system for doctors to ensure they are able to prioritise patients appropriately.
- Ensure appropriate skill mix review of the specialist end of life team and plans in place to meet the increased number of patient referrals.
- Follow best practice guidance and ensure there is sufficient specialist medical and nursing staff to provide a service seven days a week.
- Prioritise the release of ward staff to attend the 3 month continuously funded secondment post staff to work with the specialist end of life team.
- Review the templates on foundation-year doctor rotas with Health Education England to find a solution to the ongoing issue of workload pressures on this group of staff.
- Update the trust website to advise people of the opening times of the hospital pharmacies.
- Make sure patients in the emergency department have something to eat and drink as often as is safe and practical.
- Reflect on our concerns with privacy and dignity for patients waiting in the corridor in the emergency department and look for solutions where some of this will be avoidable.
- Review the design and layout of the clinical decision unit, which has no discrete areas for male and female patients to be accommodated separately.
- Find a solution to the poor response rate by patients to the Friends and Family Test.
- Have systems in place to routinely gather feedback on the end of life service provided from patients or those people close to them. Evidence how this information has been used to inform service improvements.
- Improve staff understanding that end of life care extends beyond the last few days and weeks. Improve documentation of advance care planning during the last twelve months of life.
- Improve the completion of treatment escalation plans by doctors to ensure full compliance with policy.
- Look at finding a solution to the lack of resources or space in the emergency department for meetings, seminars, education, IT and library resources.

Summary of findings

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 	We rated this service as requires improvement because: • There had not been sustained improvement in incident reporting and analysis to recognise trends and demonstrate change and learning. • The recognised issues with delays in medicine administration had not been addressed and resolved. • There were aspects of safety that needed improvement. This included clear access to emergency facilities, including the resuscitation room, access to call bells, equipment maintenance and cleaning, and evidence of staff competency to use the equipment. • The overcrowding in the department meant there were times when the nursing staff levels were not adequate. • There had not been a sustained or satisfactory improvement in the timeliness of observations, and management of sepsis. • Medical audits did not provide evidence of receiving sufficient priority, or bringing immediate learning and improvement. • There were breaches in patient privacy, dignity and confidentiality when the department was overcrowded. Some of these were avoidable. • Waiting time targets for patients to be transferred out of the department were not being met, and had deteriorated. • The department was managing the arrival of medically expected patients and some surgical patients, and this was contributing to long waits for patients on trolleys at times. • The evidence from governance quality and safety reviews did not provide assurance for all aspects of care and risks. There were a number of areas not being considered, or not being scrutinised with enough priority or depth. However:

Summary of findings

- There were reliable systems and training to protect people from abuse. Staff were knowledgeable in safeguarding, although numbers of staff updating training in high-level child safeguarding needed to increase.
- Mandatory training compliance was improving with a notable amount of time given over to this and other continuous professional development for all clinical staff.
- Response to patient risk, including triage times, was improving. The new rapid assessment and treatment service was making a noticeable difference.
- Levels of nursing staff were coming up towards planned levels, although the number of consultants was below recommended levels.
- Patients were treated in line with legislation, standards, and evidenced-based guidance.
- There were competent and experienced staff who worked together to deliver effective care. Annual assessments of the competency (appraisals) had much improved.
- Patients and people supporting them were treated with compassion and consideration and vulnerable patients were supported.
- A high number of patients received their first treatment within the standard of 60 minutes and no patients had waited on a trolley for more than 12 hours after a decision was made to admit them.
- There was experienced, committed, caring and strong leadership. The leaders understood the challenges they faced and had ambitions for improving and innovating.
- Staff felt respected and valued. There was encouragement of openness, candour and collaborative working. There had been strong innovation and encouragement through continuous professional development, and acknowledgement of success and excellence.

Medical care **Inadequate**

We rated this service as inadequate because:

- There were significant flow issues out of the hospital. During the inspection there were over 100 patients unable to leave the hospital due to an inability to access community services. On

Summary of findings

(including older people's care)

average 97 patients a month were waiting longer than seven days to be discharged. As a result of this patients were at risk of deteriorating both physically and mentally.

- As a result of the flow issues there was not enough capacity within the hospital to manage the patients. There were 40 medical outliers on surgical wards, and areas such as theatre recovery were regularly being used to accommodate medical patients overnight.
- Due to arrangements for getting agency staff there were frequently times on wards where they were short staffed which patients felt the impact of. Some patients told inspectors how they had soiled themselves as a result of waiting for staff to attend to them.
- Some practices of infection control were unsafe. We found that on one occasion two bowls of bodily fluid were left in the sluice room and that some wards were physically messy, with incontinence pads on the bathroom floor and litter by beds.
- Staff were not sufficiently trained to recognise the abuse of children. Safeguarding children training was well below the trust targets. Some consultant staff did not have sufficient manual handling training to keep people safe. In some ward areas less than 50% of the staff were sufficiently trained in children's safeguarding.
- In the Medical Admissions Unit we found a resuscitation trolley that did not have regular checks conducted on it to ensure the equipment was safe to use. In 2016 there were 45 separate occasions where the check was not complete. Weekly checks were rarely completed. We also found on the Medical Admissions Unit that medicines were not secure. Treatment room doors and medicine cupboard doors were left unlocked and despite CQC escalating our concerns found that practice did not change.
- We found on numerous occasions that records trolleys were left unlocked.
- Due to the high pressures of the job (at all levels) there was a disconnect between the local and divisional teams resulting in staff on the wards

feeling that they were not supported. As divisional teams were focused on large issues such as flow through the hospital there was limited capacity to manage the ongoing risks on wards.
- There were many risks which the divisional team should have had oversight of which they did not. When risks were escalated wards felt that they did not get the support to address or mitigate them.
- There were low levels of staff satisfaction on wards and staff did not feel respected, valued, supported or appreciated. Although staff understood what the vision and values of the trust were they were not able to fully live by them due to the job pressures.

However:

- There was adherence to the duty of candour throughout the incident investigation and complaints investigation processes. Staff we spoke with understood the principles of the duty of candour and their responsibility to report incidents on the computer systems.
- Despite the high workload patients were consistently positive about the care they received. Patients were overwhelmingly positive on Wellington Ward and in the Coronary Care Unit.
- We saw that treatment was planned and delivered in line with evidence based practice. There were innovative ways to record observations and ensure that appropriate risk assessments were completed.
- There had been significant improvements in the stroke service. In the national stroke audit the trusts rating had improved from a level E to a level D.

End of life care

Inadequate

We rated the end of life service as inadequate because:

- End of life risk and quality information was not fully understood by ward staff and issues were not routinely reported as incidents.
- End of life care incidents were not routinely or robustly scrutinised for safety and quality improvements.
- Improvements were required to how treatment and care plans were completed by staff. This

Summary of findings

included how doctors completed treatment escalation plans and how all clinical staff assessed and documented patient's personal, psychological and spiritual needs, goals and wishes.

- There was a lack of understanding by staff throughout wards that end of life care extended to the potential last year of life and care was not restricted to cancer.
- Some medical staff lacked training and understanding regarding when it might be appropriate to consider end of life care instead of active treatments.
- The specialist end of life team was small and the rate of referrals to the team was increasing. There was limited cover for absences and no succession planning in place.
- There was inconsistency in understanding by senior ward staff regarding which nurses had in date training and competence to set up and monitor syringe drivers (used to automatically deliver medicine under the skin).
- Governance processes were not fully developed to ensure safety and quality issues were thoroughly reviewed and appropriate actions put in place.
- There was a lack of routine audit activity and no systems in place to gather feedback from patients and those people close to them in order to make safety and quality improvements.

However:

- There was access to specialist advice regarding end of life medicines at all times. There were sufficient stocks of medicines and syringe drivers (equipment used to automatically deliver medicines under the skin) available on wards. Patients records documented they had been prescribed anticipatory (when required) medicines to manage pain and other symptoms.
- The specialist end of life team was committed to the provision of high quality end of life treatment and care and was held in high regard by ward staff throughout the trust. The team focused on

Summary of findings

supporting generic hospital staff by building competence and confidence through the provision of direct support, education and information.

- There was a newly built cancer resource centre which provided counselling and a wide range of other support to any person affected by cancer. The centre also provided training and education to professionals and services linked to cancer treatment and care.
- The end of life care link meetings were a productive forum for learning and sharing clinical and policy updates and were valued by those staff who attended.

Royal Cornwall Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); and End of life care

Detailed findings

Contents

Background to Royal Cornwall Hospital

Royal Cornwall Hospitals NHS Trust provides care to around 415,783 people across Cornwall, which can increase twofold during holiday periods. This includes general and acute services at Royal Cornwall Hospital, elective surgery at St Michaels Hospital, day surgery, medicine and renal services at West Cornwall Hospital and maternity services at Penrice unit at St Austell Hospital. CQC only inspected the main Royal Cornwall Hospital site during this unannounced focused inspection.

At the time of the inspection and over the last few years, there had been a significant and ongoing period of instability at board level. Since the first inspection in January 2014 there had been three chief executives in post, two of those on an interim basis. A permanent chief executive was appointed in April 2016. A new chair was appointed in 2015 and had since stepped down in August 2016, with an interim chair covering whilst awaiting the start date for the newly appointed chair whose position had recently been confirmed. The director of nursing was an interim post at the time of the inspection, having been in post since December 2015, and this post was due to end in April 2017, with plans for recruitment to a permanent post underway. An interim medical director was in post since October 2016 for a period of 6-9 months and this post has been advertised externally. Similarly, the chief operating officer post was interim from October 2016, with this post also being advertised externally. The newly appointed director of human resources commenced in post in December 2016, and the director of corporate affairs commenced in post in January 2017. The director of finance was the longest standing executive member of the team having been in post for six years.

This inspection was carried out to follow up on the inadequate ratings for the emergency department and end of life care, and as a result of increasing concerns around the safety and quality of care in the medicine services, from various sources of intelligence.

Our inspection team

Our inspection team was led by:

Chair: Sean O'Kelly, Medical Director, University Hospitals Bristol NHS Foundation Trust

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

Inspection Manager: Julie Foster, Care Quality Commission

Detailed findings

The team included seven CQC inspectors and a variety of specialists: pharmacist, two medical directors, medical consultant, two senior medical nurses, senior A&E nurse specialist, chief nurse and governance specialist, end of life nurse specialist and an expert by experience.

How we carried out this inspection

To get to the heart of patient's experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

The inspection team inspected three core services:

- Medicine
- End of life care
- Urgent and emergency care

We also looked at the governance and risk management arrangements supporting those core services.

Before, during and after visiting, we reviewed a range of information we held about the trust and asked other organisations to share what they knew about Royal Cornwall Hospital. These included the local commissioning group, NHS Improvement (NHSI), NHS England, the local council and we reviewed information from Cornwall Healthwatch.

We carried out an unannounced inspection of the main hospital site only, and we held three staff drop in sessions for a range of staff with various roles and levels of seniority across the hospital. 50 members of staff came to these sessions to share their experiences. People also contacted us via our website and contact centre to share their experience.

We talked with 64 patients and 205 members of staff from across the hospital, including nurses at all levels, consultants and junior doctors, health care assistants, allied health professionals, chaplains, administrative staff, volunteers, managers and senior leaders. We observed how people were being cared for, talked with carers and family members, and reviewed over 77 patient records, including individual patient care records, patient treatment escalation plans, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms, medical notes, observation charts and pharmacy records.

Facts and data about Royal Cornwall Hospital

Key figures for the Royal Cornwall Hospital:

Local Population:

- Around 415,783 people are served by the trust, although this figure can double during busy holiday seasons
- According to the 2011 Census, Cornwall's population was 98.1% white
- Twenty-three per cent of the population were aged 65 and over
- In the 2015 Indices of Multiple Deprivation, Cornwall was in the second-to-worse quintile for deprivation
- Cornwall performed better than the England averages for 25 of the 32 indicators in the Area Health Profile 2015. Areas where the county performed worse than average included excess weight in adults and incidence of malignant melanoma

Bed capacity and activity:

- 731 general acute beds
- 107,668 general admissions between April 2015 and March 2016 (down 1% on previous year)
- 717,112 outpatient attendances between April 2015 and March 2016 (down 1% on previous year)

Detailed findings

- 84,047 A&E attendances between April 2015 and March 2016 (up 6% on previous year)

Staffing:

- 4,502 whole time equivalent (WTE) staff, comprising 586 medical staff, 1,099 nursing staff and 2,817 categorised as other staff groups.

Revenue:

- Annual operating income was £354,043,000
- Financial deficit was -£6,906,000

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
End of life care	Requires improvement	Inadequate	Good	Inadequate	Inadequate	Inadequate
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

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

Information about the service

The Royal Cornwall Hospital emergency department is open 24 hours a day, every day. The department is located within the hospital's Trelawny wing (the main building) and around to the right of the main reception. It was redeveloped into a far larger department in 2013. It has its own patient entrance with a few short-stay parking spaces for patients being dropped off by car. The patient entrance leads to the department's dedicated reception area. There is also a multiple ambulance and helicopter bay at the front door with a separate secure entrance for their personnel. The department is well marked throughout the hospital site with signs highlighted in red.

The department is led by a team of consultants in emergency medicine. The consultants, doctors and nursing teams provide emergency treatment to both adults and children with serious or life-threatening injuries or conditions. This includes chest pain, breathing problems, abdominal pain, and neurological conditions. The department also has a unit for patients who need prompt treatment for minor injuries such as suspected fractures and lacerations. There are two areas for serious injuries or conditions, known as 'majors' with 22 curtained bays. There is a three-bay resuscitation room, with specialised equipment, and one of these bays is adapted for children and young people, but can be used also for adults. The minor injuries area has treatment rooms for six patients, two of which can be switched between the adults or children's area, depending on need. For patients who need further investigation or longer periods of treatment, there is an eight-bed clinical decision unit. Patients are admitted to this unit with the expectation they will be discharged home within 24 hours following treatment and support.

The emergency department has a dedicated area for children and young people. Children are met at the main reception, and will then be admitted to the paediatric unit. This area has its own secure waiting area for children and parents or guardians.

The department provides patients with a dedicated X-ray, ultrasound and CT scanning service.

Royal Cornwall Hospital provides the only emergency department in the county of Cornwall, although it is supported by an urgent care centre at West Cornwall Hospital in Penzance, and 12 other minor injury/illness units around the county. Waiting times and the number of patients attending all these units are displayed in the emergency department, on a smart-phone App, and the trust website.

In the 17 weeks from 14 August to 4 December 2016, the department saw and treated 23,408 people. This equates to an average of 1,377 patients a week or 71,600 a year. Around 15%, or around 11,000 patients, are children and young people under the age of 16. Young people over the age of 16 are treated as adults.

We visited the department on 4 and 5 January 2017. The visit was unannounced. We met and spoke with patients, relatives and friends, reception staff, consultants, doctors, nurses, healthcare assistants, and personnel from the ambulances crews arriving at the hospital. At the time of our visit, the emergency department was receiving

unprecedented demand. There were patients being held on trolleys in the corridor, a large number of whom were awaiting to be admitted to a ward, and others waiting to be seen.

Summary of findings

We rated this service as requires improvement because:

- There had not been sustained improvement in incident reporting and analysis to recognise trends and demonstrate change and learning.
- The recognised issues with delays in medicine administration had not been addressed and resolved.
- There were aspects of safety that needed improvement. This included clear access to emergency facilities, including the resuscitation room, access to call bells, equipment maintenance and cleaning, and evidence of staff competency to use the equipment.
- The overcrowding in the department meant there were times when the nursing staff levels were not adequate.
- There had not been a sustained or satisfactory improvement in the timeliness of observations, and management of sepsis.
- Medical audits did not provide evidence of receiving sufficient priority, or bringing immediate learning and improvement.
- There were breaches in patient privacy, dignity and confidentiality when the department was overcrowded. Some of these were avoidable.
- Waiting time targets for patients to be transferred out of the department were not being met, and had deteriorated.
- The department was managing the arrival of medically expected patients and some surgical patients, and this was contributing to long waits for patients on trolleys at times.
- The evidence from governance quality and safety reviews did not provide assurance for all aspects of care and risks. There were a number of areas not being considered, or not being scrutinised with enough priority or depth.

However:

Urgent and emergency services

- There were reliable systems and training to protect people from abuse. Staff were knowledgeable in safeguarding, although numbers of staff updating training in high-level child safeguarding needed to increase.
- Mandatory training compliance was improving with a notable amount of time given over to this and other continuous professional development for all clinical staff.
- Response to patient risk, including triage times, was improving. The new rapid assessment and treatment service was making a noticeable difference.
- Levels of nursing staff were coming up towards planned levels, although the number of consultants was below recommended levels.
- Patients were treated in line with legislation, standards, and evidenced-based guidance.
- There were competent and experienced staff who worked together to deliver effective care. Annual assessments of the competency (appraisals) had much improved.
- Patients and people supporting them were treated with compassion and consideration and vulnerable patients were supported.
- A high number of patients received their first treatment within the standard of 60 minutes and no patients had waited on a trolley for more than 12 hours after a decision was made to admit them.
- There was experienced, committed, caring and strong leadership. The leaders understood the challenges they faced and had ambitions for improving and innovating.
- Staff felt respected and valued. There was encouragement of openness, candour and collaborative working. There had been strong innovation and encouragement through continuous professional development, and acknowledgement of success and excellence.

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- Not all incidents were being reported and there was insufficient evidence of how trends were recognised.
- Not all recognised trends in incidents, such as late administration of medicines, had actions against them to resolve the issues.
- There was insufficient evidence to show lessons had been learned from incidents categorised as 'near miss' when some of these could have led to serious harm to a patient.
- There was some inconsistency with the quality of serious incident investigation reports and evidence of learning from patient deaths. There was no evidence to show actions identified following serious incidents were reviewed for progress and led to improvements.
- There had not been a sustained or satisfactory improvement in the timeliness of observations, and management of sepsis.
- We observed a lack of hand hygiene at times among the staff.
- The overcrowding in the department meant there were times when the nursing staff levels were not adequate.
- The overcrowding in the department was causing reduced access to some areas, including the resuscitation room. This meant emergency evacuation may also be hindered.
- Not all patients were able to reach their call bells. These were not provided in some areas, or within patients' reach in others.
- There was no up-to-date record of review of equipment skills for staff, and a number of pieces of equipment were indicating they were overdue for servicing. Not all cleaning of equipment was recorded.
- The issues with some delays in medicine administration had not been resolved. There were two incidents during our inspection of a lack of security with the drug cupboard keys. There were some issues with medicines' management and storage in some areas, although this was mostly well managed.
- The safeguarding training was not meeting targets, particularly the advanced training for child safeguarding.

- There was a variable level of completion in patient records from comprehensive to poor, although audit work in the department demonstrated this was improving.
- The number of consultants and the hours they worked were below recommended levels, although there was active recruitment. There was good coverage by junior doctors.
- Not all patients were receiving a timely electrocardiogram (ECG) test when presenting with chest pain.
- There were increasing delays in ambulances waiting over 15 and 30 minutes to handover patients.

However:

- The treatment areas of the department were logically laid out to maintain visibility of patients.
- Mandatory training was much improved and coming up towards targets. There was an impressive length of time given over to nurse mandatory and continuous developmental training.
- There was still further progress to be made, but a much improved assessment and response to patient risk, triage and urgent treatment.
- Levels of nursing staff were rising towards planned numbers, but staff raised concerns about cover in the minor injuries' area at night being adequate.
- There was a dedicated physiotherapist in the department on weekdays.
- The department would be prepared in the event of a major incident.

Incidents

- There was a straightforward electronic system for incident reporting and analysis. All the staff we met were able to access the system and knew how to use it, and it was available to all employees. Staff were trained in the use of the system at their induction. Incident reports captured the main issue being reported (such as a patient fall, a medicine error, or a staff injury). Staff recorded the person reporting the incident, when it happened and where, the level of harm, if any, and written comments describing the incident. These sections were used to produce reports, look for trends, and demonstrate when changes or improvements were needed. Any temporary staff who did not have access to the system were required to notify a nominated member of staff of any incidents. They would then sit alongside the member of staff who would report the incident from their information.
- There was an understanding of the importance of incident reporting and feedback among staff. Those we spoke with said they knew that reporting incidents was not to apportion blame when something went wrong, but to improve systems and processes to avoid them being repeated. Staff knew that feedback from incidents to staff who reported them was important. They said it not only recognised they were providing important information about quality and safety, but they saw the information was being considered. Staff told us they were encouraged to report incidents and be open and honest.
- Staff knew what events constituted an incident, but not all incidents were being reported. We recognised this was due almost entirely to staff, particularly the nursing staff, not having enough time when faced with unprecedented demand. Staff described incidents as events such as a patient falling (with or without injuring themselves), the department being overcrowded and patients being held on trolleys, and medicine errors or delays. It included staff or patients being threatened or abused by others, and a misdiagnosis, or error in treatment. Staff admitted to us that the current difficulties being experienced by unprecedented demand on the service was negatively affecting their time and resources. One member of the nursing staff said they had gone home after a long shift and recognised, while they were thinking about it, that there had been "probably a number of incidents I should have reported, but then it's the choice between that and patient care." The member of staff said the unreported incidents were not serious, and they would have reported anything significant. However, they recognised the incidents would have been evidence of pressure in the department and failings in the system to manage it. When we visited the department, we found three delays in patients being given prescribed medicines. None of these had been reported as incidents, although the minutes of the safety meetings in the department showed there had been reports of this nature in the recent past. This would suggest the frequency of this incident was higher than recognised.
- There was insufficient evidence to show lessons were learned from events that were categorised by the

department as a 'near miss'. This included a patient having records from six other patients in their medical notes, an unsafe transfer of a patient, and the wrong medication given to a patient. The comments made in the 'lessons learned' section of the report rarely demonstrated any learning and related more to reasons for the incident having happened. This lack of a demonstration of lesssons being learned from near miss incidents did not provide assurance these would not recur and become something more significant.

- Some events were listed as 'no harm' in the incident report, when this would not have been possible to determine. A patient had been transferred to a ward without having had any pain relief and said to be in pain. This was described as 'no harm'. Another example was a patient having "a significant delay in the management of his sepsis." This was also described as no harm. Our concern around this is because incidents of low harm and no harm were not specifically analysed or reviewed by the department, and there were some that should have been subject to an investigation.
- Incidents were being discussed at monthly safety meetings, although there was limited reference to any trends in general reporting. Serious incidents were presented at the meetings and minutes were made of the discussions held. There was some evidence of learning and improvements, including changes to treatment plans and communication to patients. Those actions that were agreed were highlighted on an action log and were the responsibility of a named member of staff. Actions remained open until they had been completed. There was some evidence, albeit limited, of recognition of trends in reporting. The most often quoted was the issue with overcrowding in the department. There was also mention in the December 2016 minutes of incidents of patients not receiving timely treatments, including analgesia and antibiotics, but no actions against this.
- The investigation reports (known as root-cause analysis reports) had improved since our previous inspection, but there were still inconsistencies. For example, in one report from an incident in January 2016, the lessons learned as written in the executive summary were almost entirely a copy of the contributory factors, although they were more relevant in the detailed section. In another from an incident in July 2016, the lessons learned were around notable practice only. In a report from an event in March 2016, the lessons learned were poorly written. There was also a significant issue. The patient, who subsequently died, had a history of mental health problems and was described as probably having a learning disability. In addition, this was noted as a contributory factor, but not considered as a learning point around management of vulnerable patients. Otherwise, there was good detail in the reports, but without any obvious consideration of human factors that should have been considered (such as staffing levels, status (workload) of the department, and skill mix of staff on duty). There was discussion of serious incidents in the departmental safety meetings, but no evidence to demonstrate action plans were reviewed for progress.
- The emergency department had not reported a 'never event' in at least the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were regular mortality and morbidity meetings as part of the safety-meeting programme. One of the consultant team was the department lead for mortality and morbidity and regularly presented cases to the monthly safety review meetings. Discussions with staff and in the department gave some assurance that mortality and morbidity was a regular area of both learning and investigation, but the notes kept did not provide evidence to back this up. There was a limited report on the cases investigated at one of the four recent safety meetings we reviewed. However, although learning points were highlighted, there was no accountability shown for how the lessons or changes to practice were going to be embedded in ongoing practice. There was no reference to whether there had been any avoidable or unexpected deaths. However, staff were able to talk about learning from a case involving a patient with an abdominal aortic aneurysm (known sometimes as a triple A) and this had resulted in a review and changes to clinical procedures.

Duty of Candour

- There was acknowledgement among the senior team and an understanding of the requirement to apologise and explain to people when something went or could have gone wrong causing significant harm. Regulation

20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The staff we met were aware of their responsibility to be candid, open and honest with patients, and to apologise for mistakes. There was reference to this responsibility in four investigation reports into serious incidents. The reports indicated that senior staff had spoken with and written to patients or their relatives in the event something had gone wrong. In some cases, the emergency department had not been at fault, and the harm had been judged as unavoidable in the circumstances. The department had, nevertheless, written to the patient or their relative to tell them what had happened and explain how the event had been investigated.

Safety thermometer

- The department had been performing relatively well in the NHS Safety Thermometer. The NHS Safety Thermometer is a monthly snapshot of patients staying within the hospital and records any avoidable patient harm in certain categories. This was measured each month for the clinical decision unit in the emergency department, which was the area where patients were admitted for one night or potentially more if necessary. In the 12 months from January to December 2016, the department had reported four months of 100% harm-free care. In the remaining eight months:
  - In seven months, harm was caused to patients from falls in the unit. There were between one and two a month, totalling nine falls among 45 patients (20%), although these originated at the patients' homes.
  - In the other remaining month, harm was caused by a catheter-associated urinary tract infection.

Cleanliness, infection control and hygiene

- The majority of the department was visibly clean, well organised and tidy to make cleaning easier and optimal. This visit was unannounced, and on our arrival, there was unprecedented demand on the service. Despite this, and patients queueing in the main corridor on trolleys, the cleaners were working hard to keep the department clean. In all areas we visited, the floors, walls, curtains, beds, trolleys and areas in general were visibly clean. We did highlight a significant amount of dust in one of the leaflet containers in the minor injuries area, which was particularly difficult to clean. One of the cleaning staff attended to this immediately and it was clean within a short space of time. The cleaner told us they would make sure this was placed onto the rota in future as they recognised cleaning of this container was not being regularly undertaken.
- Some areas in the department were showing signs of age, wear and tear, which was making them harder to keep clean. There were residues of sticky tape on the staff workstation desks in the clinical decision unit. Sticky tape should not be used in clinical areas as it is prone to be removed or fall off, and this leaves a sticky residue, which can harbour germs. The resuscitation area was kept clean and tidy, but as with the clinical decisions unit, had not been part of the 2013 department rebuild. Areas were becoming less easy to maintain and therefore harder to keep as hygienic as possible.
- There was an observed lack of hand hygiene at times. We stood to observe staff working on a number of occasions, and particularly on the main corridor area where patients were queueing. There were no facilities in the corridor for staff to wash their hands, and as this was not designed to be a place for patients to wait, we would not expect this to be the case. However, we did observe a number of staff, including doctors and nursing staff attending patients without having washed their hands first (or after attending the previous patient). There were also too few clinical sinks to be able to do this beyond patient cubicles or rooms.
- There was an isolation/decontamination room in the department. This is a requirement within an emergency department and should be available for use in certain incidents including serious contamination incidents or infection outbreaks. As required by the Department of Health guidance (HBN 15-01), the room was set aside for this purpose and located close to the ambulance entrance to the department. The room was also accessible from outside through a set of external doors, and the surrounding external area was able to accommodate containment tents and fire and rescue services if needed. The risk register described how there had been a review and improvement in staff training to ensure the right staff were trained, and appropriate equipment was available should there be an incident.

Environment and equipment

- The department was laid out logically. The areas for patients with more serious injuries (called 'majors') was the central hub of the department and directly beyond reception and ambulance access. Each area had staff workstations from where most patients were visible. Staff said they would not locate patients with significant risks in the corner bays, which were not easily overseen by staff. The minor injuries area was in its own co-located but discrete area, and within this was a room specifically for patients with ophthalmic problems. There was a well-equipped treatment room for provision of minor surgical procedures. The diagnostics and screening department was co-located with the emergency department, and there were dedicated X-ray and CT scan facilities within that service.
- There were good facilities in the paediatric area. Access was secure and patients and relatives could only be admitted by emergency department staff. The cleaning staff we spoke with said they would ensure they did not admit people who might ask them for access to the paediatric area. The way the reception area in the paediatric area was situated gave nursing staff a good view of the waiting area.
- The department followed most of the Department of Health guidance (HBN 15-01) for emergency departments although there were some issues with safety due to overcrowding in the department. One area of concern was with the resuscitation room. The guidance stated this area should have "easy unimpeded access". As recommended, it was located close to the ambulance entrance to the department, and entry avoided the main waiting area. However, on two occasions during our visits, trolleys for patients being held in the main corridor were impeding access to the first set of doors. This meant patients would have needed to be moved in the event of an emergency requiring access to the resuscitation room. In the interview room for patients who might be suffering a mental health crisis, one of the two required access doors leading into the main corridor was locked, and blocked by patients who were being held on trolleys. This increased the risk for safe entry and exit from the room.
- There were problems with access to emergency call bells. There was a public toilet located in the waiting area, but this had no cord pull attached to the emergency call bell to alert staff to a problem. Some toilets within the department had call bells that would be difficult to reach, and one toilet in the clinical decision unit had no cord pull attached to the call bell. We visited the department again on the 25 April 2017 and found all the cord pulls had been replaced with highly visible straps which were fit for purpose. Not all patients were given or enabled to reach their call bells, which were on a length of cable designed to reach a patient in a cubicle bed. We looked into 16 of the cubicles on the first day of our inspection and in these, 10 call bells were out of reach of the patient. We looked into five of the eight bed spaces in the clinical decision unit. Only one of the call bells was in reach. We walked around with the matron on the second day of our inspection and further highlighted the problem. There was no call bell in the interview room for patients who might be suffering a mental health crisis. A call bell in this location was a clear recommendation of the Royal College of Emergency Medicine (2013). This was raised with the matron at the time of the inspection and we were told arrangements were being made for installation of an emergency call system.
- There was no clear or comprehensive summary record held locally covering staff competency for using equipment. There were, however, individual statements for staff demonstrating they had been assessed for their competence in using equipment. These had not, however, been logged to get an overall picture which was available to show us. However, there were centrally held records available on the trust's electronic staff records system which could have been downloaded. There were study days set up by the lead for medical devices, and a number of staff we met said they had attended these and found them useful, particularly when a device had changed or something new had been introduced.
- There was a lack of assurance about the maintenance and servicing of some of the monitoring equipment in the emergency department. A number of the monitors and other equipment in use were labelled as being out of date for portable appliance testing for between six and 12 months. Two paediatric patient monitors had electrical safety certificates that were out of date by six months.
- There was a lack of assurance about the cleaning of equipment. There were well-structured and comprehensive books called 'cleaning diaries'. These

contained daily and weekly records as appropriate. In majors' area one this was rarely completed. The last dated entry was 10 October 2016. In majors' area two, we could not locate the book. In the resuscitation room, the book was fully completed and up-to-date. In the clinical decisions unit there was no entry since 14 November 2016. It was relatively well completed in the minors' areas. Our inspection of this equipment did not find any evidence of unsatisfactory cleaning, but there was no record to support this.

Medicines

- The department was aware of a problem with some delays in the administration of medicines to patients, but had not found a failsafe solution to this. The overcrowding in the department was not helping staff who were trying to treat multiple patients. In the safety meetings minutes from December 2016, incident reports of patients not receiving timely treatments of analgesia, antibiotics or fluids was recorded as a trend. There were no actions recorded to deal with this. On the first day of our inspection we found two patients had not received medicines on time, and the eventual administration was around two hours late. We then found a person had not had their insulin administration and it was overdue for around two hours. We alerted a member of the medical team who attended to this urgently. Putting this into context, all other patient charts we reviewed showed patients had received their medicines on or near the time they were due.
- There was good medicines' management in some, but not all areas. Medicines, including intravenous fluids, were stored securely. Medicines' cupboards in the resuscitation room were unlocked when the department was occupied to enable quick access to medicines, but locked when unoccupied. Controlled drugs were stored, recorded and handled appropriately. Spot checks on balances showed that contents of the cupboard matched the register and daily stock checks were undertaken. Medicines observed in minors and majors were within their expiry dates. Any medicines administered by ambulance staff were on a record made when the patient was admitted to the emergency department, and kept with the patient to reduce the likelihood of duplicate doses.
- There were some areas where medicines' management needed improvement. These related predominantly to the clinical decision unit. Some medicines in the trolley were out of date. Many individual strips of tablets stored in the trolley were out of their original packaging. Several of these had been cut and did not have the batch number and expiry date. This meant staff could not confirm if the medicines were within their expiry date, and safe to administer. In addition, medicines should be stored in their original packaging to reduce the risk of selection error. There were two unidentified loose white tablets in the medicines' trolley. There was a strip of diazepam 5mg tablets in the medicines' trolley. A senior member of staff said this should have been stored in the controlled drugs cupboard, due to the risk of diversion and misuse. Despite these issues, we found, the department had scored 100% in its medicines' storage audit for November 2016 (most recent data).
- There were two breaches in the security of the drug cupboard keys. On two occasions we witnessed the keys left unoccupied and not under the supervision of the nurse in charge. This was raised with senior staff. Following our inspection the hospital trust has pointed out that the drug cupboard required staff to have both the keys and also a swipe card to gain access. This dual security system meant there was a second-stage prevention of unauthorised access to medicines.
- There was safe storage of medicines requiring cold storage, and safe handling of prescription pads. Medicines that required refrigeration were stored at the correct temperature and fridge temperatures were monitored and recorded electronically by the pharmacy. Prescription forms were stored securely and the serial numbers were recorded when prescribers issued them to patients.
- Patient identity was checked before medicines were given. We observed nurses administering medications to patients and carrying out appropriate checks first. This included checking the patient's name, date of birth and allergy status on both the patient's wristband and the drug chart.
- An appropriate range of emergency medicines was available. Resuscitation trolleys were secure and tamper evident. Daily and weekly checks were carried out and recorded, although there were some gaps in the written checking records. This had been noted by staff and reported in the department's December 2016 newsletter with a reminder to staff to ensure this was done. There was piped oxygen to patient bays, and portable oxygen in use. The oxygen in use was in date and stored safely.

- There was provision for medicines for people to take home. Venous thromboembolism (VTE) prophylaxis kits were available for people to take home when prescribed a course of subcutaneous low molecular weight heparin. These were provided in a cardboard carrier containing the prescribed medicine, a sharps' box for safe disposal of used needles, and a VTE information leaflet.
- Nurses were able to prescribe or administer medicines under guidance. There were a broad range of Patient Group Directions available to staff. These were approved documents permitting authorised members of staff to supply or use prescription-only medicines with certain groups of patients within approved guidelines.

Records

- There was a variable level of completion with patient records, with some having a high level of completion, but others being poor in places. We saw a number of examples of patients in the corridor with no nursing documentation produced. There was a record of intravenous fluids started for a patient, but with no evidence of the date or time. Some patients had no pain score. Some of the reviews by doctors had no time recorded. We reviewed the notes for a patient in the clinical decision unit at 3:30pm. There had been no care-record entries since 7:30am, which could suggest the patient had not received any support. There was no falls assessment for this patient who was in their mid-70s and living with dementia. There was, however, a good 'This is Me' leaflet with helpful information about the patient. Other records in this sample of 10 sets of records were better, but we found inconsistency and variation in what was mandatory to complete, and what was completed following risk assessments.
- Some patient paper notes were not always securely stored to prevent them being removed, tampered with or seen by unauthorised people. On the first day of our inspection, paper records for patients in the corridor were in their files in a cardboard box sitting on a desk in one of the majors' areas. On the second day, without our prompting, these had been removed and were in slightly improved storage within a workstation. The notes relating to patients in the cubicles were kept appropriately in secure locked storage.
- There had been an improving picture in audits of completion of documentation. Results for the period January to mid-December 2016, produced by the nursing staff, showed completion rates rising almost continually. Documentation audits in January 2016 showed completion of around 60%. By the end of the year, this had risen to around 95% with gradual month-on-month improvement. Care-round records in January 2016 showed completion of around 50% (one week as low as 39%). By the end of the year, this had risen to around 90%.
- Patient records were updated on the electronic system in real time. The department was required to commence nursing observations, for example, on paper notes. Other records, such as medical notes, and the majority of medicine prescribing, were made within an electronic patient record. An audit of data entry to the electronic patient record system showed that in November 2016 (the most recent data) 98% of entries were made within 30 minutes or less.

Safeguarding

- There were processes, practices and systems to keep people safe from abuse, or protect them. There were policies and tried and tested procedures that staff were aware of and knew how to follow. The department had link nurses for providing support to staff who recognised when a patient might be at risk of abuse, or had clearly been subjected to abuse. The trust had senior staff who had overarching responsibility for adult and child safeguarding, and staff were well aware of who these people were and when and how to contact them.
- Staff were knowledgeable about what constituted abuse and how to recognise it. Staff recognised that abuse would include some of the more obvious things, like injuries and fractures, but also the less obvious markers, like neglect, frequent attendance at the department, or living in vulnerable circumstances. Staff said they would seek senior nurse or doctor review if they had concerns, or where the evidence could lead to uncertainty. Staff said they would err on the side of caution with any suspicions, and always ask for advice or make a referral. Each patient who was subject to completion of a nursing care record (which should be all patients) would have a safeguarding check. There was written guidance in the record as to how to proceed with any concerns. The electronic patient record system had a system for alerting staff of child protection concerns regarding a child or young person attending the department.

- Updated safeguarding training for staff was not meeting trust targets (95%) at any of the required levels, although there was a variation in compliance. The situation at the end of November 2016 (the most current data) was:
  - Safeguarding adults level 1 (to be undertaken by all staff) 91%
  - Safeguarding adults level 2 (all clinical staff) 76%
  - Safeguarding children level 1 (all staff) 86%
  - Safeguarding children level 2 (all clinical staff) 75%
  - Safeguarding children level 3 (all registered nursing staff and above) 58%
- Staff were able to explain the application of the law and their responsibilities in relation to suspected female genital mutilation. There was clear guidance available for staff to follow.

Mandatory training

- There was much-improved compliance with mandatory training updates, although not quite at trust targets of 95%. Of the staff in the emergency department, 79% had undertaken their mandatory training updates by the end of November 2016 (the most current data). The consultants were mostly up-to-date with their mandatory training, although with a few gaps to be closed. However, it appeared that no consultants had updated their patient manual handling training. The trust updated us following the inspection to confirm that this course was not available to consultants in the 2016 training programme. However, it has now been added to the curriculum. In the nursing teams, the courses that were below 70% were control of infection, fire safety awareness, and health and safety awareness. There was no evidence of mandatory training being discussed in the department and the detail within this interrogated to see where improvements were needed.
- Nursing staff were given a somewhat unique (as compared with other NHS trusts and emergency departments) and notably good length of time to undertake their annual mandatory training. A new scheme in the department had introduced a mandatory training programme that took place over three days. These sessions were for nursing staff to update the training they would have received at induction and which was updated on a regular basis. There was a broad range of subjects including statutory training like safety and fire risk, but also service-specific topics. These subjects ranged from conflict resolution, sepsis, duty of candour, alcohol awareness, and aseptic non-touch technique, among others. Staff were able to attend the training days, which were run at various times throughout the year, as teams.
- There was some possible contradiction within the mandatory training data. All nursing staff were now enrolled in the three-day sessions. However, there was no consistency in the numbers of staff completing the courses. For example, as staff attended in teams, it was not clear why completion of some courses were completed and others were not.

Assessing and responding to patient risk

- A detailed audit of sepsis management carried out within the emergency department had not provided reassurance that management had improved. Few of the results had improved over similar measures in the April 2015 to March 2016 year. In November 2016, of 18 patients with severe sepsis, only four had all the elements of the sepsis six standard (the collection of the vital signs) completed within an hour, although 92% were eventually completed (although the report does not say when). This left 8% of the vital signs not completed, and this affected eight of the 18 patients. Seven of the patients had one vital sign not recorded, and one had two missing. Nine patients (50%) had antibiotics administered within an hour, which was a significant deterioration from the audit results for the Royal College of Emergency Medicine (see Effective section).
- There were local safety procedures for staff to follow in the event of overcrowding in the department, but the document produced to describe these did not include a rule around constant nursing presence. The safety procedures document concentrated on staff not compromising safe care. Handovers were to continue uninterrupted. Safety rounds were to be completed every two to four hours to reassess patients, particularly those who had been in the department longest. There were, nevertheless, a number of occasions when there was no nursing presence in the main corridor and several patients waiting on trolleys. This meant there were times when staff did not have oversight of patients.
- There had been good results in completion of National Early Warning Score (NEWS) documentation. This was documentation used for patients to alert to staff to one or a combination of six vital signs being measured at a high enough rate to require medical intervention. This

could be from one or a combination or measures of, for example, high blood pressure, poor respiratory rate, or a poor level of consciousness. The management and response to NEWS documentation had been high, being above 90% in the majority of 2016, and up to 96% by year-end.

- The department operated with two systems for making a rapid assessment of patients. The triage process was designed to look for indications of risk or deterioration and get patients seen urgently by a doctor if this was needed. It was also designed to provide pain relief and gather essential information, which would determine the priority for the patient to be seen. The rapid assessment and treatment service was provided to patients attending with potentially serious conditions. This included clinical investigations and observations and commencing patients on care pathways relating to their condition or suspected risks. These pathways included care bundles being started for acute kidney injury, sepsis, chronic obstructive pulmonary disease, chest pain, stroke, heart failure and pneumonia.
- The emergency department rapid assessment and treatment service was showing improvements to triage times. The service had been established for around a year, and had been through a number of changes, before settling into its nurse-led procedure. The service had a dedicated team providing assessment and treatment to majors' patients, with a target for patients to be seen within 15 minutes. The service was provided around the clock. Due to the high demand on the service, described below in the Access and flow section of the report, the triage times were not meeting their 15-minute standard, but were showing a noticeable improvement. Nevertheless, the triage time, on average, had not reached 15 minutes since at least April 2015. However, since May to October 2016 it had dropped below 30 minutes and was only slightly above this in November 2016 (32 minutes). Triage times were important to ensure staff were aware of patients who were high priority.
- There were systems and processes for the management of deteriorating patients, although this was not always working effectively with patients presenting with sepsis. However, there was an effective response to patients presenting with a strokes or trauma. Although there was no computerised central monitoring system for doctors and nurses, all patients were under the care of a named nurse and doctor during their stay. Doctors we spoke with said they had support from the consultants when they had concerns about a patient's potential deterioration. Nurses said they would also escalate concerns to more senior staff, or the medical team. Consultants were available 24 hours a day on an on-call rota and all lived within the specified 30-minute journey to reach the department in person.
- There had been delays with patients presenting with chest pain getting an electrocardiogram (ECG), which had been acknowledged by staff. ECGs test for problems with the electrical activity of the heart. A request to staff had been made to improve times for performing an ECG in these and other possibly linked circumstances. This included looking at a patient's history if they presented with other local pain, as this might indicate a myocardial infarction (heart attack). If patients were not being triaged in 15 minutes due to overcrowding, chest-pain patients should be prioritised, and the nurse in charge made aware of a risk of the ECGs not being carried out in 10 minutes.
- There were increasing delays in ambulances waiting over 15 and 30 minutes to handover patients. The NHS national quality requirement was for all ambulance handovers to take place within 15 minutes, with none waiting for more than 30 minutes. The delays over 15 minutes was 10% of ambulance admissions. In the most recent data from the trust board integrated performance report, delays for over 15 minutes had increased since April 2015 from 45% to 60% in October 2016. The number of ambulances waiting over 30 minutes was also climbing, but there had been a number of significant drops recently. In April 2015, 150 ambulances were delayed by 30 minutes or more. By August 2016, this had increased to 400. In September 2016, there was a significant drop to 100, but this increased again to 225 in the following month. The ambulance personnel we met and talked with on our inspection said this was due to overcrowding, and recognised the staff teams were doing their best to take handover of a patient.

Nursing staffing

- There were times when the nursing staffing was not at adequate levels to manage the queueing of patients in the emergency department corridor. This had been raised by the senior staff and was on the trust's risk register. The nursing staffing levels were established to run a department that was expected to be busy. However, unprecedented numbers of patients'

queueing to be moved to a ward, or multiple arrivals meant nursing staff were managing unexpected numbers of patients. The clinical governance meeting minutes from December 2016 stated:
  - "Corridor queue discussing. Occurring daily, becoming the norm."
  - "Concern over nursing staff levels to adequately manage the corridor queue."
  - "Band seven nurses acknowledge having to fight for additional nurse on daily basis."
- The emergency department nursing staffing numbers had improved and were coming closer to planned levels. This was after a strong performance in recruitment particularly towards the end of 2016. There had been 31 staff recruited in the year 2016. There were nine new staff due to start in the near future. However, there had been a significant level of vacancies during 2016. The 2016 year started with a vacancy rate of 17%, which fluctuated around one or two percent either up or down until October 2016. At this point, there was a review of the nursing establishment and increase in the number of nurses employed within the department. This led to a rise in vacancies for band four and five nurses and an overall vacancy rate of 31% while the newly created posts were recruited to. The recruitment reduced this to 21% by December 2016, and in January 2017 it had further reduced with the recruitment of band four and five nurses to 12%. The vacant posts were covered in the meantime by long-term agency staff.
- Due to recruitment, there was a reducing use of agency staff to fill vacant posts, although the levels had been high. However, the matron and service manager told us they were assured there were rarely more than two agency nurses on duty at any time. The use of agency staff would no longer exceed 20% on any shift, which was a level where it was recognised that care could be compromised by too high a proportion of temporary staff. In 2016, the percentage of agency nurses had started the year at 11%, risen to a high point in June 2016 of 17%, but by the end of December 2016 had dropped to 8%. The recruitment coming through in January 2017 and the falling vacancy rate would be expected to reduce this to the lowest level for at least 13 months. The most often-employed agency nurses were now staff who had been regulars in the department and familiar with systems and processes, and the members of the substantive team.
- There was a good mix of skilled and experienced nurses and healthcare assistants in the department. There were senior nursing staff in bands eight (matrons), seven (senior sisters and senior charge nurses) and six (sisters and charge nurses) supporting band five nurses and band two, three and four healthcare and emergency department assistants. The band seven nurses were in charge of the day-to-day running of the nursing teams in the department, with the band six nurses in charge of their own sub-teams in the different areas.
- There was appropriate paediatric nursing cover. Emergency department staff had access to a senior paediatric nurse at all times and there was a nurse with advanced paediatric life support skills on each shift.
- There was a period built into each shift to provide handover for the nursing teams. Each nursing team worked 12.5-hour shifts. Handovers took place at 8am and 8pm. There was a formal handover of the situation within the department, key messages and risks, with time for brief teaching sessions. There was then a handover by the shift leaders to the new shift leader coming into manage their area.
- When there were pressures in the emergency department, nursing staff were requested or volunteered to come to the emergency department to provide support. Although this was usually appreciated, it also brought some difficulties with team leaders being temporarily distracted from tasks in order to organise additional members of staff. Some staff told us they felt out of their depth when asked to go to the department at short notice to help. The senior nursing staff said most staff who came to them to help had appropriate skills, and, on balance, the help was valued.

Medical staffing

- The consultant team understood their roles and those of others to maintain a safe department. The clinical director had convened a meeting of the whole team in June 2016. The minutes reported how there was discussion and approval as to what commitment was expected from the consultants, including on-call and call-in criteria (when the consultant came in person to the department when on call). These criteria related to there being high levels of patients, multiple patients who were significantly unwell, and a significant problem with patients being moved on from the department.
- The consultant numbers were not up to planned levels. There were 10 consultant posts budgeted for the

department, and currently 7.5 full-time equivalent consultants in post. This, according to the Royal College of Emergency Medicine (RCEM), was just slightly above (better than) the average number of consultants in NHS emergency departments – which was a recognised area of shortages in staffing. The RCEM recommended the minimum level of consultants in an emergency department was 10. Another emergency medicine consultant was starting work at Royal Cornwall Hospital shortly, and the department was actively advertising. There was often support and care provided by other consultants in the hospital, and one of the consultant physicians from the medical assessment unit worked between both units and we saw them in regular attendance in the department.

- On weekends, the consultant hours of presence were below the target of the Royal College of Emergency Medicine (RCEM) of 16 hours a day, every day. This was not helped by the vacancies for consultants in the department. At the time of our inspection, the consultant cover from Monday to Friday was from 8am to 10pm, and therefore close to the target. We were told by staff, including the nursing staff, that most consultants tended, however, to stay later and worked longer hours. The weekend cover was from 8am to 6:30pm, again with consultants often staying later. This level of cover fell below the RCEM target. Consultants were then on call for trauma, paediatric and stroke patients, and any other patients who met the criteria. They could be back at the department within 30 minutes.
- There were senior doctors working with the consultants in the department around the clock. There was at least one, and usually two middle grade doctors on duty at all times. The department had 10 foundation year one and two (newly qualified doctors) and a range of specialty registrars (ST1, ST2 and ST3), clinical fellows, core trainees (CT1 and CT3). There were also three GPs who worked from 6pm until midnight on Friday, Saturday and Sunday to provide a GP walk-in service.
- We were concerned with the rota for the foundation year two doctors on duty. A report from Health Education England raised concerns about the rota and the working patterns for this group of doctors. This had been an issue in the department for the past five years. In response, there had been a change to the rota times for junior doctors in August 2016, but Health Education England remained concerned this had yet to fully address the problem.

Allied health professionals

- There was support from allied health professionals, both on a permanent basis and ad hoc. The emergency department had a dedicated physiotherapist working Monday to Friday from 9am to 5pm. As well as providing therapy and advice to patients, they were involved with teaching for trainee and student doctors and nurses. Other allied health professionals were available to attend the department upon request for a review. This included occupational therapists, and regular review and support from the hospital pharmacist team.

Major incident awareness and training

- The hospital had a detailed and current major incident policy. The policy in current use had been published in November 2015 and was valid for three years. The policy outlined the roles of every member of staff and contractor in the event of a major incident, significant incident, or emergency. The risks the trust might be subject to were outlined. All of these would be likely to involve the emergency department. The nurse and consultant in charge of the emergency department were therefore at the top of the cascade list for staff to be contacted in the event of an incident. Actions and responsibilities of key emergency department staff were then listed, along with how they would coordinate with senior executive staff managing the incident.
- The major incident policy included instructions on how to respond to chemical, biological, radiological or nuclear incidents (CBRN) or hazardous materials (HAZMAT). As well as emergency department staff, members of the other emergency services including the police, fire service and ambulance service would be instructed.
- There were training and table top exercises to prepare for major incidents. This had recently included the department being involved in a simulation exercise as part of their training in emergency and disaster management.

Are urgent and emergency services effective?

Urgent and emergency services

(for example, treatment is effective)

Good

We rated effective as good because:

- National guidance and evidence for best practice was used to plan and deliver care.
- Pain was being effectively managed.
- The department excelled in the timeliness, care and treatment of patients suffering a stroke or trauma.
- There were competent staff with the right skills, experience and knowledge. Appraisals of staff had improved and were heading towards trust targets.
- Professional development and competency training had improved. There was an excellent range of training for medical staff, including outstanding simulation training and production of high-quality case studies, teaching materials, guidance and protocols.
- There was a strong ethos in the hospital and the emergency department for multidisciplinary working.
- All services needed to provide effective care were available seven days a week.
- There was a good understanding and application of the legal principles for gaining patient consent, or what to do when that was not possible.

However:

- The Royal College of Emergency Medicine (RCEM) audits were not given a satisfactory priority in the year in which they were to be undertaken, and the results of the asthma audit were from an audit done outside of the required period, and with an insufficient dataset.
- The results of the RCEM asthma audit were poor, although from a small dataset.

Evidence-based care and treatment

- Policies, care and treatment pathways, and clinical protocols were based upon recognised guidance, including that of the National Institute of Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM). For example, pathways referenced NICE guidance around acutely ill patients in hospital (NICE 50) – which included guidance for use of the National Early Warning Scores. NICE guidance was used for adults receiving intravenous therapy, and patients at risk of venous thromboembolism. Quality improvements were based upon guidance from the RCEM. Clinical standards were based upon those of the RCEM Clinical Standards – this included standards for children and young people. Overcrowding guidance for staff was based on RCEM guidance for Tackling Emergency Department Crowding (2015). Policies, procedures and guidelines were available for staff to access on the trust intranet.
- The department undertook the annual national audits from the Royal College of Emergency Medicine (RCEM). (Results are reported in Patient outcomes below). These audits were designed to benchmark current performance in certain topics across emergency departments, and identify areas of improvement. The audits were to be undertaken from January 2016 and completed by the end of December 2016. Two were done almost at the end of the 2016 year, and one was done over a three-day period in January 2017. For 2016, the three RCEM audits were:
  - Consultant sign-off: This involved four high-risk patient groups who should be reviewed by a consultant in emergency medicine or senior trainee prior to their discharge.
  - Asthma: This involved patients from two years old with moderate or acute severe asthma. This looked at how the department complied with the national standard for asthma treatment.
  - Severe sepsis and septic shock: This involved patients over the age of 18 years diagnosed with either severe sepsis or septic shock within certain definitions.

Pain relief

- Most patients we spoke with said their pain had been well managed. With one exception, the patients we met who were waiting to be seen, or waiting for admission to a ward, said they had been asked about pain. Those who had said they did have some pain or discomfort had been asked if they wanted some pain relief, and those who had requested it said it was provided shortly afterwards. One of the mechanisms for finding out about pain from a patient was to use a scale of one to 10. The answer was recorded in the patient's notes to look for improvements after administration of pain relief. Those patients who told us they had admitted to some pain said they were asked to describe this on a scale of one to 10. They also said staff had come back to check if the pain relief was working.

- Children and young people had their pain assessed and appropriate methods of reducing pain were offered. Nurses assessed children's pain by using age appropriate assessment tools such as smiley faces (Wong Baker diagram), indicators from behaviour or responses, and numbers for older children, in the same way as was carried out with adults. These assessment tools helped children of all ages and abilities to communicate about any pain. The assessments were included in every child's nursing record we looked at.
- The department had audited pain relief against three questions and results had been improving to high levels of compliance. The results we looked at were for June to mid-December 2016. Most weeks had been audited, although there were a few gaps towards the end of the period.
  - The first question about patients having a pain assessment within the first 20 minutes had a compliance average over the period of 96%. This result had always been relatively good and was backed up by what patients told us.
  - The second question about patients being given pain relief within 20 minutes of the assessment had an average compliance of 91%. Of the three questions, this result had improved, but then declined again to 80% by the end of the period.
  - The third question about patients being re-evaluated within an hour had an average compliance of 81%. This area had steadily increased and was an area the department had given focus to following poor results of only 50% in the first week of June 2016.
- A survey in June 2016 of trauma patients coming into the emergency department demonstrated that not all pain had been fully controlled (although there could be reasons for this). Of the 29 patients questioned, 19 said pain was fully controlled, eight said partially, and two said pain was not controlled. One patient said the reason for this was not explained to them.

Patient outcomes

- The department had excelled in stroke patient care. At one point in 2016, the department was delivering the fastest thrombolysis times in England. Providing thrombolysis (treatment with a clot-busting drug) for patients in the emergency department (as opposed to them being admitted elsewhere) reduced the time from a patient suffering a stroke to them receiving this potentially life-saving care. A review of stroke care had shown that no patient had been missed for thrombolysis or misdiagnosed in the last 12 months.
- There was a strong performance in the indicators for management of trauma patients in the emergency department. In an audit from the Trauma Audit and Research Network for the period July to September 2016 (just published), the emergency department performed in almost all measures above the national average. The department supplied information on 100% of eligible patients (national average 67%). Some of the notable results were as follows:
  - Proportion of patients meetings National Institute for Health and Care Excellence or NICE guidelines to receive a CT scan within 60 minutes of arrival was 77%. This was against a national average of 54%.
  - The emergency department delivering consultant-led trauma teams within 30 minutes for patients with an injury severity score of more than 15 was 61%. This was against a national average of 48%.
  - The proportion of patients with a Glasgow Coma Score of less than nine, with definitive airway management within 30 minutes of arrival was 71%. The national average was 41%.
  - The one area for improvement was for patients receiving care from a doctor of grade ST3 or above on arrival. This happened for 56% of patients against a national average of 59%.
- The results of the RCEM audits were variable. The consultant sign-off audit did not have targets set, but the results showed around a third of high risk patients being missed. There were problems with the sample size in the asthma audit and poor results against delivering or reporting fundamental standards of asthma care. There had been, nevertheless, no serious incidents related to poor asthma treatment in the last 12 months. There were areas of sepsis treatment that fell below delivering or reporting fundamental standards, although a high compliance rate (95%) with giving antibiotics within four hours. Details of the three audits were as follows:
  - Consultant sign off: This was undertaken over a period of just over nine weeks (with two of those outside of the reporting period being in January

2017) and involved a group of 99 patients in the defined groups. Consultants (or delegated doctors) had 'seen and assessed' or 'discussed' 62% and 77% of patients respectively.

- Asthma: This was undertaken in the week of our inspection and the number of cases (10) was unsatisfactory, as the audit required 50 cases at least. The results were based on a number of fundamental standards of asthma treatment protocols. The sample size was low, and the results were therefore not particularly meaningful. However, they showed there needed to be significant improvements in meeting the fundamental standards of asthma care. For example, all patients should be given oxygen on arrival to maintain their oxygen saturation. This happened in one of the 10 cases (and two had no record either way). All patients should be given a form of muscle relaxant within 10 minutes of arrival. No patients were provided with this from the sample of 10. All patients should be prescribed with oral prednisolone on discharge. Only two patients were recorded as being given these common steroids and the other eight had no record made.
- Severe sepsis and septic shock in adults: This was undertaken from mid-October to late December 2016. There were 100 records audited. One of the three fundamental standards was recording patients' certain vital signs (sepsis six) on arrival. This was done for 24 patients and partial recordings for 75. There was no record for the other patient in the dataset. Of the partial records, the significant area of concern was with capillary blood glucose, where only eight patients had a recording. With the other records, there was a high level of partial completeness – so most records were almost all completed. The second standard was the first intravenous crystalloid fluid bolus must be given to all patients within four hours of arrival. This happened in 61 cases with 36 not recorded, and 3 not given. The third standard was for antibiotics to be given within four hours of arrival. This happened in 95% of cases and was a strong performance by the department.

- There had been a recognisable improvement leading from local audit activity for nursing staff activities. As reported in more detail in other areas of the report, the four nursing audits (called the Sense Check audits in the department) had all shown improvements. National Early Warning Score management had improved, but from an already high level of compliance. The others, where compliance was poor, had shown significant improvement. This related to pain management, care rounds, and documentation and had risen from around 50% compliance in early 2016 to above 90% by the end of the year.
- There was a high level of compliance with patients being given an assessment for the risk of them developing a venous thromboembolism or VTE (blood clot). In November 2016, 99.4% of patients had been assessed for this risk. This was linked with the electronic prescribing system requiring an entry to confirm a risk assessment for the patient against VTE.

Competent staff

- There was a focus upon teaching, learning, and professional development in the department in both the medical and nursing teams. There were set times each week for junior doctor training within the department, and one of the consultants was a college lecturer in emergency medicine for the University of Exeter Medical School. A newly qualified doctor we met commented upon the high levels of support by the consultants and other doctors. We were told that all the staff were approachable, including the nursing staff, and there were no barriers to asking for guidance and support on any subject. They said there was "tonnes of teaching, which is great." One of the consultant team was co-author of the Oxford Handbook of Emergency Medicine (being updated in 2017), and another was on the editing team of the next edition.
- There was an outstanding contribution by the department to medical simulation training. This was undertaken in a controlled environment, but within the live working emergency department. This training had led to the production of high-quality case studies and teaching materials, guidance and protocols. The simulation training was a multidisciplinary session, which focused on the best practice, but also on the human factors affecting the working environment. This included real and simulated distractions, successes and failures in teamwork, the how the physical environment affected inputs and outcomes. The consultants talked specifically about a recent paediatric simulation exercise in a crowded department, which had been particularly successful and instructive.

- The appraisal of the non-medical staff had improved since our last inspection in January 2016. Only around half of the nursing staff had been appraised for their competency when we reviewed this (data for October 2015). Training of staff to undertake appraisals was ongoing, and this was leading to rising numbers. As at the end of December 2016, 84% of nursing staff and 89% of clerical/administration staff had undergone their appraisal.
- The hospital trust had introduced a 'manager's passport'. This was a tool to help nursing staff develop and work towards a managerial position. For staff who wanted to progress in this way, evidence of their experience and skills was required. The passport document had sections for staff to complete to demonstrate this, and show discussions with their line manager. There were a range of activities and courses made available. These needed to be completed with evidence of learning. Courses included, among others, managing individuals and teams; managing conduct; developing assertive and confident communication skills; and recruitment and selection. The programme was hospital-wide, designed to be completed within 12 months, and was available to staff in the emergency department.
- There had been a significant improvement in training for the nursing staff following the appointment of a practice educator (band seven nurse). They were away during our inspection but other nursing staff talked about improvements in structure, workbooks, and induction for new staff. Staff had the opportunity to undertake extended emergency department courses, including advanced life support, trauma immediate life support, and the trauma nursing core course. A triage training course had started in August 2016, and 31 nurses had already completed their competencies.
- The staff working in reception were trained in their roles, which included recognising when a patient needed urgent attention. They had been provided with a list of 'red flag' or serious complaints with trigger words to raise their concerns. They were clear about summoning staff and their role in monitoring people where they had concerns over their condition or behavioural issues when in the waiting area.
- All the consultants and doctors working in the department were subject to the General Medical Council revalidation programme. Revalidation is a process by which all licensed doctors are required to demonstrate, on a regular basis, their fitness to practise. Licensed doctors are required to revalidate every five years, and have an appraisal of their competence every year. All the doctors and consultants in the emergency department were subject to this process and had undergone revalidation. By the end of December 2016, 87% of the consultants had undergone their appraisal for the 2016/17 year.

Multidisciplinary working

- There was a strong ethos in the hospital and the emergency department for multidisciplinary working and the benefits of teamwork and cooperation. Multidisciplinary working was having input into patient care for staff from different specialties and areas of expertise to provide a holistic approach. Senior medical and nursing staff said they felt there had been a positive change in support and cooperation provided to the department, particularly with moving patients on as soon as possible. This extended to relationships with other local hospitals with specialised services or centres. To extend learning within and beyond the emergency department, paediatric ward staff were being invited to attend a shift in the paediatric emergency department. This was to familiarise themselves with working with acutely ill children and share learning with the wards.
- There was essential close multidisciplinary working with the ambulance personnel. Staff from both NHS organisations were clearly familiar with one another, and treated each other with respect. The ambulance personnel told us they would endeavour to provide as much support and treatment to the patient when they were waiting on a trolley at the entrance to the emergency department. This was with the intention of improving the handover to the nursing staff. The nursing team said they received a good handover from the ambulance crews, and there was a good relationship where suggestions and requests were made, received, and acted upon. One member of staff said ambulance crews were endeavouring to have placed ECG dots on patients who were potentially going to need this test due to a suspected myocardial infarction (heart attack). This had been agreed to help with the timeliness of ECG tests.
- There was good support to the department from other staff within the hospital in difficult times. When possible, staff would attend the department to offer support and

assistance with overcrowding and other pressures to help treat, care for and move patients. During our inspection, we met a number of staff from other disciplines and departments who had come to the emergency department to lend a hand.
- There was a particularly good information folder on mental health in the emergency department. There were simplified and clear procedures and flowcharts. It included what staff were to do in certain specific circumstances to keep everybody involved safe, and contact details of various agencies.
- There was an alcohol/substance misuse liaison team who were on call for patients in the emergency department. A patient we met was waiting for a consultation with this team prior to being discharged from the clinical decision unit.
- There was access to psychiatric input from a psychiatric liaison nurse. The department was staffed from 8am to around 10pm. There was out-of-hours cover provided by a junior doctor, but this was covering the whole of the county.

Seven-day services

- The emergency department was open 24 hours a day throughout the whole year. This was for both adults and children, and included those with major and minor conditions or injuries. There was radiology support for 24 hours a day, with rapid access to dedicated X-rays and CT scans. There was seven-day access to MRI scans, echocardiography, endoscopy and pathology. There was an effective on-call pharmacy service to support the department at all times.
- There was round-the-clock advice and support from consultants. They were not present in the department 24 hours a day, but were on call for guidance and support and able to attend the department under agreed circumstance (based on patient risk) within 30 minutes. The rota for consultants made it possible for all patients to be seen and have a clinical assessment at the latest within 14 hours from the time of arrival at the hospital.

Access to information

- There was access to electronic patient records for patients already recorded in the system. Staff were able to check medical and social histories of known patients and update these records during the care and treatment in the emergency department. There was also access to a patient's GP records where the patient was held within the local-area electronic system. This enabled staff to review treatment escalation plans for people with long-term or terminal conditions. Any patients who were not in the system were recorded in a new record and any care and treatment details sent onwards to their GP when appropriate.
- Any paper records made during the patient's stay were scanned and stored within an electronic record. These were then available to other wards and departments within the hospital if the patient was transferred or required to return for examinations or consultations. There was a comprehensive form used to provide information for patient transfers. This included clinical observations, risks, medicines prescribed and personal information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a good working knowledge of the law around consent. The nature of emergency medicine dictated that there were rare occasions when written consent was required. Staff were therefore focused upon patients giving them verbal or implied consent. Verbal or implied consent would follow once staff had explained effectively to a patient what they were consenting for. This might include the risks or advantages or any treatment or procedures, or an explanation of why a medicine, treatment or procedure was in the patient's best interests. We observed this happening in practice, with nurses explaining to patients about medicines they were being given or asked to take. We heard doctors explaining that a patient needed to have an X-ray, and why. We observed patients being prepared for X-rays and scans and told why these were being carried out, and whether the patient had any questions or concerns.
- Staff acted within legal principles when treating patients who were unable to consent due to the nature of their injuries. Patients who arrived unconscious, or not in a fit mental state to provide valid consent (but would otherwise have been able to) were treated in order to save their life or provide essential emergency care. Doctors would talk with patients when they were recovering in order to explain what had happened, what procedures had been carried out, and why they were necessary.

- There was understanding and application of the law as it related to patients who were not able to make their own decisions. Staff were aware through training of the application of the Mental Capacity Act 2005. This meant staff took responsibility to act in the best interests of a patient who had a cognitive impairment that meant they were not able to make valid decisions. Patients were assessed usually by the medical staff for any impairment in their mental capacity. It would be recognised in some patients that they were unable to retain or understand information, or recognise risks. In this case, staff would record their assessment that the patient did not have the mental capacity for giving valid consent. Staff would then seek input from family members or carers, if they were available, as to any advance decisions or previous refusals of consent for the same process, before undertaking any treatment. Treatment would be undertaken in the best interests of the patient and be the least restrictive in the circumstances.
- There was good knowledge of consent as it related to children. Staff understood that children over the age of 16 years were presumed to be capable (unless they demonstrated otherwise) of providing or withholding their own consent. Children under the age of 16 years would be able to give, or withhold their consent if staff assessed them as being competent to do so. This involved an evaluation of their maturity and ability to rationalise and understand what was being asked of them. All other children would need consent from their parent or person with approved parental responsibility.
- The department knew how to respond if a patient needed to be deprived of their liberty for their safety or that or others. Staff understood how a patient could be subject to Deprivation of Liberty Safeguards if they met the requirements for a lack of mental capacity under the 2005 Act. The hospital was a managing authority under the law, and could therefore grant a temporary licence to (as was usually the case) treat a patient in their best interests, while applying to the local authority alongside this for a formal licence.
- Staff were aware that patients could withhold consent if they had the mental capacity to make that decision. This would be the case even if the refusal to continue with treatment or an element of treatment would place the patient at high risk, and was against all medical advice. Staff would follow the safeguarding route and possibly court proceedings if a parent or guardian was refusing to give consent for essential or necessary treatment for a child.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- Patients were treated with compassion and kindness.
- Despite, often, the urgency of the need to deliver patient care, staff took time to interact with people and give them reassurance.
- There was warmth and consideration from staff to patients and those accompanying them. We saw this in evidence particularly when the department was overcrowded due to high demand.
- Staff communicated clearly with patients to help them understand what was happening to them. They kept relatives and people accompanying patients informed.
- The department was recommended in the NHS Friends and Family Test by a higher number of people than the England average – although the response rate was improving but remained low.

However:

- Due to overcrowding in the department, it was difficult to avoid breaches of privacy and dignity for some patients.

Compassionate care

- There was a compassionate and caring approach to patients. We observed staff being kind, thoughtful and compassionate with patients. This was particularly noticeable when we arrived in the department, and the nursing staff did not know who we were, as we were not expected. We witnessed kindness and empathy to the patients who were waiting in the main emergency department corridor on trolleys.
- Most of the patients we talked with confirmed staff had been caring. An expert by experience (a trained member of the public who joined us on this inspection) had the following comments from some of the 13 patients they spoke with:

- "Since arriving the staff have shown me a lot of respect and dignity."
- "I find the staff very understanding."
- "The staff could not have done any better. They are brilliant."
- "Can't knock it in here, couldn't ask for better."

- Due to the overcrowding in the department, there were challenges with staff providing privacy and dignity for patients. There were up to 20 patients being held on trolleys in the main emergency department corridor at various points during both days we were on site. We were advised this was an unprecedented situation for the hospital. It was particularly prevalent in the morning of Wednesday 4 January 2017 around 9am when there were 17 patients in the corridor of which 12 were waiting for transfer to a ward. We talked with five of these who had been there for between four and six hours. There were a further 19 patients in the cubicles waiting also for transfer. The number of patients held on trolleys in the corridor peaked at 22 during our observations on 4 January 2017. There was a similar situation around 4pm on the same day with patients arriving and waiting to be seen (although these patients had been through a rapid assessment and treatment process). Most of the patients we spoke with said they had been well treated and comforted by staff. However, we witnessed one patient who carried a strong smell of urine, who was on a trolley for at least an hour. The patient alongside them told us they found this distressing.
- Other patients were being treated, examined, and interviewed by medical and nursing staff in the vision and hearing of others in the busy corridor. Staff were heard to shout at some patients who had hearing impairment. This was not something the staff could do much to help, and they were acutely aware of the privacy and dignity issues. However, there was a portable screen at the entrance to the corridor, and this had not been brought into use when there were numerous opportunities for this to happen.
- Elsewhere in the department, we observed patients treated with respect, privacy and dignity. Curtains were drawn around patients when treatment or support was being provided. Otherwise, curtains were generally kept open to allow staff to observe patients. Some patient treatment areas were rooms with doors, and these were closed when patients were being treated. We observed staff knock on doors and wait to be admitted to rooms that were otherwise occupied. They also asked to be admitted to curtained cubicles before entering.
- Staff took time to interact with people in a respectful and caring manner. Despite the overcrowding, and some patients with high levels of anxiety, and exhibiting some aggression at times, we observed staff being patient and considerate. People were encouraged and there was humour (when appropriate) and warmth in the interactions.
- There was a high level of recommendation from patients completing the NHS Friends and Family Test, although a poor response rate. The percentage of patients who would recommend the service was better than the NHS average, but the response rate was worse than the NHS average. This had, nevertheless, improved since low results in the summer months. Over the last six months of data published by NHS England (June to November 2016), the recommendation rate was between 93% and 96%. This was against a national average for emergency departments of around 86%. There were between 1% and 2% of patients who would not recommend the service. This was against a national average for emergency departments of around 8%. The response rate ranged from, at best, in October 2016 at 7.8% and, at worst, in November 2016 of 2%. This was against an NHS national average of around 13%.
- There was reasonable privacy for patients and their relatives or friends in the waiting area. Reception staff were not sitting behind glass walls, so people did not feel they had to shout at staff greeting them. People were therefore able to give information and details with reasonable auditory privacy. Reception staff we observed did not ask patients unreasonably personal questions. They spoke with clarity and at a reasonable volume so people who had hearing impairments were able to hear what was said to them.

Understanding and involvement of patients and those close to them

- There was good evidence that staff involved patients and those close to them in decisions and actions. We observed staff asking patients if they understood what they were telling or asking them. Those patients, relatives and friends of patients we met all said they understood what was going on. We had comments including:

  - "I've been kept well informed about my relative since she arrived last night."
  - "It's been a long wait, but they have been keeping me informed all the time, and saying sorry about the wait."
  - "They wanted to get me down for a test, and explained why, and I was very happy with it so fully agreed. They are very kind."
  - "I wasn't very good when I came in, but they told me why things have happened and it all makes sense. They told me after what medicines they gave me, and I was okay with everything."
- Patients said they were able to ask questions and raise concerns. Most of the concerns patients had on our inspection were about the waiting and why they were in the corridor. All those we asked said staff had apologised about the situation. Patients wanted us to know they had been understanding and patient with staff and one said: "they are doing everything they can to keep us posted about what is happening, and I am getting moved along all the time, which is good." Three patients told us they had asked about their safety in the corridor, and staff had been reassuring. The patients said staff had regularly checked on them and asked if they had any changes in their condition, pain, or were in any discomfort.
- Staff recognised when a patient or someone accompanying them needed more help to communicate. Staff said they would try to write things down for patients if they had a hearing impairment – although we did not see this happen in practice. We observed staff talking gently but also clearly, with a patient who had been admitted with an alcohol dependency. Staff showed high levels of tolerance when the patient was struggling to understand, and used gentle encouragement to explain why the patient needed nutrition and hydration guidance and advice.
- A survey in mid-year 2016 of trauma patients indicated that most relatives were informed of a patient admitted to the emergency department. From a survey of 29 cases, 27 patients said their relatives were contacted. However, not all relatives were given sufficient information, and this was addressed by the department updating and improving information about trauma cases and transfer.

Emotional support

- A patient's wellbeing was taken into account when staff provided treatment and support. Staff explained how patients were given self-help advice that fitted with their personal circumstances. People from all lifestyles came through the emergency department, and staff said they certainly could not deliver a 'one size fits all' service. Staff said they recognised where there were underlying problems or other issues in a patient's life that needed addressing. Patients would be signposted to other services, advocacy or support groups if this were relevant. In addition, they were encouraged to attend their own GP for less urgent issues, but matters the GP could help with.
- There was support also for carers and dependents. Staff said they had many examples of where they had recognised a patient's relatives or friends were struggling. They had provided advice and guidance, for example, to relatives or carers of people who were living with dementia. Staff said they were guided by their training to look out for signs of relatives or carers struggling with the pressure of caring. Staff showed us posters about support groups that they had signposted people to in the past. Staff also talked about young carers and similar local support groups they were aware of.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We rated responsive as requires improvement because:

- There was not always timely flow through the department. Demand on the service and the way it had been required to operate meant too many patients were, at times, waiting on trolleys to be admitted to a ward.
- The department had not met the target to admit, discharge, or transfer 95% of patients within four hours for at least the last two years. At the time of our inspection, this was running at around 77%.
- Queueing in the department meant patients could not always be responded to with privacy and dignity.
- There was insufficient evidence to show complaints led to changes and improvements.

However:

- The care and treatment to patients was prioritised for those with the most urgent needs.
- People were kept informed about waiting times, and waiting times of alternative services in the county.
- The time taken to first treat patients was consistently better than the standard of 60 minutes.
- There was a relatively low number of patients leaving the department before being seen.
- The emergency department had moved up the national rankings in terms of accident and emergency target waiting times.
- The service was planned to meet the needs of local people. People using the service could all do so on an equal basis.
- There was an appropriate service and response to people in vulnerable circumstances and with individual needs.

Service planning and delivery to meet the needs of local people

- The service had been planned in most aspects to meet the needs of local people and those who visited the area. The department had been significantly expanded and predominantly rebuilt to twice its original size in 2013. The emergency department team dealt with both serious and life-threatening illnesses and injuries, and also minor injuries and illnesses. The service was offered 24 hours a day throughout the year. The service was the only emergency department in the county of Cornwall. It was supporting a population that doubled in the summer months with the influx of tourists and visitors. It was supported by an urgent care centre run by the Royal Cornwall Hospitals NHS Trust at West Cornwall Hospital, and 12 minor injury/illness units throughout the county run by another NHS trust. The overcrowding in the emergency department was caused, we were told by senior departmental staff, by being unable to transfer people onto a hospital ward, due to a lack of available beds. This was coupled with the use of the department to admit medically expected patients, rather than through the medical assessment unit, which was being used as a short-stay medical ward.
- The low number of beds in the resuscitation area of the department (three for the county of Cornwall) was being addressed by application to the trust board to increase this provision. The inability of this part of the service to perform safely at all times had been investigated by the senior medical and nursing team as part of the business case. An outcome from the request for a step up in provision to five beds was awaited.
- The reception area was well appointed. There was adequate space for people to be able to sit and we did not see patients or people with them being expected to stand to wait to speak with someone. The reception area staff were seated behind a desk area with various heights to enable people who were using wheelchairs to be able to be treated respectfully.
- There was a GP out-of-hours service provided to assist with patients with minor illnesses at certain times. There were four GPs employed to cover one shift each evening from 6pm to midnight on Fridays, Saturdays and Sundays.
- Gender separation was not made possible at all times. There were inevitable issues with the design and layout of the clinical decision unit. This was a small unit of eight beds, which had not been part of the rebuild. Six of these beds were in an open small ward layout, which could have curtains pulled around them. There were two single-occupancy side rooms together at the end of the unit. Staff endeavoured to locate females at one end of the unit and males at the other. This was how the unit was operating when we inspected, with three male patients at one end (two occupying the side rooms) and the females at the other end. This would inevitably not work all the time. Staff said they would have to disrupt this, for example, at night, when a patient was admitted. It would be unfair to move the other patients in the middle of the night to try to preserve gender separation.

Meeting people's individual needs

- There was a protocol for responding to patients when the department was overcrowded and patients might be waiting on trolleys in the main corridor. This had been produced by the department's clinical director in May 2016 and staff were aware of how it should be put into practice. The protocol started with the clear instruction to staff to "provide reassurance to patients who arrive to a crowded ED (emergency department)." The protocol went on to describe how this should be done, and included asking staff to apologise to patients for the circumstances. We observed this being put into practice by both nursing and medical staff. There were no significant breaches of patients' privacy and dignity (such as requiring them to undress, or undergo intimate

examinations while in the corridor), as there were places made available for any intimate procedures or examinations. However, non-intimate routines, such as taking of blood, observations, or insertion of a cannula into a hand, were being undertaken in the corridor, which was unacceptable. In one case we observed, a patient had to remove half their shirt for an arterial blood gas check. There was a portable screen available at this time, but no attempt to use it.

- When it was appropriate, patients were given something to eat and drink, although crowding in the department appeared from our observations to reduce the frequency of this being undertaken. On the first day of our inspection, we met a number of patients who had not had anything to eat or drink for a number of hours, although others had. We observed one patient had a cup of tea, but it had been placed out of their reach and had gone cold. The patient said they had not wanted to bother anyone in order to be able to drink it. Another patient who had been on a trolley in the late afternoon for a number of hours said they were "gasping for a drink or something." We did see other patients being given something to eat and drink, but it was not consistent.
- There were facilities for patients and visitors with specific needs. This included a relatives' room for people accompanying seriously ill or injured patients, or where the recently bereaved could sit, talk and meet with staff. This was sited away from the main areas of the department in a quieter area of the main corridor. However, the department was overcrowded when we visited, and patients (and people accompanying them) were queued directly outside and opposite this room at times.
- There was access to a translation service by telephone, although there was a problem with the technology, which was temporarily not working during part of our inspection. Staff said the service was, however, efficient and helpful when they had to use it. Those staff we asked said they would use an adult relative to provide translation if this was entirely appropriate. They said they would only use a child or young person in an emergency life-threatening situation. NHS England states that using "anyone under the age of 16 for interpretation…is not acceptable under any circumstances, other than when immediate or necessary treatment is required."
- Services were planned to take account of the access needs of the population. There was ground floor and flat-ground entry to the department to allow people using wheelchairs or with mobility issues to be able to access the service on an equal basis to others. There was no evidence that anyone with any of the protected characteristics (such as age, gender, race or religion) would be discriminated against in any way.
- The service would take action to provide additional support to people living with dementia, or with a learning disability. Staff had been trained as part of their mandatory training to understand the needs of people with cognitive impairment. They told us they would endeavour as best as they could, particularly in times of overcrowding, to find a cubicle or somewhere quieter to care for a person who might be anxious or confused.
- There was entertainment and diversion activities for children. Within the paediatric area were toys for varying ages, and a television on which staff could play a selection of films. To engage and divert the children, and make them more at ease, staff would get the children to choose their favourite film to watch together in the waiting area.

Access and flow

- There was a system for admitting patients to Royal Cornwall Hospital that put unacceptable pressure on the emergency department at times. The hospital was using the emergency department to admit medically expected patients and some other surgery patients. Medically expected patients were those who, generally, had been seen by an external healthcare professional (usually their GP or an out-of-hours service). Arrangements had then been made to admit them to hospital for further examinations or treatment. These patients did usually not have life-threatening conditions, but needed hospital care. Patients, estimated by senior staff to be between 25 and 30 a day, tended to arrive often by ambulance towards the end of the afternoon, in the evening or at night, when GPs had undertaken their home visits or out-of-hours doctors were working in the community. At times, this was putting unacceptable pressure on a department not established for this purpose. This significantly added to the failure to meet waiting-time targets, created the privacy and dignity failings for patients, and the increase in delays for releasing ambulance crews. The decision to take medically expected patients though the emergency

department had been made by the hospital trust in response to previous safety concerns in the medical assessment unit (MAU). Prior to taking patients through the emergency department, it was recognised that too frequently, medically excepted patients were being held in the MAU. They were often also waiting on trolleys, and more often due to a lack of space, in chairs when they were not well enough to sit in a chair. There was less room than in the emergency department, and this situation was deemed unsafe by the hospital trust. Bringing patients through the emergency department remained, and was recognised as not ideal. The problems we have described above were acknowledged by senior staff.

- Due to demand in the emergency department and elsewhere in the hospital for vacant beds, patients had to wait on ambulance or hospital trolleys. In the department, on the first day of our inspection at around 9am, we found:
  - Twelve patients waiting on trolleys in the corridor for admission to a ward.
  - Nineteen patients in cubicles waiting for admission to a ward.
  - Of the 41 patients in the department, there were therefore 31 (75%) waiting for a bed.
- Due to sustained and intense pressure in the hospital for beds to admit patients, the flow of patients out of the emergency department was not meeting targets. This issue was recognised on the trust risk register and categorised as an extreme risk. On a monthly average measure, the emergency department had not met the target for patients being either admitted, discharged or transferred in less than four hours for A&E in at least the last two years. It had almost achieved the target of 95% of patients being seen in under four hours in a week of November 2016 (94.3% achieved) but this had declined again directly after that and the improved result could not be sustained. In the 17-week period from 14 August to 4 December 2016, the average number of patients being progressed within four hours was 76.9%. We can compare this with the monthly NHS England national results for type 1 patients (majors). This shows the department was more significantly below (worse than) the national average in the winter months. Results against the 95% target were as follows:
  - November 2016: 77% NHS England 83%
  - October 2016: 71% NHS England 84%
  - September 2016: 73% NHS England 86%
  - August 2016: 85% NHS England 86%
  - July 2016: 81% NHS England 85%
  - June 2016: 83% NHS England 86%
- Despite the problems as described above, the time to treat people after their arrival, although increasing, was below (better than) the standard. After initial triage, the median average time for patients to receive treatment after arrival was consistently below 60 minutes. This was for the period reported to the trust board from April 2015 to October 2016. The time had, nevertheless, increased from 40 minutes in April 2015 to 55 minutes in October 2016.
- There was a low ratio of patients leaving the department not having been seen. In the period from 14 August to 4 December 2016, there was an average of 2.1% of patients (496 patients – or around four per day on average) who left without being seen. This was below (better than) the standard recognised as good practice of less than 5% of patients leaving before being seen. There was also a slight downward (improving) trend in this indicator.
- There was a protocol for senior staff to follow to meet patients' needs when the department was overcrowded, but also to look for efficiencies. This included the need to ensure patient safety, but also to look for ways to alleviate pressure. Actions were looked for to ensure patients could be discharged as soon as possible. X-rays and scans were prioritised to enable decisions to be made. Patients were moved to chairs rather than cubicles where possible. Specialty doctors were requested to attend the department for reviews, and there was a focus on patients who could be diverted safely to primary care or minor-injury units.
- For at least the last two years, and despite the overcrowding in the department, there had been almost no patients spending more than 12 hours on a trolley from the decision to admit them to being admitted. The last occurrence of this was May 2015 when four patients waited more than 12 hours. Waiting for over 12 hours was also a rare occurrence in accident and emergency departments throughout England. For example, in the three months from July to September 2016, of almost 4 million attendances in accident and emergency departments (majors), only 254 patients waited on a trolley for more than 12 hours.
- In the last 12 months, the emergency department had moved up (improved in) the rankings for four-hour waiting time targets in NHS hospital accident and

emergency departments. For example, data published for emergency department targets in November 2015 showed Royal Cornwall Hospital NHS Trust was ranked 131 from 138 NHS hospitals delivering care to type 1 patients (majors). It had the smallest numbers of attendances of those hospitals ranked in the bottom 10. In data just published for November 2016, the trust had moved up to be ranked 107 from 138.

- The service prioritised care and treatment for patients with the most urgent needs. Information from the ambulance personnel, should a patient arrive that way, meant the department was placed on standby for the arrival of a critically ill patient needing urgent attention. Triage systems for all patients, however they arrived, would alert nursing staff to patients needing an urgent response. The department used a computerised coding system to indicate which patients they were looking after had what level of urgency or risk. We observed medical and nursing staff attending to patients according to risk or need. When the department was overcrowded, the nursing team shift leaders were required to ensure patients were reviewed in a strict priority order in accordance with the triage process results.
- There were effective systems for avoiding admissions to the department. Staff told us the local ambulance trust were effective in identifying which patients needed conveying to the emergency department. Staff also diverted patients to other more appropriate services if they had presented at the emergency department inappropriately. This would include patients who needed a non-urgent GP or dental appointment, a non-urgent X-ray at a minor injury unit, or could be helped by a pharmacist. There were two pharmacies on site at Royal Cornwall Hospital, but the website did not indicate when these were open.
- There was information provided for patients to make an informed choice about where they went for care and treatment. In the reception waiting area, on the trust website, and through a smartphone application, people could get live updates on waiting times at the hospital, urgent care centre, or the 12 other minor injury units in the county.

Learning from complaints and concerns

- There was a relatively straightforward system for making complaints to the department and these would be managed in any format they arrived in. Complaints in writing (letters or emails, or through the website) were managed initially by the complaints team. People were also able to complain in person or over the telephone. Notes from these complaints would be passed to the complaints' team. The website outlined clearly how complaints would be dealt with. This included explaining to people that a patient's permission would be needed (in most circumstances) if confidential information was to be discussed. The website explained how this would be obtained.
- Complaints were dealt with locally. Those received about the emergency department (or where the department was included in a wider complaint) were passed to a member of the department's administration team. These were logged, and paperwork gathered (if any) to be able to investigate the complaint. The details were then circulated to the senior management team, and a decision was taken about who was the right person to investigate complaints. This could be a member of the senior team, or, if it was considered appropriate, an independent member of staff. After an investigation, the response was reviewed by the departmental manager. All complaints were approved by the director of nursing before being sent. The full response was then returned to the complainant.
- Complaints were reviewed to look for themes emerging. Although it was not possible to easily benchmark numbers of complaints, there had been 153 in around 14 months, but this included the urgent care centre at West Cornwall Hospital. This was around 11 complaints per month, or 0.2% of patient visits. A general look at the type of complaint received showed small trends centred on waiting times, and a lack of communication. These were typical themes within the NHS.
- There was some indication of learning from complaints, although the minutes from the departmental meetings did not provide strong evidence of this. One set of minutes documented some learning, but complaints were otherwise not strongly featured. Complaints, along with incidents, are powerful pieces of information, which need to be learned from to improve the quality and safety of care. They were not given a sufficient hearing in the governance of the department, despite being a standing agenda item.

Are urgent and emergency services well-led?

Urgent and emergency services

Requires improvement

We rated well-led as requires improvement because:

- The evidence from quality and safety reviews and clinical governance did not provide assurance for all aspects of care. There were a number of areas not being considered through this mechanism, or not demonstrating sufficient priority.
- The risk register had few clinical risks; concentrated on mostly potential environmental risks; and beyond the ongoing situation with crowding, did not address known or current concerns.
- There was a conflict between delivering high quality patient care, and the time to commit to good governance and risk management.

However:

- There was experienced, committed, caring and strong local leadership. The leaders understood the challenges they faced and had ambitions for improvements and innovation.
- Staff felt respected and valued. There was encouragement of openness, candour and collaborative working.
- There had been strong innovation and encouragement through professional development and acknowledgement of success and excellence.

Vision and strategy for this service

- There was a vision for the service, although this needed to be developed into a future business plan taking the department forward. The clinical director and his team had a clear vision for an emergency hub for Cornwall. The view was to provide a broader and more comprehensive service encompassing emergency medicine (both physical and 24-hour psychiatric care). This extended with all-round provision for urgent care, a GP service covering in and out of hours' provision, minor injuries/illnesses treatment, and the specialisms of emergency medicine, such as major incident and accident response.
- There was a strategy for the service, although there was limited evidence recording overall progress against the 2016/17 priorities. The strategic aims were, nevertheless, clear. These included providing compassionate, safe, effective care. They included attracting, developing and retaining excellent staff, offering integrated care as close to home as possible, and making the best use of resources. Within those headlines were details, which reflected some of the known issues within the department. For example: improving the time to triage patients, improving the Friends and Family Test response rate, recruiting consultants and specialty doctors, and improving collaborative working with colleagues. We were able to see progress with a number of these from our inspection, and evidence provided.

Governance, risk management and quality measurement

- There had been improvement in governance work in the emergency department following our previous inspection. However, there was still work to do. Management of risks had improved, but there were still some areas not receiving sufficient attention. The minutes of the governance meetings did not provide a complete overview of the issues affecting the department. Many issues were discussed, but the following issues raised in this report were not reflected in those minutes we read:
  - There had been no discussion of the lack of improvement, and also deterioration in some elements of sepsis management. This included completion of the sepsis six bundle.
  - There was no evidence of actions taken to improve the known failures with giving medicines to some patients on time.
  - There had been a relatively high incidence of falls with harm in the clinical decision unit – 20% of patients reported to the NHS Safety Thermometer (a snapshot of avoidable harm) in the last 12 months. There had been no report on this to the safety committee in the minutes of the four months we reviewed.
  - There had been an overall improving picture in pain assessment and management, but in the area of giving pain relief following an assessment, there had been a recent decline. This had not been raised through the clinical governance team to agree on a plan of action.
  - There had been no recognition as yet of the poor data collection and performance against one of the three Royal College of Emergency Medicine audits (asthma). This was poor performance in both the

failure to meet the lower limit of records required to be audited (and the audit had missed the reporting deadline of the end of December 2016) and the poor results from those being audited. There was little evidence to support learning from complaints and incidents in governance.
  - The actions raised from investigation into serious incidents were not reviewed to ensure progress had been made and had led to the identified improvement in care and treatment,
- There was limited discussion and presentation of the departmental risk register at the clinical governance meeting. The specialty risk register was a standing item on the safety agenda for discussion each month, although the discussion each month was limited to the risk of crowding (risk 3411). Additionally, at one meeting, the discussion included also target performance (risk 2930), but without any minutes to show what was discussed or concluded. Some of the risks on the register had been added a number of years ago, and could be considered as no longer relevant. For example, the need to increase the levels of nursing staffing for the increased capacity for patients in the 'new' majors area, which was opened at the end of 2013. This had been addressed, and resolved, but was still on the register. The majority of the other entries were potential risks from health and safety incidents and appeared as being kept under review. However, there was no evidence of when these were reviewed by the governance committee. Given some of them were seven or eight years old, there was limited review of whether they were still entirely valid or if there were any gaps in risks emerging from the service developing. Many of them did not require review for around three years, although these were low risks.
- There were a limited number of clinical risks on the register. The only risk we could identify was that relating to the overcrowding in the department (categorised as quality of care risk), which had been on the register since 2011. Other risks the department had been aware of, such as sepsis management, the limitations of the resuscitation area, and risks of receiving medically expected patients, were not recorded. There had been no entries made to the register in 2016 and only one in 2015, which was not a clinical risk.
- There was contradictory handling of entries rated as extreme risks and elevated to the corporate risk register. The 'overcrowding' risk (coded 3411) was scored as 16 on the departmental risk register. However, it was not listed on the December 2016 corporate risk register as would be required for any risk scoring over 15. The risk coded 2930 (breaches around the four-hour target) was on the corporate risk register rated as 20. This was no longer on the departmental register. There was conflicting information on the departmental risk register, which finally suggested risk 3411 had been closed and combined with 2930. This complied therefore with the entry on the corporate risk register, but meant the departmental risk register was not correct.
- There were regular departmental meetings to look at governance, risk and quality. These regular meetings had been set and agreed by the consultant team. On the first Wednesday of each month, there was a teaching, training and rota review. On the second Wednesday, business, finance and IT was discussed. An executive member of the hospital was also invited to attend. On the third Wednesday was a specialty meeting with the acute medicine team and other disciplines if required. The fourth Wednesday was for the quality and safety review. If there were a fifth Wednesday in the month, this would be to discuss long-term planning.
- There was a common approach to patient safety. There was a weekly meeting of the emergency department senior management team. We attended as observers at one meeting during our inspection. The first part of the meeting was an informal exchange of concerns and information for around 30 minutes. The more formal part of the meeting was for an hour, where minutes were recorded and actions followed-up, updated, and produced. The meeting indicated to us how the department was run by an integrated senior team. They were both supportive to one another, and able to challenge appropriately internally and externally when necessary.
- The governance meetings had been presented with shared learning opportunities from incidents in other areas of the hospital, although the recording of this was variable. This had included learning from a thrombolysis case and consideration of whether protocols in use in the department needed to be revisited. There was insufficient use of learning from multidisciplinary teamwork, including, for example, the weekly trauma cases review, which had not been presented.
- There was a hospital-wide approach to trauma care. The department was involved with weekly meetings each

Thursday where a number of cases were looked at in some detail. Minutes showed a high level of attendance, and this had included the local ambulance trust. There was learning from some the trauma cases discussed in the three meetings for which we saw minutes. However, there was no record of this learning being brought back to the emergency department, when relevant, through the safety meetings.

- The hospital trust was represented by the emergency department at the Peninsula Trauma Network. The team attending (a group of 15 members of staff) presented one of the three cases for consideration.

Leadership of the service

- There was experienced, committed and dedicated leadership in the emergency department. The team was led by an experienced consultant in emergency medicine appointed in April 2016. They were supported by a team of knowledgeable and skilled consultants and doctors. The nursing staff were led by two experienced matrons who worked complementing shifts. They were supported by staffing teams led by experienced sisters or charge nurses.
- The leadership team had the capability and experience to lead the department effectively, although capacity was affected by pressure on the service and an under-staffed consultant workforce. The department was able to deliver effective emergency care to keep people safe and meet their needs, but there was pressure for time to learn, audit, improve and excel.
- The leadership, both within medical and nursing staff, clearly understood the challenges to delivering good quality care. They could identify areas where the department needed to improve and what it would take to address these. Since our previous inspection, the leadership had implemented actions and strategies to resolve some areas of poor service delivery. This was done through various processes, including valid auditing of systems and care delivery; changes to care plans and pathways to address gaps and risks; piloting new approaches to patient flow, and recognising when these had not worked as hoped.
- Leaders within the department were visible and approachable. The leaders were treated with respect by their staff, and seen working in and among their staff at all times providing guidance and advice. They took time and space to lead effectively, and step back at times from the detail, but we observed they always had time for staff concerns and questions.
- There were supportive, appreciative relationships among staff. The clinical director spoke warmly of his staff and how they were part of the reason for coming to work each day. We were impressed on both days of our inspection by the atmosphere of calm in the emergency department despite unprecedented demand on the service. This was recognised independently by all of our inspection team.

Culture within the service

- There was a respected and valued staff group in the emergency care department. We heard from staff on all levels about commitment to their teams, their managers, the hospital and each other. One of the consultants remarked that with Royal Cornwall Hospital being the only acute trust in the country, and therefore it being the only accident and emergency department, how culture and teamwork were essential. Not only was this due to the commitment of staff, but staff, their families and friends all being actual or potential patients: this was their hospital too.
- There was support and cooperation between the emergency department and the executive team. The clinical director and other senior staff met regularly with the chief executive and the director of nursing. When the emergency department was in a period of escalation (overcrowding or similar pressures) this was rapidly escalated to the site coordinator and the executive team. We were told and observed that medical and nursing staff were requested or volunteered to come to the department to do what they could to help. A number of nurses and doctors had arrived in the emergency department during our inspection (not at that point knowing we were there) to help with the situation of overcrowding.
- Culture, honesty and openness was encouraged. Staff told us they had a professional and moral duty to recognise and act when something went wrong, or had the potential to go wrong. All the staff we asked said they would be willing to raise any serious concerns to the leadership team. None said they felt they would not be heard or would need to raise the concerns with the wider hospital leadership in the first instance, as there was already trust and honesty in the department.

- All the staff we met said they felt supported by their teams and their line manager. However, the reception staff sometimes felt they were not included in consultations or outcomes of matters that would or could affect their roles. They often found out about changes by word of mouth and not formally.

Public engagement

- The emergency department was the first in the Cornwall peninsula to gain regular structured feedback from trauma patients. The survey undertaken in June 2016 with 29 patients led to improvements in the information sheets given to patients and relatives being transferred to another hospital.

Staff engagement

- The facilities for staff to meet, have quiet times, undertake pre-arranged or spontaneous learning were poor. The Department of Health guidance stated that a seminar room should be provided within the emergency department for teaching, tutorials, meetings, case conferences and clinical instruction. This seminar, or resource room, should contain library and IT facilities for staff to use. There were no facilities of this nature in the emergency department. There were some small offices for consultants and senior staff, but meetings, seminars or case conferences needed to take place away from the department. Although the hospital had facilities for staff to meet which were not significantly far away (although one was a porta-cabin), having to leave the department excluded some staff from being able to be called into the meeting for a short review, or join the meeting to contribute to one of the topics. It also meant key staff were away from the department in the event of an emergency.
- There was a monthly emergency department newsletter for all staff, which had been recently introduced. It covered predominantly clinical matters, training opportunities and areas for improvement.
- The emergency department had produced a short video about why it was "great to live and work in Cornwall". This had been uploaded to the internet, and leaflets produced to give away with contact details. This had led to other departments wanting to produce their own videos and promotional materials. There had been 3,807 views of the 5-minute video by 20 January 2017.

Innovation, improvement and sustainability

- The department was innovative and staff were keen to make improvements and celebrate in their success. The Blood Transfusion Team had won a national award in February 2016 (NHS England's Innovation Challenge Prize) for developing a secure labelling system for blood samples. This had been introduced and successfully implemented in the emergency department and had demonstrated a significant drop in rejected samples. This had also meant a reduction in blood taken from patients as it was managed correctly the first time.
- There were other innovations and improvements. These had included:
  - The transfusion team attending all code red trauma calls. The transfusion coordinator remained with the patient throughout their treatment to ensure the correct use and type of all blood and blood products.
  - Medical staff were now able to book a scan for a patient with a head injury without referring first to a radiologist (providing the criteria met National Institute for Health and Care Excellence or NICE guidance).
  - A deep-vein thrombosis (blood clot) protocol had been improved to ensure prophylaxis (preventative treatment) was given for all lower limb fractures.
  - There had been improvements to the clinical pathway and tests given to patients presenting with potential heart attacks (acute myocardial infarction). A certain specific test (high sensitivity troponin assays) was now undertaken earlier to diagnose and treat patients with acute myocardial infarction.
  - There had also been the work with thrombolysis, which we have written about elsewhere in this report.

Medical care (including older people's care)

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

Information about the service

Medical care at the Royal Cornwall Hospital Treliske is delivered by the medicine division. Within this division there are four directorates which are then split into 10 clinical specialties. These are acute medicine, cardiology, respiratory medicine, eldercare/stroke medicine, gastroenterology/hepatology, endocrinology, neurology, nephrology (renal medicine), chronic fatigue service and clinical psychology. The trust provides a range of cancer services, which are managed by the clinical support services and cancer division, which, for the purpose of this inspection, are reported under medical care in this report. The division has a budget allocation of £64.4 million and employs approximately 1,107 whole time equivalent staff.

There are 303 medical inpatient beds. The division also provides endoscopy, renal dialysis (the trust supports three renal dialysis units across the county) and outpatient clinics at multiple sites across Cornwall.

Inpatient care is provided as follows:

- Phoenix ward: stroke medicine
- Wheal Prosper ward: infectious diseases
- Roskear ward: cardiology
- Wellington ward: respiratory medicine with a six-bedded higher level care bay for patients who require additional care and support which may include non-invasive ventilation
- Kerensa ward: care of the elderly
- Grenville ward: renal medicine and endocrinology
- Carnkie ward: gastroenterology and care of the elderly
- Tintagel ward: Care of the elderly and neurology
- Coronary care unit: Cardiology
- Cardiac investigation unit: Inpatient and day case cardiology
- Medicines Assessment Unit

Medical care was provided on Lowen Ward which is an oncology ward. However, does not fit within the medical services structure within the trust.

There is a discharge lounge which operates Monday to Friday, from 7.30 am to 10pm, excluding bank holidays. The unit can accommodate up to eight seated patients and six patients requiring a bed and aims to improve patient flow in the hospital by freeing up beds once a patient is ready to be discharged. There was also an intermediate care ward which had been opened for patients who were clinically stable who were awaiting discharge.

During our unannounced inspection between 4 January 2017 and 5 January 2017, we visited all of the medical wards. This included Carnkie ward, Grenville ward, Phoenix ward, Roskear ward, Wellington ward, Kerensa ward, Wheal Prosper ward and Tintagel ward. We also visited the Medical Admissions Unit, the discharge lounge, the cardiac unit and the intermediate care ward.

During this inspection a team of inspectors, specialist advisors, an expert by experience and a pharmacy inspector spoke with 98 members of staff, 42 patients and their relatives and looked in 25 sets of patient records (including medical notes, observations charts and pharmacy records).

Medical care (including older people's care)

Summary of findings

We rated this service as inadequate because:

- There were significant flow issues out of the hospital. During the inspection there were over 100 patients unable to leave the hospital due to an inability to access community services. On average 97 patients a month were waiting longer than seven days to be discharged. As a result of this patients were at risk of deteriorating both physically and mentally.
- As a result of the flow issues there was not enough capacity within the hospital to manage the patients. There were 40 medical outliers on surgical wards, and areas such as theatre recovery were regularly being used to accommodate medical patients overnight.
- Due to time consuming arrangements for getting agency staff, staff vacancies and redeployment of staff to other wards there were frequently times on wards where they were short staffed which had an impact on the care provided to patients. Some patients told inspectors how they had soiled themselves as a result of waiting for staff to attend to them.
- Some practices of infection control were unsafe. We found that on one occasion two bowls of bodily fluid were left in the sluice room and that some wards were physically messy, with incontinence pads on the bathroom floor and litter by beds.
- Staff were not sufficiently trained to recognise the abuse of children. Safeguarding children training was well below the trust targets. Some consultant staff did not have sufficient manual handling training to keep people safe. In some ward areas less than 50% of the staff were sufficiently trained in children's safeguarding.
- In the Medical Admissions Unit we found a resuscitation trolley that did not have regular checks conducted on it to ensure the equipment was safe to use. In 2016 there were 45 separate occasions where the check was not complete. Weekly checks were rarely completed. We also found on the Medical Admissions Unit that medicines were not secure. Treatment room doors and medicine cupboard doors were left unlocked and despite CQC escalating our concerns found that practice did not change.
- We found on numerous occasions that records trolleys were left unlocked.
- Due to the high pressures of the job (at all levels) there was a disconnect between the local and divisional teams resulting in staff on the wards feeling that they were not supported. As divisional teams were focused on large issues such as flow through the hospital there was limited capacity to manage the ongoing risks on wards.
- There were many risks which the divisional team should have had oversight of which they did not. When risks were escalated wards felt that they did not get the support to address or mitigate them.
- There were low levels of staff satisfaction on wards and staff did not feel respected, valued, supported or appreciated. Although staff understood what the vision and values of the trust were they were not able to fully live by them due to the job pressures.

However:

- There was adherence to the duty of candour throughout the incident investigation and complaints investigation processes. Staff we spoke with understood the principles of the duty of candour and their responsibility to report incidents on the computer systems.
- Despite the high workload patients were consistently positive about the care they received. Patients were overwhelmingly positive on Wellington Ward and in the Coronary Care Unit.
- We saw that treatment was planned and delivered in line with evidence based practice. There were innovative ways to record observations and ensure that appropriate risk assessments were completed.
- There had been improvements in the stroke service. In the national stroke audit the trusts rating had improved from a level E to a level D.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

We rated safe as inadequate because:

- We found multiple incidents where patients came to harm which were reported as 'no harm' or were not investigated properly. This meant that opporrtunities for learning were missed.
- There were frequent staff shortages and systems to secure agency staff meant that staffing levels in areas fell below safe levels. There was an impact in patient care as a result of this.
- The electronic system for sending alerts to doctors sometimes meant doctors were inundated with messages and found it difficult at times to prioritise patients.
- Although staff understood their responsibilities to raise safeguarding concerns they were not adequately supported by training. Staff did not receive sufficient training to adequately recognise or respond appropriately to the abuse of children. In some ward areas less than 50% of the staff were sufficiently trained in children's safeguarding.
- Many consultants did not have the required levels of mandatory training to keep people safe. Insufficient numbers of consultants had training in infection control, manual handling, fire safety, health and safety or information governance.'
- Resuscitation trolley checks on the Medical Admissions Unit and Tintagel ward were frequently missed which meant that there was an increased risk to the patient if the equipment was needed.
- We found that medicines were not stored securely in the Medical Assessment Unit and despite raising our concerns found that medicine security got worse as the inspection went on.
- On regular occasions we found that records trolleys were left unlocked and unsupervised.
- Although infection control practices were generally good they were unsafe on the Medical Admissions Unit. We found that staff were not using appropriate personal protective equipment and that there was some litter on the floor. We also found in a sluice that two bowls containing bodily fluid were left on the side.

However:

- When something went wrong, people received a sincere and timely apology and were told about any actions taken to improve processes to prevent the same happening again.
- Openness and transparency about safety is encouraged. Staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses.
- Risks to people who use services are assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or behavior that challenges.

Incidents

- Staff we spoke with understood their responsibilities to raise concerns, record safety incidents, and near misses and were encouraged to report them. Most staff told us that they would have no hesitation in reporting incidents and were clear on how they would report them but felt that limited action would be taken as a result.
- We found that some opportunities for investigating, identifying and sharing learning were missed. We found evidence which showed that incidents with resulted in harm to the patient were not always being reported appropriately. There were examples of incident reports for pressure ulcers, ranging between grade three and grade four which were reported as 'no harm'. Some of these incidents included patients being transferred between wards without grade three ulcers being identified or handed over. This increased the risk of preventative action being taken and the ulcers getting worse. One incident reported highlighted that an effective risk assessment of a grade four pressure ulcer had not taken place increasing the risk of it not being managed. We were told that the trust validated all incidents and re-categorised them accordingly, however this was not always found to be effective.
- The Serious Incident Framework 2015 states that an incident should be considered as a serious incident if a patient's death was unexpected or avoidable which was contributed to or caused by weakness in care or service delivery. There were several incidents which resulted in a patient's death which were reported as 'no harm' and was not subject to a thorough review. This meant that lessons could have been missed.

- One patient incident reported as 'no harm' was a hospital acquired sepsis pneumonia. This incident was subject to a 24 hour report and was later considered to not be a serious incident. However, there was no discussion or review of the events leading to the undiagnosed pneumonia as a result of X-rays not being looked at which may have contributed to their death. Subsequent to this the full root cause analysis was not conducted. When the incident was raised by CQC the trust said they would commence additional work to ensure the incident was properly investigated.
- One patient who had a cardio-respiratory arrest and died as a result did not have a full investigation, therefore learning may have been missed. This patient was discussed at a morbidity and mortality meeting which identified that there was no treatment escalation plan in place for the patient and there was poor documentation of the patient's respiratory function in the medical notes. There was one action noted as 'request that this is recorded as an incident on datix' rather than robust changes to practice or dissemination of learning. The incident form provided by the trust confilicted with the information from the morbidity and mortality meeting as it states there was a treatment escalation plan. There were no lessons learnt or action taken recorded and the report states that it was "unclear as to what needs to be investigated further" and that it was "unclear as to what incident is being reported – medication given appropriately and appropriate care and treatment provided to the patient".
- One patient reported as 'no harm' was a potentially avoidable hospital associated thrombosis. The patient was discharged from hospital without a Venous Thromboembolism care plan in place which may have prompted a prophylaxis prescription. The patient presented at hospital three days later and died. The cause of death was a pulmonary embolism and pneumonia. This patient's death may have been contributed too by a faliure in care delivery and should have been subject to a rigorous review. When asked to provide further evidence on this the trust did not provide any.

- During our inspection we found on Wellington ward that an incident occurred where medication which should have been administered through a nebuliser (a device which allows the inhalation of a medication) was given intravenously (given through an injection into a vein). This was investigated as a 'serious incident'. Learning was cascaded at a ward level and systems were put in place to mitigate it happening again. A sense check (where a walk around from a senior member of staff is conducted) was done to understand the incident better. The action plan stated that learning was to be shared through a newsletter. The incident was mentioned in the meeting minutes of a medication safety group, but was only to record that it had happened and that learning needed to be shared.
- On average there were 500 incidents reported each month. During the inspection we found that there were many incidents that were not investigated in a timely way. It was reported on a quality and safety report that 208 incidents had not been reviewed in the 14 day handling time. This means that there were delays in changing practice and sharing learning to staff.
- On the wards lessons were learned and shared within teams as a result of investigations when things went wrong. Staff said they felt the trust shared outcomes of investigations to encourage improvements in practice. Daily safety briefs had details of any relevant incidents and learning from them at a local level. The Coronary Care Unit and Wellington Ward safety briefs had been adapted to include an incident report learning section which kept the information about learning on for a week to ensure all staff had been made aware of the issue and subsequent learning. However, we found that there was little sharing of learning between wards. Some specialities made newsletters for all staff in the division to read which included learning from incidents although this wasn't done throughout the trust.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Staff at all levels in the service, had a good understanding of the duty of candour and could describe when it would be used. Incident reports seen showed adherence to the duty of candour regulation,

including processes and evidenced written apologies. Senior staff had told us that the quality of their written apologies had improved since the last inspection and that they were more sincere and sympathetic.

- The incident reporting system had a section for duty of candour which automatically became active if patient harm was reported as moderate, major or catastrophic. However, opportunities to implement the duty of candour may have been missed through the reporting of incidents as 'no harm' where they may have been moderate, major or catastrophic. Most staff we spoke with had an understanding of duty of candour, when they would use it and the actions they would take. They explained there was an open and honest culture with patients even if the incident did not reach the threshold for duty of candour.

Safety Thermometer

- The NHS patient safety thermometer is used to record the prevalence of patient harms at ward level, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Data collection took place on one day each month and looked at pressure ulcers, falls, catheter care and urinary tract infections and venous thromboembolisms. During the last inspection in January 2016 data showed that in November 2015, 90.43% harm free care was achieved compared with 91.65% in October against a national average of 94.30%. This means that safety thermometer results were slightly worse than the national average. A report showed that a number of actions had been agreed and were being supported and monitored by the Safety Thermometer Group. During this inspection we found that in November 2016 harm free care was 98% which was better than the national average.
- The National Institute of Clinical Excellence quality standard three states that all patients should receive an assessment of venous thromboembolism on admission and again within 24 hours of admission. QUANTA (nursing and midwidery indicators) audits for December 2016 showed that that this was being done 100% of the time in the Integrated Discharge Unit, all wards in cardiology, and on Carnkie ward. On Wheal Prosper ward this was only being done 80% of the time, on Grenville ward this was only being done 89%, on Kerensa and Phoenix wards this was only being done 90% of the time. On the Medical Admissions Unit where audits showed that these assessments were only being done 70% of the time.
- The National Institute of Clinical Excellence quality standard 89 states that people admitted to hospital should have a pressure ulcer risk assessment within six hours of admission. We found that between October 2015 and December 2016 there were 336 pressure ulcers reported. Of these 30 were acquired at the hospital. One of which was a grade three pressure ulcer. Audit data from December 2016 showed that this was being done 100% of the time in all cardiology areas, the Integrated Discharge Unit, Phoenix ward, and Carnkie ward. Kerensa ward, Tintagel ward, Grenville ward, and Wheal Prosper wards scored 90% which was above the trusts target. However, the Medical Admissions Unit only scored 67%. This meant that patients were at higher risk of acquiring a pressure ulcer. The management of this measure was the responsibility of the matrons and the ward managers who would raise staff awareness of the risks at safety briefs.
- The National Institute of Clinical Excellence quality standard 86 states that older patients who present because of a fall should have a multifactorial risk assessment. Audit data from December 2016 showed that falls risk assessments were completed on admission 100% of the time on all cardiology wards, on Phoenix ward, Tintagel ward, the Medical Admissions Unit, Carnkie ward, Grenville ward, and Wheal Prosper ward. Although above the trusts target, the Integrated Discharge Unit completed assessments 86% of the time, and Kerensa ward completed assessments 90% of the time. This measure was the responsibility of medical staff, however, ward managers and matrons helped to raise staff awareness of the risks and safety briefs. We also saw evidence of this being discussed in matrons' meeting minutes.
- The National Institute of Clinical Excellence clinical guideline states that falls interventions should promptly address the patient's identified individual risks of falling. Audit data from December 2016 showed that intervention plans were implemented appropriately 100% of the time in most of the wards apart from Phoenix ward (where this was done 89% of the time). However, on Grenville ward this was only completed 63% of the time. This increased the risk to patients as

they would be more likely to have a fall. The management of this measure was the responsibility of the matrons and the ward managers who would raise staff awareness of the risks at safety briefs.

- Between October 2015 and December 2016 there were a total of 289 falls reported. Six of these falls were reported as serious injuries including three fractured femurs, two fractured neck of femurs, and one head injury. It was identified in a medical services quality and safety report that falls remained an area requiring improvement and that matrons were involved in the trust wide falls action plan.

Cleanliness, infection control and hygiene

- During this inspection on some wards levels of cleanliness and hygiene were maintained. However, we did see some poor practice which compromised safe care. Most wards were seen to be visibly clean, tidy and well maintained. This included patient bed spaces, corridors, staff areas and equipment used both regularly and occasionally. Patient bed spaces were visibly clean in both the easy and hard to reach areas such as beneath beds. Bed linen was in good condition, visibly clean and free from stains or damage to the material. Storage cupboards were well organised with most equipment on shelving units to prevent dust and dirt gathering around and beneath objects. We regularly saw the cleaners on wards during our visit. Some areas we visited had regular cleaning and hostess services staff who knew their ward/unit well and were able to meet the specific requirements of the area, for example Lowen ward. However, we found on the Integrated Care ward and on Kerensa ward there was lots of clutter in the corridors. This included equipment, linen bags, trolleys, plastic chairs stacked up and boxes from the trusts stores needing to be unpacked.
- The National Institute of Clinical Excellence quality standard 61 Statement three states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. We observed doctors and nursing staff washing their hands and using anti-bacterial gel in line with infection prevention and control guidelines. Visitors were asked to use alcohol gel when arriving on the wards and this was freely available and clearly visible at the entrance to wards. Most staff were bare below the elbow and used personal protective equipment (PPE). Hand sanitiser gel was placed appropriately on the wards and staff were seen to be using them appropriately in line with best practice and there were posters promoting good infection control.
- Disposable items of equipment were disposed of appropriately, either in clinical waste bins or sharps instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were over filled.
- However, on the Medical Admissions Unit we found that sometimes there was litter on the floor. We found that there was an incontinence pad on the floor in one of the bathrooms and some litter by a patients bed. When we entered the sluice room we found two bowls of bodily fluids left on the counter by the sluice. We also saw a member of staff take an open container of urine to the sluice without gloves on. On Kerensa ward we found some packaging was left on the floor by a patient's bed and on Tintagel ward a member of staff was wearing a watch, therefore was not bare below the elbow.
- We found that room cleaning did not always take place quickly enough. On Kerensa ward we found a patient who was sat in the corridor waiting for admission onto the ward. We were told that they were waiting for the room to be cleaned. This patient was waiting for over three hours for this room to be cleaned.
- The implementation of safety systems, processes and practices were monitored through the use of audit. Hand hygiene results for November 2016 were good. For hand hygiene audits all wards apart from one were above the trusts 95% target with most being 100% compliant. Wellington ward scored 94% in the audit which was just below the trusts target. The sister on Wellington ward said that they spoke with the cleaning contractors lead and as a result the hostess and cleaner had been attending the 7am safety brief and if they have not been available a liaison hostess had attended to raise awareness of the importance of maintaining good standards of cleanliness and hygiene.
- The ward completed audits around infection prevention and control as part of its key performance indicators report. The wards conducted an audit of aseptic technique (a method designed to prevent contamination for interventions, such as the insertion of cannulas) on a monthly basis. Most ward areas had received training in the theory and practice of this technique. However, the cardiac investigations unit, Roskear ward, and the medical admissions unit had not

received the training. The wards conducted an audit on a monthly basis to identify if patients who should be isolated were. In December 2016 all wards were compliant apart from Carnkie ward which was only 67% compliant. This increased the risk of patients acquiring a hospital acquired infection.

- The National Institute of Clinical Excellence quality standard 61 statement four states that people who need a cannula should have the risk of infection minimised by the completion of specified procedures to ensure safe insertion and ongoing care. If this was not maintained there is an increased risk of infection. The trust audited against this quality standard and in December 2016 found that not all wards were fully compliant. Roskear ward, the medical admission unit, Kerensa ward, Tintagel ward, and Carnkie ward were non-compliant for the completion of documentation. The medical admissions unit, Kerensa and Tintagel ward were non-compliant for insertion details being completed appropriately. This increased the risk of patients acquiring a hospital acquired infection.
- The National Institute of Clinical Excellence quality standard 61, statement four, states that people who need a urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for safe insertion and ongoing maintenance. If this was not maintained there is an increased risk of infection. The trust audited against this quality standard and in December 2016 found that all but three wards were fully compliant. The audit showed that Wellington ward, the medical admissions unit, phoenix ward, Carnkie ward and Grenville ward were non-compliant for completing the appropriate documentation associated with catheters. This increased the risk of patients acquiring a hospital acquired infection. There was a list of actions at a local level. However, there was no ownership of actions, timescales for completion or evidence of actions being completed.

Environment and equipment

- Generally the design, maintenance and use of facilities, premises, and equipment kept people safe. Similarly to the reported findings from January 2016, premises were mostly appropriately designed, laid out and equipped to keep people safe. Wards were well lit and there were appropriate floor finishes to reduce the risk of slips, trips and falls. Toilets and bathrooms were large enough to allow people to be assisted with personal care and could accommodate equipment, such as lifting aids. However, we found on the Medical Admissions Unit that some equipment was being stored in front of a door into an occupied side room which may have been a trip hazard. We also found on Tintagel ward that one bay had been without running water for a month but a single basin had been put in place with a separate water tank which mitigated the impact.
- Equipment store rooms were mostly locked. This meant that equipment such as syringes and dressing packs were stored safely and securely to prevent theft, damage or misuse. However, we found on Tintagel and the Medical Admissions Unit that these rooms were unlocked. We also found on Tintagel ward that the cleaners store and the sluice were unlocked, both of which had antichlor tablets on the worktops which would be harmful if ingested.
- The arrangements for managing waste and clinical specimens generally kept people safe. We found that on all but one occasion sharps bins were not overfilled and were closed as stated in the trusts policy. The trust audited the use of sharps bins on a monthly basis to assess if bins were only being used for appropriate items, were correctly assembled, stored correctly, only in use if below the fill line, labelled correctly, the temporary closure lids in use, and visible safety devices been activated. All ward areas were compliant against a trust 90% target apart from the Coronary Care Unit, and the Tintagel ward which scored 70% for appropriateness of items in the bins. Roskear ward scored 70% compliance for the temporary closure of lids and Kerensa ward scored 70% for the correct labelling of bins. The Integrated Discharge Unit scored 70% for the correct storage of bins and only 60% for the correct labelling of bins. This increased the risk that either a patient or a member of staff would get a sharps injury.
- We found that all patients who required it had quick access to pressure relieving equipment based on their grade of pressure ulcer in line with the Royal College of Nurses management of pressure ulcers guidelines. All patients who had a grade one or two pressure ulcer had a foam mattress or appropriate cushion. All patients who had a grade three of four pressure ulcer had an alternating or low pressure mattress.
- During this inspection we looked at seven resuscitation trolleys. They were readily available on every ward and had tamper evident seals. We found that all but one of the resuscitation trolleys were fully checked both daily

and weekly as appropriate. . We found that resuscitation trolley checks on Tintagel ward were consistently missed. We found that in 2016 daily checks (the checking of the equipment on top of the trolley) had not been completed on 45 separate occasions. We found that in 2016 the weekly checks (the checking of the consumables inside the trolley and the testing of equipment) were rarely completed and had only been done nine times in 2016. In January 2016, March 2016, September 2016, and December 2016 no weekly checks had been conducted at all. We found on the Medical Admissions Unit in the most recent checks, the trolleys tamper evident tag did not match the records, indicating that it had not been checked properly. This meant than in an emergency all of the relevant equipment may not be available or be within its use by date putting patients at increased risk.

Medicines

- Arrangements for managing medicines and medical gasses did not always keep people safe (including the obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- We found that on Roskear ward, Kerensa ward, Carnkie ward, Wellington ward, Phoenix ward and in the Intermediate Care Discharge Lounge that medicines were stored securely. However, on the Medical Admissions Unit medicines were not stored securely. We went to the Medical Admissions Unit on 4 January and found that both doors to enter the treatment room (where medicines were stored) were both unlocked and propped open. We also found that there were tablets on the floor which had been stepped on and that a tray of injectable medicine was left on the counter. This medicine had been left on the counter for several hours. Although the cupboards which stored medicines were lockable, they were frequently left unlocked and unattended. We also found that computerised prescription pads were left unlocked and on the counters. Our concerns were raised with the sister of the Medical Admissions Unit while we were there and trust executive team on the evening of 4 January 2016 to ensure that the unit was made safe. We went to the Medical Admissions Unit again on 5 January and found that both doors were still unlocked and propped open. We also found that one of the medicines cupboard doors had been removed leaving medicines unsecured. We were told that the doors bring propped open had been risk assessed in the 6 months prior to the inspection. However, recognised that the cupboards within the treatment rooms should be locked. We also found that fridges which stored medication were not lockable which meant that they were not secure. On Tintagel ward we found that some injectable medicines were not stored in their original packaging which increased the risk of selection error and on one occasion a medicines trolley was left unlocked and unattended.
- On Tintagel ward we found that medicines were not always administered safely. We looked in one patient record and found that medicines were being given covertly without the appropriate decision making process being recorded. The deputy sister on the ward said that the arrangement had been agreed with pharmacy but was not recorded. Also, when rapid tranquillisation for agitation was given we found that appropriate observations to ensure patient safety were not carried out immediately after administration. This meant that the patient was at risk of deteriorating which may have gone unnoticed.
- Controlled drugs were stored, recorded, and handled appropriately with spot checks being conducted on medicines. We also found that twice daily stock checks were undertaken to ensure that the contents of medicines cupboards matched registers. All the medicines we checked were within their expiry dates and we found that there was adequate pharmacy cover on all of the wards. However, we found that on Phoenix ward there were two dates in November 2016 where stock checks were not completed or signed for.
- We found that medicines which required refrigeration were always stored in fridges which had temperature checks monitored and recorded.
- There were systems and processes in place to ensure that patients were safe. On all of the wards we visited an electronic observation system was in use which prompted staff to administer medication on time. As a result of this very few medication doses were missed. We also found that guidance and support was available from the intranet on best practice and protocols around medications and that nurses were aware of the policies and how to administer medication in line with the Nursing and Midwifery Council Standards for Medicines Management.
- Discharge nurses completed a discharge checklist for each medication to ensure that patients had adequate information about the medicines they would be taking

home. In the Intermediate Care Discharge Lounge people were using their take home medicines while they waited to be discharged from the hospital. Although the intermediate care discharge lounge did not have a dedicated pharmacist a pharmacy technician restocked patients medication to ensure that they had medication for ten days after discharge.

- The pharmacy department worked closely with partners to develop a medicines support service to provide expert pharmacy advice and support to people recently discharged from hospital. Information regarding medicines, for patients who consent, was sent electronically to the patients GP and named community pharmacy. This allowed community teams to identify changes to people's medicines during their hospital stay (e.g. dose changes, new medicines, discontinued medicines or those that are to continue but have been temporarily stopped) and allows community pharmacies to see how much medicine people have been discharge with and when a new prescription is likely to be due.

Records

- Patients individual care records were mostly written and managed in a way that kept people safe. We looked at 25 care records and patient notes and found them all to be complete, accurate, legible and up to date on all of the wards we looked on apart from on Kerensa where care plans were not always personalised or fully completed.
- We found that individual care records were not always stored securely. On the Medical Admissions Unit on 4 January we found that on six separate occasions records trolleys were left unlocked and unattended. We also found that in the treatment rooms the electronic prescription pads were often left unlocked and unattended. On one of these occasions patient records were left on top of the trolley unattended. We found that there were also patient records left unattended in the ward sisters office which was often left unlocked with the door open. On Tintagel ward on 4 January we found that on three separate occasions records trolleys were left unlocked and unattended. We also found on the floor by the entrance to Kerensa ward and the Integrated Care ward zip lock bags with records in. These were unsupervised and meant that patient notes could be removed by unauthorised staff.
- We found that of all of the 25 care records and patient notes we looked at, the risk assessments, admission notes, and discharge information was legibly documented in line with national guidance. Paperwork was clear and ensured appropriate escalation when required.
- On some wards we found that there were integrated medical, nursing and therapies records which improved the workflow of staff. Staff we spoke with said that this reduced duplication and ensured that records were contemporaneous. We found that all medical records were clear, accurate, legible, and completed quickly in line with the General Medical Council guidance on keeping records.

Safeguarding

- There were systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff. The trust safeguarding policies described the definition of abuse and who might be at risk. These policies were easily accessible on the trusts intranet and internet pages along with information provided by the trusts safeguarding team (including contact details and phone numbers). Staff we spoke with described the different types of abuse and processes they would follow to contact the local authority if they suspect abuse. The safeguarding policies for adults and children were up to date and in line with the latest legislation and guidance.
- Staff understood their responsibilities to raise concerns and report abuse. Between January 2016 and January 2017 there were 519 referrals made for children and 617 referrals made for adults. However, training rates could have been improved. For nursing staff levels of adult safeguarding training, as of November 2016, were mixed with varying levels of compliance. The average percentage compliance for nursing staff in the medical directorate for adults safeguarding level one training was 95% which was within the trusts target However, level two training fell below this at only 89% compliance.
- For adults level two training only Roskear, Carnkie and Phoenix wards were above the trusts 95% target. The worse performing wards were Grenville ward (with 82% compliance), the Coronary Care Unit (with 88% compliance) and Wheal Prosper ward who's compliance was well below the trust target and were only 74% compliant.

- For nursing staff levels of children's safeguarding training, as of November 2016, were considerably below the trusts 95% compliance target. The average percentage compliance for nursing staff in the medical directorate for children's safeguarding level one was only 79% and level two training was only 67%. This increased the risk that abuse to children may not be recognised or appropriately escalated to the local authority.
- The worse performing wards were Kerensa ward (with 67% level one and 50% level two compliance), Carnkie ward (with 64% level one and 47% level two compliance) and the Coronary Care unit (with 67% level one and 42% level two training). All of which fell considerably below the trusts target. Only Roskear ward had training levels above the 95% trust target for children's safeguarding, with both level one and level two training compliance at 96%.
- Staff told us that training was delivered to meet their needs and attendance accommodated where possible. However, some staff told us that they were unable to attend other training due to capacity and time restraints and there was little time to share learning with colleagues.

Mandatory training

- Staff reported that mandatory training has improved recently and is more interactive and interesting. Some staff understood that manual handling training was going to take place on the wards and units, where the areas own equipment could be used and therefore be more relevant. On CCU staff said that the manual handling trainer would visit the unit to carry out bespoke training for example bariatric training if asked to do so.
- Statutory and mandatory training records for wards showed mixed compliance but average compliance was 92% which was just short of the trusts 95% target. In November 2016 the wards had compliance levels above the trusts target for equality and diversity and human rights and manual handling theory. Compliance rates were slightly lower, but still good, for conflict resolution, infection control, fire safety, information governance and patient manual handling. Compliance with resuscitation training was mixed. On Kerensa ward only 66% of staff were compliant and on Tintagel ward only 83% of staff were compliant. All other wards had training levels above the trusts 95% target.
- Statutory and mandatory training records showed that of the consultants employed within the medical services division, compliance with mandatory training was mixed. We found that, as of November 2016, consultants were fully compliant against the trusts 95% target for conflict resolution, equality and diversity and human rights, and the theory of manual Handling. However, in December 2016 consultants were significantly below the trusts target for the control of infection (44% compliance), fire safety (44% compliance), health and safety awareness (50% compliant), information governance (70% compliance). Only 9% of consultant staff had completed the patient manual handling training. This increased the risk of harm to both patients and staff.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. Of the records we looked in we found that all risk assessments were completed and evaluated. These included assessments for pressure ulcers, nutrition and mobility. There were clear processes in place to deal with deteriorating patients.
- All patient records we looked in showed that people were admitted and continually assessed using the National Early Warning System (NEWS). Each chart recorded the necessary observations such as pulse, temperature and respirations. Staff were able to articulate and were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the patient to be seen by medical staff.
- An electronic device was used by all staff to identify when observations were needed automatically. This also provided clear triggers for escalation and allowed for instantaneous alerting. Alerts were sent to doctors through the device which ensured that the need for escalation was not missed. Nurses were also able to add comments to the alerts to give more information to the doctors. Most staff were complimentary about this service, which allowed for quick responses and notifications. However, some doctors said they were inundated constantly with alerts which did not have an impact on patient care, but meant it was more difficult for them to prioritise patients.
- Staff responded appropriately to the changing risks of people. When a risk was escalated the increased requirements of observation were alerted to staff

through the e-observation device. We saw multiple example where if a patient was assessed as at risk of falling, there were care plans in place. This would then inform the daily safety brief, and a sticker on the patient notes. Yellow socks (non-slip socks that indicated to staff that a patient was at risk of falling) would be worn, with the agreement of the patient. If a patient fell, neurological observations would be carried out alongside a medical review, an incident report would be made and duty of candour carried out, in the form of an apology to the patient and/or their relatives.

Nursing staffing

- Audit data provided by the trust showed that actual staffing and planned staffing levels were comparable in almost all wards. All wards apart from Wheal Prosper had a day and night shift fill rate for both registered nurses and healthcare assistants over 90%. Wheal Prosper ward only had a fill rate of 75% for day shifts in November 2016. During November 2016, Wheal Prosper ward reduced the required number of registered nurses in line with a temporary 25% reduction in beds to enable estates work.
- There were high vacancy rates on the wards. The Cardiac Investigation Unit had a 14% vacancy rate, the Medical Admissions Unit had a 16% vacancy rate, Roskear ward had a 12% vacancy rate and Wheal Prosper ward had an 11% vacancy rate. Phoenix ward had the highest vacancy rate with 23% vacancy.
- To ensure that shifts were filled to safe levels agency nurses were used. Carnkie ward, Phoenix ward, the Medical Admissions Unit and Tintagel ward were each filled three whole time equivalent nurse posts with agency staff. Phoenix ward, Kerensa ward and Wellington ward each filled two whole time equivalents with agency staff. The use of agency staff put significant pressure on the established nursing staff as they had to supervise and support them more.
- There was rapid assessment of acuity. The 'safe care ' acuity tool which used the Association of UK University Hospitals (AUKUH) dependency tool was introduced on all wards. There were daily morning meetings to discuss staffing across the trust. The meeting was chaired by an associate director of nursing and matrons from across the hospital attended to assess staffing and priority areas. This meeting was used to determine if staff should be moved from other areas to meet the hospitals need. These meetings were repeated twice a day to change staffing accordingly.Senior staff said that regularly staff were moved to manage a greater risk in other areas, leaving wards short staffed.
- Redeployment to other wards and areas had become part of normal working practice which compromised the safety of patient on the wards. When staffing levels were low (for example due to sickness) staff felt there was reluctance within the organisation to hire additional agency staff and therefore moved staff from other wards. This left wards short staffed as a result and left staffing below the acuity needs of the ward increasing risks to patients.
- Staff were regularly moved to the emergency department. Staff we spoke with said they did not feel comfortable working within this area due to the specialist knowledge needed. When wards were short staffed, staff were sometimes redeployed to that ward area. However, the nurses brought in may not necessarily be competent to work in that area.
- When there was no choice but to get agency staff, the processes to get these staff were long which compromised patient safety. Staff we spoke with said it could take a whole day to get additional staff. When patients were admitted or patients had deteriorated and required one to one care to keep them safe, staff needed to leave the bays to sit with the patients. This often left bays without healthcare assistant support. When requiring urgent cover, for example staff sickness, staff felt this process was long winded and complicated.
- Patients we spoke with felt the impact of this on the quality of care they received. Most patients discussed how the nurses were very busy and that they were sometime too busy to meet their needs. One patient we spoke with said "I don't think they have enough staff on at night and that's why I think somebody fell last night". On several occasions on Kerensa ward we found that some staff were too busy to answer call bells, and were curt to patients who were waiting. One patient on this ward said that in the morning they had to soil the bed as they were waiting too long for a call bell to be answered. We also witnessed a patient whose call bell was sounding who was in distress and shouting that she needed the bathroom. We witnessed a member of staff telling her that she had to wait and that it took several more minutes before staff were available to assist her.

One patient we spoke with said "The staff are a bit slow at attending call bells because they are so busy". Another patient said "There's not enough staff, I do things in bed that I don't want to happen".

- On the Coronary Care Unit there were ten high care beds. Patients in these beds required more detailed observation and require advanced support and care. They usually had one bed designated for primary PCI (Percutaneous Coronary Intervention) (urgent balloon angioplasty (with or without stenting) without previous anticoagulants to open an artery during an acute myocardial infarction (heart attack).The staffing levels on this unit were based around having enough staff to support the patients based on acuity and with additional cover for a percutaneous coronary intervention between 8am and 6pm during the week.
- During times of pressure in the department redeployment was common, especially to the emergency department. The unit sister told us that they could be called back if someone was required in theatre. However, several staff from the coronary care unit said that this regularly didn't happen. We were told that on some occasions several members of staff would either be redeployed or be in theatre leaving only two staff to manage the high care patients. This puts patients at a higher risk of harm as they were not being monitored sufficiently. An external review was conducted of the service provided which recommended that more staff should be employed. However, no action was taken.

Medical staffing

- For medical staff actual levels did not compare to planned levels. There was a 14% vacancy across the medicine division. However, some areas had higher vacancies. For example, in the acute emergency speciality medicine service out of an establishment of 45 whole time equivalents there was a 20% vacancy rate (mostly for junior doctors), equalling nine whole time equivalents. In cardiology out of an establishment of 21 WTE there was a 21% vacancy rate, equalling five WTE. Within this, there was a cardiology consultant establishment of 9, with 8 in post including a long term locum and only one WTE cardiology consultant vacancy.
- Medical cover on some wards was stretched with little flexibility to cover during periods of absence. All doctors we spoke with said the workload was heavy and they did not always have enough time to get to the root of things through extended conversations with patients and their families. They were concerned that the interpersonal element of their role was being eroded and current staffing was not sufficient to provide the level of care required. Staff on most of the wards and units we visited spoke of good medical cover by committed junior doctors and consultants. The medical cover overnight and at weekends on the care of the elderly ward varied and staff sometimes had to wait a long time for a doctor to see their patients.
- All junior doctors we met said they felt supported by their consultants in terms of their day-to-day work and their ongoing professional development including teaching sessions.
- The way the cardiologist's rota worked meant that clinics run on the Coronary Investigation Unit where patients could need to progress to a procedure were sometimes cancelled due to no cardiologist being available. This meant that the waiting list for elective treatments, such as transoesophageal echocardiogram (a test that uses ultrasound to obtain pictures of the heart valves and study blood flow through the heart), continued to increase. However, the trust was working within the two week target for urgent referrals and all patients were seen within seven weeks.

Major incident awareness and training

- We saw red 'emergency preparedness' folders on each ward/unit we visited. On Kerensa ward there were two folders in the designated holder and out of date information in both folders. As soon as this was pointed out steps were taken to ensure the most up to date information was available to staff.
- The CCU sister described the clear and formalised escalation plan in place to be used if there were issues with flow in the unit. (RCHT Capacity Management Escalation Plan v 6.9 December 2016: The Senior Nurses/Matrons are responsible for: Pro actively actioning issues identified within their area of responsibility. Providing support and advice to ward teams to support them in management of effective discharges).

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

- Appraisal rates could have been improved. Only two wards had appraisal rates higher than the 95% trust target. Some wards were significantly lower with Kerensa ward having 56% compliance and Tintagel ward having 65% compliance.
- There was not robust MDT working around discharging patients. All patients were subject to standards set in the SAFER care bundle. Achievement in standards of discharge was significantly lower than the trusts target. Examples of these targets included the timeliness of discharge and discharge on the patients clinically stable date.
- There was no seven day consultant cover for neurology patients. This increased the risk to patients at weekends. The use of a consultant of the week model had an impact on the effectiveness of treatment. Staff were not supported well and patients were missing important medicines as a result of a lack of accountability form staff
- We were not provided with up to date audit information for some national audits. The results of these in the previous inspection were worse than the national average.

However:

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- People had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- Information about people's care and treatment, and their outcomes, is routinely collected and monitored.
- There is participation in relevant local and national audits. We saw that there had been significant improvement in the national stroke audit. The trust had gone from a level E to a level D.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national policy. These included the National Institute for Health and Care Excellence (NICE) guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. We saw examples where best practice guidelines had been used to ensure effective patient care.
- For example, on the coronary care unit the National Institute of Clinical Excellence Clinical Guideline 167 (Myocardial Infarction with ST – segment elevation: acute management) was used. This meant that patients may have different treatments for their heart attack and therefore some had to stay on the unit longer than others based on the treatment they received. We saw Wellington ward used National Institute of Clinical Excellence guidelines for management of conditions associated with Cystic Fibrosis.
- The radial lounge, with two reclining chairs, on the coronary investigation unit had been developed using the money from the Trusts cardiac fund. This enabled patients to have their cardiac catheter procedure as a day case patient, eating and drinking normally before the procedure and wearing their own clothes. This had proved successful and patient feedback was very positive.

Pain relief

- Pain relief on wards was well managed. Patients prescribed pain relief to be given 'when required' were able to request this when they needed it. Patients told us they were asked by staff if they were in any pain and medicines were provided in line with the patients' prescriptions.
- Pain charts were used on all wards and were present and complete in all patient records we looked in. Audit results from the trust showed that on medical wards pain assessments on admission and documentation of outcomes following a pain assessment were completed 100% of the time.

Nutrition and hydration

- Patients were screened using the malnutrition universal screening tool (MUST) to identify those who were malnourished or at risk of becoming malnourished. This was a validated nutritional screening tool and was designed to identify adults at risk of malnutrition and to categorise them as being at low, medium or high risk.
- Care plans included information about nutritional care and fluid needs and how they were to be met.
- There were protected meal times on medical wards to provide an environment conducive to people enjoying their meals and being able to safely consume their food and drinks.
- All staff had the appropriate skills and competencies needed to ensure that the nutritional and fluid needs of

people using care services were met. All staff received regular training on nutritional care and management. We observed caring interaction between a patient and their family, and a nurse about their nutritional needs. Nurses we spoke with could also describe escalation processes around nutrition and hydration.

- Menu planning advice included design and structure; content and capacity; nutritional analysis; guidance on common dietary categories and supported patients from nutritionally vulnerable to nutritionally well. It also covered texture modification, cultural and therapeutic diets.
- We observed two organised meal services. They were well organised and efficient with good team working. Catering assistants served the food from a trolley and nurses and/or health care assistants delivered the food to patients. Food was delivered politely, tables were cleared to make way for the plate and assistance was provided to remove the lid from the plate. Food was piping hot, well presented and portions appeared adequate. Meals were delivered methodically from one end of the ward to the other. A red tray system was used for patients who were at risk of malnutrition
- We saw clear instructions for altered texture foods for patients with swallowing difficulties.
- The sister of the Coronary Care Unit gave an example of when staff found a patient had not received a mid-morning drink two days in a row. The person serving the drinks had not informed the staff on the unit or updated fluid charts. This meant that staff were unaware the patient had missed drinks. Once staff were made aware they asked the person serving the drinks to inform a member of staff if they had not had time to offer patients a drink and a strategy had been put in place to ensure staff members asked the patients they were looking after if they had had a mid-morning drink.

Patient outcomes

- The trust had improved the management of patients who were admitted with a suspected stroke although were still performing worse than the expected level. All cases of stroke were audited through the Sentinel Stroke National Audit Programme (SSNAP), to ensure patient safety and to evaluate the impact of the stroke management pathway together with thrombolysis rates. The audit assessed ten individual indicators representing important aspects of acute stroke services. Between June 2015 and July 2016 the overall rating for the trust had improved from a level E (score less than 60% compliance) to a level D (between 61% and 79% compliance, and the national average) for the management of stroke patients. The percentage of stroke patients spending more than 90% of their time in a stroke unit increased from 65% in January 2016 to 78% in December 2016% (though this remains below the national average of 82%). The proportion of patients directly admitted to the stroke unit increased to 57% in January 2016 to 71% in December 2016. This was due to a reconfiguration of wards which meant there were more dedicated stroke beds in the hospital.
- However, some indicators for the stroke pathway had worsened. In January 2016 70% of patients were having a CT scan within 60 minutes. However, this had dropped to 67% in December 2016. Another measure is that patients should receive a CT scan within 12 hours of presenting. However, performance had dropped from 95% in January 2016 to 87% in December 2016.
- The trust performed well in the national lung cancer audit and either met or exceeded in all key indicators including for data completeness, processes of care, and the treatment or outcome.
- The trust had participated in the National Audit of Dementia, to measure the care delivery and its impact on people living with dementia. The data had been submitted and verified and the trust were waiting for the results and feedback. The trust had also submitted data for the National Diabetes Inpatient Audit for inpatient care, secondary care, and general practice and were waiting for the results. It was noted in the last inspection report that the trust scored worse than the England and Wales median for 12 of the 20 indicators in the 2013 national diabetes inpatient audit.
- We asked the trust for the most recent data from myocardial ischaemia national audit. However, the trust failed to provide this information within the designated timeframe. During the last inspection we found that performance was mixed. A higher proportion of the trust's patients with non-ST segment elevated myocardial infarction (nSTEMI) was referred for or had angiography. A lower proportion was seen by a cardiologist or member of their team and a lower proportion were admitted to the cardiac unit or ward.
- We asked the trust for the most recent data from the heart failure audit. However, the trust failed to provide this information within the designated timeframe.

During the last inspection the trust performed worse than the England and Wales average on all but one indicator relating to in-hospital care and worse than average for all indicators relating to discharge.

- The trust participated in the National Clinical Audit for Rheumatoid and Inflammatory Arthritis in 2015. However, they did not have a large enough case size to benchmark against other providers. The trust took lessons from this to make improvements for the next submission.
- In the Coronary Care Unit patients may need to have non-invasive surgery to treat emergency coronary heart disease. This intervention is known as a Percutaneous Coronary Intervention. The target for receiving primary percutaneous coronary intervention is within 150 minutes of calling for help. The trusts local target is 75% of patients who are eligible should receive it within that time. Audit results were positive and showed that in December 2016, 8 of the 10 patients achieved the target. All cases that failed to meet the target were discussed at a monthly audit meeting with the consultant cardiologists who discussed how the pathway could be improved.
- Lowen ward worked to JACIE (Joint Accreditation Committee- ISCT (International Society for Cellular Therapy) & EBMT (European Society for Blood and Marrow Transplantation) standards when caring for their patients who required stem cells and had regular inspections by the committee with positive results.

Competent staff

- Appraisal rates were mixed across the medical directorate. This meant that staff did not always have their learning needs identified. The average compliance for appraisal rates across all of the wards, in November 2016, was 85% which was below the trusts 95% target. Some wards were significantly below the target. Kerensa ward had only 56% completion of appraisals; Tintagel ward had only 65% completion of appraisals and Carnkie ward had only 76% completion of appraisals. Some wards had a higher completion rate. Wheal Prosper ward had a 82% completion rate; Phoenix ward had a 93% completion rate; the Medical Admissions Unit had a completion rate of 92%, Grenville ward had a completion rate of 88%; and the Cardiac Investigation Unit had a completion rate of 92%. Wellington ward and Roskear ward had a 100% completion rate.
- Some nurses we spoke with said they had access to additional training when required. The sister on Lowen ward told us their skill mix was generally good. She added the ward needed more staff trained to give chemotherapy and were using agency staff who were competent to deliver chemotherapy until the ward had the required numbers. Chemotherapy practice educators had been appointed and were starting work in February 2017, it was hoped they would be crucial in ensuring enough staff were trained in giving chemotherapy. Trained nurses on the cardiac units and respiratory wards had extended skills for example cannulation, venepuncture, non-invasive ventilation. However, staff on Tintagel ward were not supported to get additional training to manage neurological patients. The nurses on this ward felt that they could not manage this patient group appropriately.
- All nurses on Wellington ward had attended a non-invasive ventilation (NIV) study day.
- Trained nurses on Wellington ward were studying a variety of topics – including asthma, COPD, care of the critically ill adult. The ward had two trainee assistant practitioners who were being well supported. Each band 6 nurse on Wellington ward had a personal development plan in order that they gained the skills needed for managing respiratory patients.
- Specialist nurses told us they had access to support from other specialist nurses in their region for example the sister on Lowen ward (heamatology/oncology and palliative patients and those that may need to be isolated) was part of the Peninsular Cancer Network who met to share information and best practice.
- Student nurses were seen on the wards/units. They told us they felt supported. The Coronary Care Unit won a Nursing Times Placement of the Year following good student feedback.
- There was a generic one week trust induction for new staff and nurses remained supernumerary for the first three weeks to ensure they were introduced to ward systems and IT systems. We spoke to a new member of staff who confirmed this to be the case. They had been well supported and felt ready to "hit the ground running". We also found that there was an induction for bank and agency staff that supported their learning. However we not speak to agency staff about this.

Multidisciplinary working

Medical care (including older people's care)

- We saw evidence that staff worked professionally and cooperatively across different disciplines to ensure care was co-ordinated to meet the needs of patients.
- We observed a multidisciplinary team meeting where patients' care and treatment were reviewed. The discussions were comprehensive and detailed and included a review of medical issues, medicines, continence, neurological and psychological status, end of life care issues, safeguarding issues, treatment escalation plans, capacity assessments and discharge planning.
- We saw a multidisciplinary rapid round on a care of the elderly ward. Each patient was discussed on a daily basis and the team included a doctor, OT, physio and trained nurses.
- Rotas for junior doctors on different contacted hours did not tie in with timetabling. Doctors working on a 9am to 5pm rota would miss the ward round at 8.30am and relied on colleagues working on an earlier start time to up-date them. This meant that information which should have been shared between doctors may have been missed. We were told that staff had ad hoc conversations with doctors to get them up to speed. Although this meant that information was being shared, it wasn't effective and if important information was not handed over, this could compromise patient safety.
- Nurses worked with pharmacists to complete a discharge checklist. This included the consolidation of medicines for the patient to take home to ensure that this was prepared in a timely manner. For neurology patients there was a staffing model known as 'consultant of the week'. This meant that there was one consultant responsible for the neurology patients on Tintagel ward each week. Senior nurse leaders and staff on the wards described this as a risk. Nurses described to inspectors a lack of support from the neurological consultants. We were told that due to the work patterns of the consultants (a weekly rotation of a consultant for the ward) meant that there lack of continuity and lack of ownership/concern around resolving issues. We were given examples where patients were missing anti-epileptic medications during their stay because no one consultant took responsibility for that patient due to the use of the 'consultant of the week' model which only neurology services used. We were also told that there were regular discharge delays as a result of this.
- The hospital had many work streams ongoing at the time of the inspection to ensure that patients were ready to be discharged. As part of the SAFER bundle multidisciplinary board rounds had to be started on time and included input from a consultant or registrar, therapists, discharge co-ordinators and ward clerks. This was to assist in early discharge allowing plans to be put in place to fill the bed. Data showed that board rounds were attended by the correct staff almost all of the time meaning that appropriate senior review was happening to reduce unnecessary waiting. We saw audit results for a one week period. On Kerensa ward the board round was attended by a consultant for three days, and by a registrar for four days. The board round was also attended by occupational therapist and a physiotherapists every day. On Wellington ward two consultants attended four days and registrars attended three days. The occupational therapist attended for four days and the physiotherapist attended every day. However, on Roskear ward over a week's period no consultants or junior doctors attended the board review, as they were on ward rounds, but it was attended by occupational therapists and physiotherapists. Also on Wheal Prosper ward no consultants attended the board round, which delayed discharge processes, as they were on ward round at the same time, but physiotherapists and occupational therapists attended daily.
- Morning discharges should be normal practice within a hospital as it reduces crowding in the emergency department, allows new patients to be admitted early enough to be properly assessed and treatment plans established and commenced. A standard of the SAFER bundle was that 30% of patients should be discharged before midday. The trust has not met this standard between April 2016 and November 2016 with an average of 21% of patients being discharged before midday despite consultant ward rounds happening at 8am.
- Discharge was a constant priority for the staff at the hospital. Discharge planning reviews were held for all patients who had been ready for discharge for seven days to put additional measure in place to support discharge. There was a matrons ward review held daily (even at weekends) with the clinical site manager to go through every patient in the hospital.
- A process of identifying a 'golden patient' had been introduced to ensure that one patient who could be easily discharged was by 10am. Bed flow meetings were held four times a day to ensure that capacity was managed to the best of their ability.

Medical care (including older people's care)

Seven-day services

- All medical specialities except neurology held ward rounds on a daily basis, even at weekends and on bank holidays. Many specialities ran a seven day consultancy service. Cardiac medicine, renal medicine, gastroenterology medicine, and general medicine all had services during the week, at weekends, on bank holidays, and provided on-call services 24 hours a day seven days a week. For respiratory medicine and endocrine medicine cover was provided during the week, and in the mornings on weekends and bank holidays. However, this was due to change in June 2017 where weekend working hours would be extended. The acute medicine speciality and eldercare had consultancy cover during weekdays, and in the mornings on weekends and bank holidays but no on call cover was provided.
- Neurology was not providing a seven day consultancy led service which put patients at higher risk during weekends as there was no specialist cover.
- There was a seven day service for physiotherapy with an out of hours on call service for urgent patients, for example patients requiring urgent respiratory physiotherapy. Occupational therapists and speech and language therapists provided a six day service. There was access to out of hours imaging, therapy and pharmacy support.

Access to information

- Notice boards at entrances to wards showed information for patients, for example, a patient safety newsletter and a cleaning analysis.
- Information needed to deliver effective care was available to staff – care plans, risk assessments, medical records.
- Staff said the diagnostic images were available quickly and were reported on in a timely way.
- We asked for some notes of a patient who had been discharged. The ward clerk liaised with the medical records department and was able to provide the notes quickly. The system for retrieval of notes was effective.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of all policies regarding consent, mental capacity act and deprivation of liberty safeguards and had access to them through the intranet. Most senior nurses felt competent to raise consent issues and to complete the relevant documentation. They were aware of the policy from initiation to best interest assessment and the revisiting and lifting of deprivation of liberty safeguards where appropriate. A review of consent forms in patient notes showed that most forms had been correctly completed by an appropriate member of the medical team.
- Patients gave their consent when they were mentally and physically able.
- We observed a member of staff taking consent verbally before carrying out test procedures.
- Staff had a good understanding and guidance to follow in relation to mental capacity assessments. There were patient mental capacity assessment forms which led on to considerations of how decisions were then made in the patient's best interests. The forms followed the provisions of the Mental Capacity Act (2005) in that they recognised a patient's mental capacity to make decisions could be temporary and related to the decision in question and not all future decisions.
- On the coronary care unit staff were very aware of the need to consent for procedures as they had patients who may have dementia, hypoxia or a learning disability. We discussed a patient who was waiting for a cardiac implant who did not have the capacity to consent for the procedure. It was clear the staff knew how to get advocate support if required and the process of assessing mental capacity before the procedure took place.
- We saw completed deprivation of liberty safeguard process in patient notes on Kerensa ward. This included a capacity assessment and documented reasons why that could not be completed effectively, as there was no known next of kin. There was a leaflet provided to the patient and documented notes to show that a full explanation of the process and the reasons behind it were given to the patient.

Are medical care services caring?

Good

We rated caring as good because:

- Feedback from patients and those close to them were positive about the way staff treated people. People were treated with dignity, respect and kindness during their stay.
- People are involved and encouraged to be partners in their care and in making decisions, with any support they need. Staff spend time talking to people, or those close to them.
- Staff had the skills and compassion to communicate effectively to patients during times of distress. This was particularly apparent in the coronary care unit.
- Feedback was overwhelmingly positive on Wellington ward. Staff were enthusiastic about the care they were giving. Patients felt that staff went the extra mile and exceeded their expectations.

However:

- Friends and Family response rates were not good across the medicine directorate. For example on Carnkie ward, Tintagel ward and Kerensa ward response rates were below 10%.

Compassionate care

- During this inspection we spoke with 42 patients and relatives. We found that feedback was consistently positive and that care was delivered in line with The National Institute of Clinical Excellence quality standard 15 statement one which states that patients should be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty. Care from the nursing, medical staff and support staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance. Patients we spoke with said "I think it's marvellous in here and that's because of the staff", and "All the staff are very professional and they treat me with respect.''. Other comments included; "the staff have been fantastic", "I'm very happy with the care I've had … I can't fault it".
- The National Institute of Clinical Excellence quality standard 15 statement two states that patients should experience effective interactions with staff who have demonstrated competency in relevant communication skills. Staff were skilled in talking to and caring for patients. We observed interactions between staff and patients and their relatives. Staff were open, friendly and approachable but always remained professional. During our inspection we observed excellent interactions between staff, patients and their relatives. We saw these interactions were very caring, respectful and compassionate. For example, when a patient became upset when their relative had to leave a member of staff went to great lengths to reassure and comfort them.
- Dignity and confidentiality were respected at all times. We found that on all of the wards whenever physical or intimate care was being done the curtains were closed appropriately. When staff entered and exited the bed areas care was taken to minimise the visibility of the patient. One patient said "All the staff are very professional and they treat me with respect.''. Another patient said ''Care's been fantastic and very respectful.''. However, on the Medical Admissions Unit we saw that one patient was walking around the ward without their gown being done up properly which compromised their dignity.
- Dignity was preserved for patients who had passed away. We saw on the Coronary Care Unit that curtains were closed around other patients when deceased patients were removed.
- We found on the Coronary Care Unit staff showed an encouraging, sensitive and supportive attitude towards patients and those close to them. Patients in this area were in close proximity to very ill patients whose care may be managed by the end of life team. Staff took the time to speak to patients about any concerns they had about their care to reassure them.
- Comments about compassionate care were overwhelmingly positive on Wellington Ward. Staff we spoke with were enthusiastic about the care they were giving which had a positive impact on patients wellbeing. Patients we spoke with said "They have restored my faith in the NHS.", "The staff here should be Ambassadors to other wards.", and "It's like living in a Bed and Breakfast, nothing is too much trouble". Other patients commented about the positive atmosphere and the attitude of staff. One patient said "The care is unbelievable; they don't let you be sick." And another said "It's a nice atmosphere and everyone has a pleasant attitude" And that "We get very good treatment in here".
- The Friends and Family test is a nationally recognised tool used to help service providers and commissioners understand if their patients are happy with the service provided, or where improvement is needed. We found that the percentage of patients who would recommend the trust as somewhere to receive care was positive,

however response rates varied. The average percentage of patients who would recommend the trust as somewhere to receive care was 95%. The average response rate was 32%.

- In November 2016 some wards which had a high response rate and a high satisfaction percentage were the Coronary Investigations Unit (99% recommendation from a 47% response rate), the Coronary Care Unit (100% recommendation from a 55% response rate), Phoenix ward (100% recommendation from a 53% response rate), Wellington ward (100% recommendation from a 52% response rate, and Roskear Ward (98% recommendation from a 75% response rate), Grenville ward (91% recommendation from a 22% response rate) and the Medical Admissions Unit (98% recommendation from a 29% response rate).
- In November 2015 some wards received a high percentage recommendation rate but had a low response rate which made the information less reliable. Both Carnkie and Tintagel wards had a 100% recommendation rate but only an 8% response rate.
- The wards with the lowest recommended percentage were Kerensa ward (75% recommended) and Wheal Prosper ward (83% recommended). Wheal Prosper ward had a high response rate of 21.4%. However, Kerensa ward only had a response rate of 9% making the information less reliable.
- The staff survey showed that all staff were committed to providing high quality care. However, they were not able to provide care as they would like. This was evidenced in the impact on patient care seen as a result of staff shortages.

Understanding and involvement of patients and those close to them

- Patients were given opportunities to discuss their cultural/ religious beliefs, concerns and preference to inform their individualised care in line with the National Institute of Clinical Excellence quality standard 15 statement four. Patients were involved with their care and the decisions taken. We observed staff explaining things to patients in a way they could understand. For example, during a complex explanation, time was allowed for the patient or their relative to ask whatever questions they wanted to. Patients were encouraged to be as independent as possible and relatives were encouraged to provide as much care as they felt able to. However, on Kerensa ward one patient said that this was not always the case. One patient said "I need to be out of bed and motivated, but they are so busy".
- All healthcare professionals involved with the patient's care introduced themselves and explained their roles and responsibilities. Patients we spoke with, who had capacity, said they felt fully involved in their care whilst in the hospital and understood their discharge plans.

Emotional support

- We observed staff providing emotional support to patients and relatives during their visit to the department. Patient's individual concerns were promptly identified and responded to in a positive and reassuring way. One patient said that "nothing was too much trouble for the staff… from the doctors and nurses to the ward clerks."
- Patients and their relatives were spoken with in an unhurried manner and staff checked if information was understood. We overheard staff encouraging relatives to call back at any time if they continued to have concerns, however minor they perceived them to be.
- Staff we spoke to were able to describe the systems in place following cardiac problems that included cardiac rehabilitation services designed to support and empower patients to manage their own conditions and remain independent.

Are medical care services responsive?

Inadequate

We rated responsive as inadequate because:

- Although processes were in place to support flow within the hospital there were not enough beds to meet the demand of the service. Bed capacity was full and escalation areas (such as theatres and day case surgery) were regularly being used. Additionally there were 40 medical outliers in surgical wards. This took up 16% of the surgical bed base.
- People were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment and people experienced unacceptable waits for some services. During the inspection over 100 patients were delayed in hospital due to inability to access community services. On

average 97 patients a month were waiting longer than seven days for discharge. This increased the risks of patients deteriorating, prevented patients who required medical care accessing wards, and caused crowding in the emergency department. Between April 2016 and December 2016 over 1700 bed days were lost as a result of inadequate hospital flow. There was evidence to show that this had been getting worse over time, and since the last inspection.

- There was a waiting list for cardiac procedures within the hospital with some patients not being seen by their see by date. Although the trust had been mitigating risks due to monitoring of patients we saw evidence that patients had come to harm as a result of waiting. There was evidence to show that this had also been getting worse over time.
- Complaints were not being handled in a timely way. A third of complaints were resolved beyond their timescales.

However:

- We found that some reasonable adjustments had been made to manage individual patient needs. This included patients living with dementia and patients with a learning disability. We found that there had been significant improvements in the stroke service which ensured that the design of services were tailored to meet their needs.
- We found that it was easy for patients to raise a concern or a complaint. There was openness, transparency, and a will to learn from complaints on the wards. We found examples where learning from complaints had resulted in changed practice locally.

Service planning and delivery to meet the needs of local people

- The premises and facilities were not always appropriate for the number of patients coming to the hospital. The wards did not have the bed capacity in the hospital for all of the patients requiring medical beds and for those patients who were clinically stable and able to be discharged but were waiting for this to take place. During the inspection the trust had activated the full capacity protocol which meant that bed occupancy was at 100%. The Dr Foster Hospital Guide 2012 identified that occupancy rates above 85% could start to affect the quality of care given to patients.
- The capacity issues of the medicine division were having an impact on the surgical division. Additional areas were opened to accommodate medical patients including Theatre Direct recovery (which had 16 patients in overnight) and Newlyn day case recovery (which had five patients in overnight). One patient in Theatre Direct recovery had been there for seven days. Additionally to this there were 40 medical outliers on surgical wards which had taken 16% of surgical beds. As a result, elective patients had their surgery cancelled which meant they had to wait longer for their procedure.
- The trust had set up an intermediate care and discharge ward where patients who were clinically stable and ready for discharge could be transferred to while they waited for ongoing care. This was meant to be an area for short term stays to free up beds on the wards. However, patients were staying in this area for a long time awaiting discharge due to delayed transfers of care.
- Improvements had been made to the capacity issues in the medical admissions unit. During the last inspection medically expected patients (patients who the hospital were expecting to arrive, usually as a referral from a GP) were being directly sent to the medical admissions unit which led to patients waiting for long periods of time in the corridor. As a result of this several serious incidents had occurred as there was not the right staff mix to safely manage these patients. During this inspection we found that there were not patients waiting outside the medical admissions unit but were being looked after within the emergency department. Please see comments relating to this in the urgent care section of this report.
- Individual services within the trust worked with patients who had to attend the acute hospital from the Isles of Scilly. This included making appointment times early or late in the day to ensure patients could travel to the mainland. The trust also offered telephone appointments if possible for these patients.

Access and flow

- Flow through the hospital was severely impacted by delayed transfers of care into community hospitals and into the wider care system. A delayed transfer of care (sometimes known as 'bed blocking') is where a patient is ready and safe to leave hospital care, but is unable to do so, and remains occupying a hospital bed. Keeping patients in hospital longer than necessary can affect patient morale, patient mobility, and increase the risk of

developing a pressure ulcer or acquiring a hospital-acquired infection. If a patient waits for more than two days the additional benefits of rehabilitation in hospital is negated. A patient waiting more than seven days is associated with a 10% decline in muscle strength. This also means that patients coming into the hospital, who require a hospital bed due to clinical need, cannot get one.

- The number of days where a bed was blocked was recorded by the trust as 'bed days lost'. In Royal Cornwall Hospital the trust had a tolerance of 576 bed days lost per month which was a high threshold. The trust was significantly in breach of their targets with an average lost bed days per month between April 2016 and December 2016 of 1767 days. This was on average 1191 bed days above the target per month. During the last inspection the average bed days lost per month was 964 showing a decline in performance.
- On 3 January 2017 there were 176 patients who required transfer into either a community hospital, a care home, or required a package of care in Cornwall (this number includes the acute trust and community hospitals in the county). Of these patients, 101 were delayed within the hospital.
- Of the 101 patients, 49 were awaiting discharge into a community hospital, 19 were waiting for domiciliary care packages, 16 were waiting for wider community placement and 12 were waiting as their community assessments had not yet been completed. On January 4 2016 there were more patients delayed in the hospital with 113 patients awaiting discharge. Of these patients 43 were waiting for a community bed and 70 for a wider community placement. During the last inspection the average number of patients delayed per day was 62 showing a decline in performance.
- All patients admitted into the hospital were subject to the SAFER care bundle. This bundle of care sets out the expectations for discharge and acted as standard best practice criteria. One standard is that 80% of patients should be discharged by, or on their clinically stable date. However, between April 2016 and November 2016 only 54% of patients were discharged on their clinically stable date putting patients at risk of deterioration and acquiring a hospital-acquired infection, and further compromising capacity.
- Another standard was that if a patient was in breach of their clinically stable date they should be discharged within seven days. The trust performed well against their internal targets, however, their threshold was high allowing 100 patients to breach the seven day target each month. The average number of patients per month in breach of this standard between July 2016 and November 2016 was 97 patients putting patients at risk of deterioration and acquiring a hospital-acquired infection.
- The trust were in regular contact with outside organisations such as the clinical commissioning groups and the local authority about the pressures around flow of patients and the inability to discharge patients who were medically fit for discharge due to capacity in the local community. However, we were told that support from these organisations was not forthcoming. For example when gold calls were held on a daily basis we were told that other organisations would regularly not attend, so couldn't offer support to the trust with discharges. We observed one gold call and not all expected participants attended the call, and those that did were ill prepared to support the trust with real time information as to capacity in the wider system.
- Staff we spoke with said that there was a culture of being risk averse to discharge. The trust has recognised this and was going to be conducting a programme of work to change this. We were given examples where consultants and therapist had set unrealistic expectations on patient improvements or mobility resulting in them staying in hospital longer.
- The trust had also commissioned an external piece of work to look at the discharge processes, and had found that they were overly complicated; work was underway to simplify this.
- There were a waiting list for cardiac procedures within the hospital with some patients not being seen by their see by date. At the time of the inspection there were 1073 new patients and 7160 follow up patients waiting for an outpatient appointment with a cardiologist. Of the patients waiting there were 713 patients waiting beyond their see by date. Of these patients 348 were waiting over three months with two patients waiting for over 10 months. There were 57 patients who had been waiting longer than three months who needed to be seen urgently as a result of increased risk when waiting. Data showed that the numbers of patients waiting for procedures had increased month on month. At the time of the inspection all urgent patients were seen within

two weeks. We were told that patients were monitored by their GP's for signs of deterioration. Where deterioration had been spotted urgent referrals were quickly made.

- These delays were caused by multiple vacancies within the cardiology team which was on the divisional risk register. There were work streams in place to incrementally reduce the size of cardiology waiting lists with the aim of seeing all patients by their see by dates by November 2017. This included additional recruitment, a review of pathways and a review of consultant job plans and rotas.

Meeting people's individual needs

- Services were planned to take into account the needs of different people. We saw that patients were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs. For example, patient specific care plans were used with behavioural charts to help staff care for patients on an individual basis.
- Services were planned and delivered around people with complex needs including patients living with dementia and patients living with a learning disability. For patients living with dementia a "This is me" document was available for families or carers to complete to provide information about the person, such as the activities they enjoyed.
- There was a learning disabilities liaison nurse to facilitate the care of patients with learning disabilities. The sister on CCU said they regularly had patients with learning difficulties admitted for cardioversion. It was their policy to always let the hospital LD team know about their admission. The unit were able to make reasonable adjustments to allow relatives or carers of patients with learning difficulties or dementia to stay with the patient, outside of the designated visiting hours, perhaps at mealtimes or during their personal care.
- On Wellington ward we saw a memory box and twiddle muffs for use with patients who were living with dementia or had delirium. Twiddle muffs are handmade gloves with items sewn onto them to provide stimulation activity for restless hands commonly associated with patients living with dementia. Patients living with dementia had red trays at mealtimes to indicate to staff that they may need some help and/or support. However, on Kerensa ward that regularly had patients who lived with dementia we did not see any memory boxes or planned activities for these patients. Not all staff had yet attended the trusts one day dementia training course, although a plan was in progress to ensure all staff attended.
- There was a dedicated stroke ward which had recently moved. The ward was nearer to other services, for example CT and critical care. The trust also provided access to a thrombolysis service. There were designated beds available on the stroke ward for the treatment of selected patients with acute ischaemic stroke where thrombolysis was recommended. There was a quiet room, close to the unit, for relatives to use if they were staying with an ill relative or after a relatives death. There was a shower and toilet, drink making facilities and a TV.

Learning from complaints and concerns

- Patients knew how to make a complaint if they needed to and also felt they could raise concerns with the clinical staff they met. Most patients and relatives told us if any issues arose they would talk to the senior nurse available. The route to complaints was publicised in all wards through leaflets and via the trust website. Patients, carers and relatives were able to complain via the dedicated web links, by letter, email, telephone or in person to any member of staff or directly to a member of the Patient Advice and Liaison Service.
- The staff we spoke to were all aware of the complaints system within the trust and the service provided by the central complaints team. They were able to explain what they would do when concerns were raised by patients. Staff told us that they would always try to resolve any concerns as soon as they were raised, but should the patient or their family remain unhappy, they would be directed to the ward sister or the trust complaints process.
- Learning from complaints were shared on wards through staff safety briefs. Staff we spoke with could give us examples on their ward of how improvements had been made as a result of learning from complaints. However, staff could not give us examples of where learning had been shared across other wards or areas.
- Oversight of complaints was observed through the medical services governance board. Between April 2016 and December 2016 there had been 145 complaints

made (an average of 16 per month). Of the closed complaints 34% were done so outside of their timescales. Of the 21 complaints that were still open 50% were already in breach of their timescales.

Are medical care services well-led?

Inadequate

We rated well-led as inadequate because:

- Although staff understood what the vision and values were, they felt they were not able to fully live by them due to the pressures of the job. We were also given examples where senior staff had showed a lack of compassion to staff which was not in line with the trusts values.
- The strategy was clear and recognised the challenges the medicine division had. However, some of the objectives were unachievable considering the status of the wider health system.
- There was no effective assurance system in place for identifying, capturing and managing risks between ward and divisional level. There was no assurance that risks were being escalated and actioned appropriately.
- There was a disconnect between the local and divisional teams which meant there was limited openness, transparency, and a culture of helplessness from filling in incident forms or raising concerns as staff felt nothing would happen.
- Leaders did not have the capacity or capability to lead effectively. There was a lack of support from the wider system which led to delays in the management of key risks, such as patient flow. This cascaded down to ward level and provided a lack of reassurance to staff that they were supported or would be listened to.
- There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported and appreciated. This was particularly apparent on Tintagel ward.

However:

- Despite the pressure on the wards there was a culture of openness and transparency between the team which was cascaded from the ward manager and matrons. All staff we spoke with were positive about the attitudes of the matrons and said that they led the service well.
- Staff were focused to continually improve the care they were giving. This was particularly apparent on Wellington ward where innovate schemes had been introduced to develop skills further.

Vision and strategy for this service

- Royal Cornwall Hospitals Trust vision and values were clear and easily accessible on the trusts website. We found that posters, leaflets, and newsletters had the vision ("working together to provide outstanding care") was on them. However, when we spoke to staff we found that although the staff knew what the values were, they found that due to the workloads, they were difficult to deliver. One member of staff said "the staff here are dedicated, and we don't see staff not being caring". However, some staff on the wards criticised how well the senior teams live the values. A member of staff said that when the wards are busy they were made to "feel like it was our fault" and there was a "lack of compassion" from higher up in the organisation.
- The trust's Operational Plan 2016/17 clearly demonstrated the challenges to delivering the trusts objectives and set out strategies to achieving them. This document also recognised the achievements of the trust as well as the short falls. The main challenges which affected medicine were hospital flow, the stroke pathway, hospital death, and workforce. However, not all objectives could be considered as achievable. For example, the document states that (through the SAFER bundle) 40% of patients would be discharged before midday which was not achievable with the wider health economy. At the time of the inspection the average percentage of discharge before midday was significantly lower than this target.

Governance, risk management and quality measurement

- There were not sufficient assurance systems which ensured that appropriate action had taken place and that the information used to monitor and manage quality and performance was accurate, valid, reliable, timely or relevant. Processes were in place to look at risks categorised as red on a monthly basis and risks categorised as amber every three months by the divisional team. At divisional level the risk register was reviewed through the medical services governance board which met on a monthly basis. A new risk management process had recently been approved and

was being implemented which amended how risks were managed and the tolerance levels of those risks. There were 313 risks on the medical services risk register. Of these risks 151 (48% were overdue a review). A validation exercise was underway which had found that there were risks on the risk register multiple times (an example being four items on the risk register for one incident where there should have been one) and risks were out of date. One example was for a computer server problem which was resolved 12 months prior to the inspection.

- There were five extreme risks and 37 high risks on the risk register. Several of these risks were associated with cardiology which the register identified were not being mitigated. There were significant backlogs of patients for elective procedures resulting in multiple breaches in referral to treatment times as a result of significant vacancies.
- Some risks were not regularly reviewed. There were two risks on wellington ward concerning the acuity of patients resulting in the potential for unsafe care and the care of non-invasive ventilation patients which had not been reviewed since August 2012. One of the risks in cardiology had not been reviewed since January 2016.
- We were told that sometimes when risks were assessed by sub specialities the scores were exacerbated as a method to get support from the divisional team for specific issues which don't require it. We were given another example from a nurse who said that for the cardiology unit writing incident forms about delays in care became a "full time job" but that "nothing happens to these incident reports."
- The divisional team provided inspectors with little assurance that risks were being managed effectively. Senior staff told inspectors that during the inspection "very little" was done to manage risks at a divisional level and that the division had narrowed its focus too much. We were told that although risk registers appear on every meeting agenda in the division the time was not being used effectively and that "the escalation of risks was not necessarily happening" and that the divisional team were not holding sub specialties to account for risks which may be under the radar.
- There were innovative systems in place to audit and to record data through the use of a quality, experience, workforce and safety dashboard, which uses data from the QUANTA audits, and key performance nursing and midwifery indicators. Risks which they identified were not being escalated or actioned appropriately with examples being seen in the use of the quality, experience, workforce and safety dashboard and the key performance indicators report. The quality, experience, workforce and safety dashboard included 32 different measures and rated them based on a score. These were not discussed at the medical services sisters meeting. The key performance indicator report looked at 118 different measures around quality and safety. However, these were not discussed in depth at the medical services directorate sisters meetings or escalated appropriately. In November 2016 this meeting identified that 26% of audits done in September 2016 failed compared to trust targets. However, actions were only to raise awareness of compliance which was not proportionate to the risks involved. These concerns were not escalated to the matrons meetings or the division's quality assurance meetings.
- We were assured however, that risks at a local ward level were being managed and mitigated. For example, the cardio-respiratory speciality risk register was available to staff. The ward sister was able to show that there were 14 risks and the register had been updated on 03 January 2017. The register showed the top three risks and the top three areas for improvement.
- We were told that newsletters were used on some ward areas to distribute and disseminate the ward messages on learning from incidents, complaints, and themes. However this was not consistently done as only Wellington ward and cardiac wards were doing this. Senior managers said that were trying to change the culture around this issue and wanted it "to be seen as useful rather than just another job to do". This meant that divisional wide learning was not always shared in a consistent way. Therefore, opportunities for learning were missed.

Leadership of the service

- Leaders did not have the capacity or capability to lead effectively. Senior leadership within the division said that they spent "their entire time firefighting" and didn't have sufficient time to improve services. Work which should be a priority (such as work on the integration of services for counties sustainability and transformation

plan) was not happening as they needed to rectify significant issues within hospital. One senior manager said "we can't get to an integrated point until our own house is in order".

- Work was in progress within the trust at the time of the inspection to improve leader's capacity to lead effectively. The medicines division had been split into four directorates since the last inspection, each with a governance and clinical lead. This was clearly evidenced on the 2016 divisional structure. This meant that workload between the senior team was spread out and that they were given the time to lead effectively. We were told that this model still had a long way to go, and that further changes may be needed.
- There was a demonstrable disconnect between the wards and the divisional management team. We were told that concerns were not being heard above matron level. One member of staff said that "concerns are escalated into oblivion". We were given examples where multiple incident forms had been filled in due to staffing levels but no actions were taken as a result. Staff we spoke with said that they did not feel that they could raise concerns as they had "resigned to the fact that things don't move forward" and that things would not change. Another member of staff said "I thought I was insane thinking it was going to get any better". One member of staff said that the divisional team react to concerns rather than act proactively and that "the only time things change is when CQC come in".
- There was a high turnover of staff within the executive team. The impact of which was being felt in the medical directorate. The high turnover had caused delays to work streams and raised uneasiness amongst staff. For example, the strategy to manage patient flow through the hospital was regularly changed as new chief operating officers came into position. Staff on wards were prepared for change and would continue to drive for high-quality care. However, staff said the continued changes at senior management level created a lack of stability and concern about a lack of commitment to the trust. Staff said "it's become the norm for people to leave we just expect it now."
- Historically relationships with the wider health system had not been good but many senior leaders told inspectors that they were improving. We were told by senior managers that the chief executive of the trust had been a large factor in improving that relationship.
- However, the pace at which improvements were made, particularly around the management of hospital flow was inadequate and staff we spoke with felt they were not supported by the wider system. Almost universally in the medicine directorate senior staff had the view that the wider system could do more. One member of staff said "the system doesn't feel the risk or the pressure" and that their actions are not proportionate to the urgency or risk involved. Another member of staff said that the trust is "coordinating the whole system" and that they were having to put pressure on external organisations to lead effectively. One example we were given was when the trust had conducted bed modelling exercises which show that over the winter period of 2016/ 2017 the hospital would need an additional 80 beds to meet demand. However, the trust did not get a response from the local clinical commissioning group as to how this could be addressed. One member of staff said that there was an "expectation to muddle through". Another example was when the trust commissioned an external report on discharge in the county, the report made a list of recommendations which were not acted upon by the wider system.
- We were told that senior staff were not visible on the wards. Many staff we spoke with could not identify who the senior team were and those who did know them said they did not have the confidence to approach them. An example of this was one member of staff said "I would not know who the executive team were if I passed them in the corridor". However, staff we spoke with said they were positive about the matrons and their ward level leaders.
- The nursing leadership of the wards had the skills, knowledge and integrity to lead the service. They were an experienced and strong team with a commitment to the patients, and also to their staff and each other. They were visible and available to staff and we received positive feedback from staff who had a high regard and respect for their managers. There was a strong senior nursing team and all staff we spoke with felt supported by their matrons. They in turn were proud of their teams and recognised that staff worked hard within their roles. One manager told us they were most proud of the "safe, high quality care given" who "always did the right thing for the patient." One nurse we spoke with said that there was good leadership in the wards and that the matrons "create a buffer to the inconsistencies in the executive team".

Medical care (including older people's care)

Culture within the service

- Staff we spoke with did not feel respected or valued which had a negative impact on their wellbeing. The senior nursing team felt that often their professional judgement was questioned by divisional staff. An example of this was the lengthy processes required when making a request to request additional shifts. At the time of the inspection these required senior approval before any changes could be made, which caused delays. Some staff we spoke with said that supportive services such as human resources, governance, learning and development and infection control did not always provide the support required and clinical staff said they had to "sort it out themselves.". We spoke with one senior nurse who said "they can't bear to see junior nurses crying anymore" and that "they had never worked anywhere as uncaring as this".
- Due to lack of support from the divisional team, morale and wellbeing on Tintagel ward had declined. The ward had changed in April 2016 from an elderly care ward to a joint elderly care and neurological ward but felt that they were not supported through this transition and that support was inconsistent. The senior team told staff that they would be getting additional training to manage the complex neurological patients, but this had never happened. We were told that any support that was needed they had to find themselves.
- Workload was high and relentless and although the teams felt they worked well together they were concerned the pace was not sustainable. The culture at ward level encouraged candour, openness and honesty. Most staff we met said they felt supported within their teams to challenge and raise concerns and anxieties. They were confident they would be heard. However, this was only at a local level. One member of staff described the workload like an elastic band being stretched that was about to snap.

Public and Staff engagement

- There were systems in place to gather the views and experiences of patients. In addition to the Friends and Family Test, patients were encouraged to make comments by email, letter or twitter. We saw a wide range of patient leaflets displayed at the entrance to ward areas. We saw there were systems in place to engage with the public to ensure regular feedback on service provision for analysis, action and learning.
- Systems were also in place to engage with staff in some areas. In both Wellington ward and in cardiac wards sisters issued regular newsletters for their teams. Issues included staffing, the ward environment, incidents and complaints, performance assurance framework, nursing quality indicators, areas of achievement and under performance, education and study opportunities, Friends and Family results, quality and efficiency projects, new policies and procedures, the matrons round and actions the senior nursing team had to address. The chief executive also issued a weekly statement and news was communicated by email. However, staff we spoke with said they didn't regularly get time to read them.
- Staff had access to occupational health services and activities such as zumba, pilates, yoga and Indian head massage. Skin screening was included as part of the annual personal development review.
- Staff had access to a canteen during the day, however, facilities for night staff were poor as the canteen closed at 6pm and staff only had access to a vending system.
- The trust held One+all/ We Care awards on a yearly basis where staff were nominated by their peers for their outstanding achievement and contribution to care. The 2016 awards were held in November and 21 individuals and teams were recognised across the trust. Staff awarded within the medicine division included a healthcare assistant on Roskear ward, staff on Carnkie ward, pharmacy staff, and a respiratory specialist nurse.

Innovation, improvement and sustainability

- Leaders had introduced innovative ways to strive for continuous learning, improvement and innovation. For example 'MASH up Monday' training had been introduced on Wellington ward which involved weekly training sessions on a variety of subjects. A ward sister involved in this won a trust pride and achievement award in November 2016. Another example of this was a respiratory doctor organising a training day in an external venue for training, discussions and lunch around respiratory care. This was well received by staff and the matron we spoke with said the doctor was enthusiastic and engaging.
- Staff were focused on continually improving the quality of care for their patients. Staff we spoke with showed a willingness among teams to develop services and the felt encouraged to share ideas. One example was where

the clinical matron for the cardio-respiratory team was shortlisted for a Nursing Times award in January 2016 for introducing 'matrons rounds' to promote good quality care and treatment.

End of life care

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

Information about the service

End of life care throughout Royal Cornwall Hospital encompassed all treatment and care provided to patients identified as approaching the last 12 months of life, as well as for patients for whom death was imminent. This included essential nursing care, specialist end of life care, and bereavement and chaplaincy support and mortuary services. Care and support was also offered as required to relatives and those people close to patients.

End of life patient care was provided by staff working on any ward or clinical setting, such as within outpatient clinics and the emergency department. Additional expertise was available from the trusts specialist end of life team. The team provided trust wide expert clinical advice, support and staff training, particularly for patients with complex care needs.

There was a newly built cancer support centre accessible to any person affected by cancer. This was staffed by Macmillan professionals who were employed by the trust and a range of training was also available to staff through the centre.

The specialist end of life team comprised of: two whole time equivalent (WTE) and one part time nurse specialists, one part time administrator and one (WTE) consultant. An identified link occupational therapist and chaplain both attended a weekly end of life patient referral and review meeting. An end of life care facilitator had been appointed on a fixed term contract during April 2016 to primarily provide generic staff with end of life education throughout the trust. During May 2016 the head of midwifery took on the role of trust lead for end of life care. The director of nursing was the trusts executive lead for end of life care.

Between 01 January 2016 and 30 November 2016 the trust reported there had been 1481 deaths in the hospital. During the same period, 808 referrals were made to the specialist end of life team. Of these 582 (72%) were cancer related, and 226 (28%) were non-cancer related.

During this inspection we visited eight wards and seven other specialist departments. These included: the intermediate care and discharge team, the onward care team, the discharge lounge, the cancer centre, the mortuary, chaplaincy service and bereavement office. We spoke with five patients and four relatives of patients. We reviewed 17 patient care records and looked at 25 combined patient treatment escalation plans and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms.

We spoke with 36 staff about end of life care. These included; the specialist end of life consultant, two of the specialist nurses and the end of life facilitator, 13 registered nurses, six health care facilitators, two chaplains, the end of life trust lead, the director of nursing, two administrators, one mortuary assistant, two consultants, two junior doctors and two volunteers.

We observed care being provided to patients and relatives and attended a specialist end of life weekly multidisciplinary team meeting. Before, during and after our inspection we reviewed the trust's performance information.

End of life care

Summary of findings

We rated the end of life service as inadequate because:

- End of life risk and quality information was not fully understood by ward staff and issues were not routinely reported as incidents.
- End of life care incidents were not routinely scrutinised for safety and quality improvements.
- Improvements were required to how treatment and care plans were completed by staff. This included how doctors completed treatment escalation plans and how all clinical staff assessed and documented patient's personal, psychological and spiritual needs, goals and wishes.
- There was a lack of understanding by staff throughout wards that end of life care extended to the potential last year of life and care was not restricted to cancer.
- Some medical staff lacked training and understanding regarding when it might be appropriate to consider end of life care instead of active treatments.
- The specialist end of life team was small and the rate of referrals to the team was increasing. There was limited cover for absences and no succession planning in place.
- There was inconsistency in understanding by senior ward staff regarding which nurses had in date training and competence to set up and monitor syringe drivers (used to automatically deliver medicine under the skin).
- Governance processes were not fully developed to ensure safety and quality issues were thoroughly reviewed and appropriate actions put in place.
- There was a lack of routine audit activity and no systems in place to gather feedback from patients and those people close to them in order to make safety and quality improvements.

However:

- There was access to specialist advice regarding end of life medicines at all times. There were sufficient stocks of medicines and syringe drivers (equipment used to automatically deliver medicines under the skin) available on wards. Patients records documented they had been prescribed anticipatory (when required) medicines to manage pain and other symptoms.
- The specialist end of life team was committed to the provision of high quality end of life treatment and care and was held in high regard by ward staff throughout the trust. The team focused on supporting generic hospital staff by building competence and confidence through the provision of direct support, education and information.
- There was a newly built cancer resource centre which provided counselling and a wide range of other support to any person affected by cancer. The centre also provided training and education to professionals and services linked to cancer treatment and care.
- The link end of life care meetings were a productive forum for learning and sharing clinical and policy updates and were valued by those staff who attended.

End of life care

Are end of life care services safe?

Requires improvement

We rated safe as requires improvement because:

- Improvements were required to how treatment escalation plans were completed by doctors to ensure compliance with policy.
- Staff throughout the trust did not consistently recognise what end of life issues could or should have been reported as an incident and so these incidents were not kept under regular review. This would have impacted on how risk and quality issues were put in place to promote and maintain safe patient care.
- There was inconsistent understanding across wards regarding which nursing staff had in date syringe driver training and competency to safely set up and monitor equipment.
- The specialist end of life team did not have enough medical or nursing staff to provide a service seven days a week and cover arrangements were limited.

However:

- The specialist end of life team and ward staff reviewed end of life patient care every day in order to respond to changeable conditions and risks.
- Specialist advice on end of life medicines to treat pain and other symptoms was available to any clinical staff 24 hours a day, seven days per week.

Incidents

- There had been no Never Events reported for end of life service. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There was a lack of consistent end of life incident reporting which would have impacted on risk and quality patient monitoring. An end of life incident prompt list was available for staff on the trust intranet. However, the ward staff we spoke with had not fully or consistently considered what types of end of life issues to report as incidents. For example, not all staff reported if an end of life patient had not been able to be moved to a side room to maximise privacy and dignity. None of the staff we spoke with reported if an end of life patient had not achieved their preferred place of care (i.e. home, hospice, nursing home), or if any other elements of the patients end of life care plan had been significantly delayed or not achieved.
- Systems were in place to identify end of life patients within the trusts incident reporting system. Whilst the system was set to make this entry compulsory, as staff did not consistenly recocgnise what incidents should be reported for end of life patients, this process did not support the improvement of incident reporting for this patient group.
- Whilst staff lacked full understanding on what end of life issue should have been reported, the general principles to raise and record concerns was understood. Staff demonstrated an understanding of their responsibility and processes used to report patient concerns, incidents and near misses. The end of life consultant received a report on incidents where “end of life” had been specified on the form and took any necessary actions in response, such as speaking with ward staff or reviewing patient care.
- At the time of our inspection, no written overview or summary of current end of life incidents was available. Incident reporting did not appear to be consistently part of the trusts multidisciplinary end of life care group standing agenda (minutes dated September and November 2016). The trust’s executive lead for end of life told us the governance committee reporting was being revised and end of life care would report directly to the quality assurance committee in the revised reporting.
- The specialist end of life team was aware of the duty of candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.

Cleanliness, infection control and hygiene

- The bereavement and mortuary areas appeared clean and hygienic. The cleaning staff followed a schedule to maintain hygiene standards within staff offices and public areas.
- Processes were in place to ensure when patients were transferred to the mortuary infection control risks were

minimised. Staff followed a range of guidance, policy and procedure to safely transfer patients into and out of the mortuary. This included processes that took account of individual religious and cultural needs.

- The mortuary rooms and equipment were cleaned by the mortuary technicians who followed a daily cleaning schedule which was checked by the manager.
- There were hand hygiene gels available on wards and other clinical areas and written reminders for visitors to clean their hands. We observed staff and visitors used antibacterial gels and wore appropriate protective clothing where required.

Environment and equipment

- Staff told us there were adequate supplies of syringe drivers (a device for delivering medicines continuously under the skin). We looked at four records of patients using syringe drivers and saw equipment checks had been completed four times per day as required by the trusts policy. Staff confirmed they understood there was a new syringe driver policy and guidance and where to access this.
- We saw records which showed there were daily checks and emergency plans in place to safely maintain the fridges used in the mortuary.
- Syringe drivers were required to be set up and monitored by appropriately trained staff. There was inconsistent evidence that senior staff across wards understood which nursing staff had in date syringe driver training and competency. Whilst on two wards senior staff confirmed they took responsibility to know which nurses were trained and were competent, on other wards senior staff were unaware of which staff had completed the training. This had been raised as an issue during our last inspection and sufficient progress had not been made. In addition to ward staff, the clinical site team and access staff had been trained to set up syringe drivers. However, contacting and requesting support from these staff had the potential to delay patients receiving pain relief in a timely manner.

Medicines

- Staff on wards we visited told us they worked closely with the specialist end of life consultant to ensure anticipatory medicines were prescribed to all end of life patients to cover all potential issues. We saw written guidance for prescribing anticipatory medicines for pain and symptom relief was also available on the trusts intranet.
- Ward staff told us they always had access to stocks of medicines commonly prescribed to manage pain and other end of life symptoms. Medicines were also prepared and available without causing delays for patients identified for rapid (fast) hospital discharge. This included during the weekend.
- Information and advice was available at all times regarding medicines for end of life patient treatment and care. The specialist end of life team could be contacted between 9am and 5pm, Monday to Friday. Other specialist medicine advice was available from a local hospice 24 hours a day, seven days per week.

Records

- We looked at 17 patient records and saw risk assessment packs had been completed, reviewed and any necessary actions taken. These included risk assessments related to infection prevention, falls, pressure ulcers and nutrition.
- We saw patients had treatment escalation plans (TEP) in place. These records were completed to document the agreed range of and limits to treatments.
- End of life care planning records had recently been introduced. We saw end of life patient care records were a combination of medical and nursing records and the new care planning records. We visited eight wards and found staff understanding of the end of life care planning tools and information was variable. The trust provided records to show approximately 100 staff had received training in May and June 2016 on the national priorities of end of life. The roll out of the new end of life records was being monitored by the end of life care facilitator and reported to the trusts end of life care group.
- We observed records were organised and stored safely in locked cabinets to ensure the privacy and confidentiality of patient's information.

Safeguarding

- Processes were in place to safeguard vulnerable adults and children from abuse. Staff we spoke to were clear about their responsibilities and what actions to take if they needed to make a safeguarding referral. Staff

demonstrated an understanding of what kind of issues might alert them to consider possible safeguarding concerns, and what they could do to respond in a safe and supportive manner.

- Records showed the specialist end of life nurses had completed, and were in date with safeguarding training for children and vulnerable adults.
- Ward and other clinical staff attended mandatory safeguarding vulnerable adults and safeguarding children's training and refresher courses. There were three levels of safeguarding training and the level staff completed was dependent upon their roles and level of interaction with patients.

Mandatory training

- Confirmation of mandatory training was requested and records were provided to confirm the compliance with this for the three end of life specialist nursesCompliance with mandatory training for the three specialist nurses ranged between 75% and 100%. At the time of our inspection , no training records were provided for the specialist end of life consultant or the end of life link nurse. The Trust has since provided evidence that the consultant was complaint with most mandatory training and was booked to attend what was not in date.
- There was no specific end of life mandatory training. Records showed the rate of compliance with other trust mandatory training for staff trust wide ranged between 65% and 97%.

Assessing and responding to patient risk

- The specialist end of life team had daily electronic board meetings where they discussed and reviewed ongoing and new referrals. Staff told us this was done in order to prioritise and respond to changeable end of life patient needs.
- On wards there were daily clinical meetings where concerns and patient risks were reviewed and discussed between the nurses and doctors. Records were reviewed for changes in condition and potential increased risks. For example; related to pressure area care, nutrition and hydration. Treatment and care plans were then amended to address any patient risks.
- We saw one end of life patient who had very complex pain and symptom management issues. This person had action plans in place which were unusual but had been fully risk assessed by the specialist end of life consultant. The risks, benefits and consequences of this patients treatment plan and subsequent action plans had been fully discussed and agreed with the patient, their family and ward staff.
- Patients had treatment escalation plans (TEP) in care records. These were used to establish what actions were to be taken in the event of deterioration. This was based on individual patient circumstances. We looked at 25 TEP records and saw treatments and actions had been identified for staff to follow.

Nursing staffing

- There were insufficient specialist nurses to provide a seven day service to patients and other trust staff. There were three specialist end of life nurses (2.7 whole time equivalent, WTE) and one WTE end of life facilitator (nurse) who worked across the trust as required. There were no cover arrangements in place for the specialist nurses in the event of any absence. Clinical leadership during the week was provided by the trusts lead cancer nurse specialist and the end of life consultant.
- The end of life facilitator was supported by one of the specialist nurses and the trusts end of life service lead to provide training and education to generic staff trust wide.

Medical staffing

- NHS England (Specialist Level Palliative Care: Information for commissioners, 2016) maintains there should be sufficient medical (and nursing) cover to allow assessment, advice and active patient management seven days a week, and 24 hour telephone advice. There was one whole time equivalent (WTE) specialist end of life consultant. There was also four sessions (total of sixteen hours) from 3 local hospice consultants, However, the hospital consultants worked solely within the outpatients' department. This was not sufficient to provide specialist medical services at all times.
- There was limited cover for the end of life specialist consultant when they were not at work. There was an honorary system in place to cover in the event of sickness, absence or annual leave. This was provided by consultants who worked in a local hospice. The hospice consultants could provide up to two days per week for annual leave cover. Any additional specialist consultant cover was provided by the trusts on call medical consultant. It was possible this person would not have

had the same level of specialist end of life clinical expertise or experience. There was an advice line at the local hospice which clinical staff could access at any time.
- NHS England (2016) advises there should be adequate cover available to allow and enable specialist staff to undertake any necessary activities and continuous professional development to maintain their own skills corresponding with their role and responsibilities. The executive lead for end of life told us they were in the process of discussing alternative working arrangements with the local hospice to improve the current limited consultant cover.

Major incident awareness and training

- There was a major incident plan in place for the mortuary department which was linked to local authority contingency plans and reviewed every year.
- We saw there were other business and management plans to support any unexpected or extended use of the mortuary service. This included the ability to increase capacity with the use of mobile storage and/or through access to community facilities.

Are end of life care services effective?

Inadequate

We rated effective as inadequate because:

- There was little evidence of advance care planning being undertaken. Most of the staff we spoke with did not recognise end of life as relevant during the last twelve months of life.
- During September 2016 a revised end of life strategy was launched based on national guidance. During December 2016 new patient care documents were launched. The strategy lacked accompanying staff training and emphasis to ensure all doctors understood what their roles and responsibilities would be.
- Whilst new end of life care plans were being rolled out across the trust, there remained a lack of recorded evidence to show end of life care provided was holistic and person centred. There was a reliance on the patient or relatives of the patient initiating and articulating any personalised wishes in order for any actions to be taken.
- There was a lack of ongoing audit information to evidence quality and progress in the delivery of effective end of life services. The trust participated in limited local audit and no national audits. Staff told us they did not have the capacity to do this.
- A continuously funded secondment post for generic hospital staff to work with the specialist end of life team to increase their skills and knowledge was available but not fully utilised.

However:

- The link end of life care meetings were a productive forum for learning and sharing clinical and policy updates and were valued by those staff who attended.
- Records maintained by the specialist end of life team showed they were prompt to respond to referrals. Staff throughout the hospital told us they understood how to contact the team and highly valued the expertise, guidance and support provided.

Evidence-based care and treatment

- The end of life care plans had been revised and were based on the core recommendations for care in the Department of Health End of Life Care Strategy (2008) and the five priorities of care in the Leadership Alliance for the Care of the Dying, 2014. This information has been emailed to wards and other clinical areas during December 2016.
- During December 2016 senior ward and departmental nursing staff had been contacted and told to disseminate the new end of life strategy and care planning tools to nursing and health care assistant staff. However, when we asked staff about the five priorities of care most of those we spoke with were unable to explain what this meant.
- How the new end of life strategy and care planning tools were disseminated and used in practice was also inconsistent. For example; on one ward staff did not have any new care plans to use (these were on order) so had not changed how they provided care. On other wards we saw one patient had the new care plan but there were gaps in information for most of the sections. We reviewed patients full care records with senior staff and could not find the missing information written elsewhere.
- There were concerns regarding how medical staff were being provided with sufficient education and information to commit to the new end of life strategy

and care plans in practice. The new care plan included many decisions and discussions which were to be led by each patient's consultant. At the time of our inspection care records showed this was not being consistently or fully achieved. Nursing staff also told us they felt some medical staff required more education to recognise and consider the appropriateness of treatments when a patient could be approaching end of life. These views were also supported by two consultants we spoke with.

- National guidance (Leadership Alliance, 2014) promotes the early identification of patients who could be potentially approaching the last year of life in order to maximise the effectiveness of care. The majority of staff we spoke with at Royal Cornwall hospital did not recognise this and were focussed on end of life care in the last few weeks or days of life.
- There was a limited audit plan in place to review the effectiveness of end of life clinical practice and the delivery of the service. The end of life care facilitator told us they planned to complete audits during 2017 to evaluate the standards achieved for mental capacity assessments and end of life care plans.
- Staff on 27 wards across the trust were also responsible for monthly audit to check the levels of compliance for the completion of patients' treatment escalation plans (TEP). The trust submitted audit records for TEP dated January 2017 to March 2017. These showed 21 of the 27 wards recorded 100% compliance, five wards had between 75% and 90% compliance and one ward had 0% compliance with TEP recording.
- We spoke with the specialist end of life team and were told audit activity had not been possible due to a number of factors. These included; the small size of the specialist team, a reduction in administrative support, that clinical activity was given priority and that the numbers of referrals had steadily increased over the past three years.
- Working in partnership with end of life patients and those people close to them is central to national policy (DoH, 2008, Leadership Alliance, 2014, NICE (NG31, 2015). We looked at 17 care records which were a combination of the new end of life plans plus other medical and nursing records. Most of these records only had ticks by actions and lacked personalised information. There was no information recorded to identify if patients and those people close to them had been asked about their wishes or requests or if spiritual needs had been discussed. Other records only had information related to the control of pain and other symptoms. We discussed these findings with senior staff who told us if patients or relatives told them what they wanted they would always try to help.
- The trust was not working towards any accreditation or framework such as the national Gold Standards Framework in End of Life Care (Acute Hospitals Training Programme) or the Healthcare Quality Improvement Partnership (HQIP) End of Life Care Audit: Dying in Hospital.

Pain relief

- We looked at 17 patient records and saw anticipatory (when required medicines) had been appropriately prescribed to meet individual needs. Nursing staff confirmed they had access at all times to stocks of medicines used for symptom relief and pain management for end of life patients.
- We saw resources to advise and support pain relief were available to staff on the trusts intranet. These included: observation charts for use when the patient could no longer verbally communicate, clinical guidelines for nurses and doctors, local and national policy and links to resources tools available at a local hospice.
- Staff said they supported patients to manage their pain and other symptoms through ongoing review and observation. We saw in patient's care records, documentations to show pain had been assessed and reviewed appropriately. Syringe drivers (used to deliver medicines under the skin) were available to all patients who required them.

Nutrition and hydration

- We observed patients had their nutrition and hydration needs assessed using a Malnutrition Universal Screening Tool (MUST) which identified nutritional risks. Records showed appropriate nutrition and hydration actions had been taken when required by staff. For example; the use of fluid balance charts to monitor fluid intake and output.
- Patient records showed as conditions deteriorated, nutrition and hydration needs had been appropriately reviewed to maximise patient comfort.

Patient outcomes

End of life care

- The trust had not participated in any national or local end of life audit programmes. The specialist end of life team told us they lacked the resources to effectively do this.
- There was a lack of understanding by staff that end of life could and should be considered for a range of life-limiting illnesses and not focused on patients with cancer. This was reflected in the referrals to the specialist end life team. Records dated January 2016 to November 2016 showed of the total referrals made (801), 73% (582) were for patients with cancer, and 27% (219) for patients with a non-cancer related condition

Competent staff

- The specialist end of life team and the end of life facilitator had appropriate skills and experience to provide specialist advice regarding patient care and to provide expert advice and support to generic hospital staff as required.
- The three specialist nurses had completed additional training and competence to prescribe commonly used end of life medicines. This helped to prevent delays to patient treatment and care.
- The cancer support centre provided and facilitated a range of training events. Recently these had included advanced communication courses. Participants had included trust staff from the mortuary, bereavement centre and a consultant oncologist.
- End of life link staff had been identified on most ward areas. The role of these staff was to share any end of life training and policy updates to all staff in their work place and to act as a resource for information and support. Most of the staff we spoke with knew who their link staff was.
- There was a three month training opportunity available for band four health care support workers or band five nurses to work with the palliative care team. The seconded staff were expected to complete an end of life project and to share this with their team. The continuous training programme was funded by the Macmillan charity. We spoke with one link nurse who had completed the secondment training. This person told us the experience had been invaluable to developing skills and understanding regarding end of life patient care.
- Not all end of life link staff had been able to access the specialist training on offer. The role had only been offered to one person who completed the rotation between March and May 2016. This followed a suspension of the role of more than 12 months. The specialist end of life team told us there was no shortage of staff who wanted to apply for the secondment, and there was funding from Macmillan. However, there had been issues at ward level finding suitable cover to back fill secondee roles.
- Clinical and policy updates were provided to link staff during meetings lasting half a day, once every three months. We spoke to staff who had attended these meetings and were told they were always well attended, informative and interesting, often with external speakers invited to provide updates on end of life care issues. We looked at the meeting minutes dated July and October 2016. These documented update training sessions on best practice regarding the diagnosis and treatment of pancreatic and bowel cancer, and children's and teenagers cancer care.
- A range of end of life forms, documents and guidelines were available to ward staff on the trusts intranet. Staff we spoke with about these resources demonstrated an understanding of how to access this information. We observed in practice this information was readily available and supported staff competence.
- Syringe drivers were required to be set up and monitored by appropriately trained staff. It was unclear which ward staff were appropriately trained, competent and available at any time to safely set up the syringe drivers. On two wards, senior staff confirmed they took responsibility to know which nurses were trained and were competent to set up and monitor syringe drivers safely. On other wards senior staff were unaware of which staff had completed the training or said it was each nurse's individual responsibility to ensure they were adequately trained.
- Staff had access to training, support and guidance regarding resuscitation and consent. Staff training on consent and resuscitation was provided as part of the trusts mandatory training on life support and the Mental Capacity Act. Bespoke advice and staff training was available on request through the trusts lead resuscitation officer. We saw information and local and national policy information regarding resuscitation was available to staff on the trusts intranet.
- An end of life conference had been organised and facilitated by the end of life facilitator and resuscitation officer during September 2016. The conference day had been attended by approximately 120 people including

trust staff and local GPs. The programme included lectures on; prescribing, legal issues and pastoral care. Workshop topics included organ donation and initiating difficult conversations. The end of life facilitator told us feedback had been positive and this was being used to plan another conference.

- Training for all consultants on the use of the treatment escalation plans (TEP) was mandatory but had not been fully achieved. Records provided by the trust dated 31 December 2016 stated of the 280 consultants employed by the trust, 182 (65%) had completed the training. The trust did not provide information to show when they anticipated the remaining 98 (35%) consultants would have completed this mandatory training.
- Following our inspecton information was provided which confirmed the the end of life specialist nurseshad in date annual appraisals.

Multidisciplinary working

- The specialist end of life team facilitated a multidisciplinary referral review meeting every week. This was attended by a designated occupational therapist and a chaplain. We observed one of these meetings and saw each patient's individual circumstances were discussed and input from the whole team was encouraged to provide a whole picture of care.
- The coroner's office worked collaboratively with the trusts mortuary and bereavement services. The coroner's service had recently acquired office space at the mortuary. Staff representatives from all three services said this had enabled a more coordinated approach to supporting families with information and with the development of shared processes.
- The specialist end of life team worked effectively across the trust with other departments and specialities for the benefit of patient care. The specialist team went wherever they were required throughout the trust to support staff to provide additional expert end of life patient advice, support and direct patient care. Based on individual patient and staff needs, the specialist team would act in an advisory capacity, working alongside the team bearing clinical responsibility for the patient's overall care. We visited eight wards and all the staff we spoke with told us they valued the support, expertise and responsiveness of the specialist team.
- The new cancer resource centre manager told us they worked closely with the specialist end of life team to coordinate how they provided support to end of life care to patients and their families. For example, we were told the centre helped patients or family to have or make difficult calls to other relatives and provided additional time in a non-clinical environment to come to terms with information.
- The discharge team worked collaboratively with other community services to support any end of life patients identified as requiring a rapid discharges from the hospital. The team worked with nursing homes and care agencies, district nurses and GPs to organise packages of care and coordinate the discharge of end of life patients.

Seven-day services

- The specialist end of life team did not have the capacity to provide seven day services in line with national guidance (Leadership Alliance, 2014, NHS England 2016). The core team of one specialist consultant and 2.7 (whole time equivalent) specialist nurses worked Monday to Friday, between approximately 9am to 5pm. At weekends and during out of hours, hospital staff could access a 24 hour advice line provided by a local hospice. Most of the staff we spoke with were aware of the out of hour's arrangement and we saw this information was available on the trusts intranet.

Access to information

- Staff had access to the information they required to provide effective end of life patient care. We saw there was a range of end of life resources, policy and guidance available to all staff on trusts intranet. This included information on end of life patient transfers, discharge processes and medication. Care summaries were sent the patient's GP upon discharge to promote continuity of care within the community.
- We saw bereavement information was available on wards and other areas such as the mortuary and public waiting areas.
- We observed the cancer support centre had an extensive range of information which was available free of charge to anyone affected by cancer or to those providing care, treatment and support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw in other care records that patients and relatives had been asked for consent before treatment and care

had been provided. For example; one end of life patient's records showed some care had been delayed or missed when the patient had specified under what circumstance they did not wish to be disturbed.

- The specialist palliative care team and other ward staff we spoke with were knowledgeable regarding processes to follow if a patient's ability to provide informed consent to care and treatment was in doubt. Staff understood how to access guidance and policy related to consent and the Mental Capacity Act.
- Consent was documented in accordance with the trusts policy and national guidance for the majority of patient records we reviewed. We looked at 25 treatment escalation plans (TEP) which were combined with Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). The TEP section recorded limits to treatments for each individual and the patient and relatives involvement with these decisions. These replaced a previous 'Allow a Natural Death' form which had been widely used across the whole county.
- Improvements were required to the completion of treatment escalation plans (TEP) by medical staff. These were used to establish what actions were to be taken in the event of patient deterioration. This was based on individual patient circumstances. We looked at 25 TEP records and saw 19 (76%) had been fully completed, three had no reason for not consulting family about decisions, and three were missing the doctors professional grade.
- We looked at the trusts TEP audit results for all wards dated January to October 2016. During this time 124 patients TEP forms had been reviewed across various wards and clinical departments. These showed improvements were required to how the TEP had been completed in most areas of the record. This included: the reason for the TEP, names of other professionals involved, counter signature by a consultant (if the TEP had been completed by junior medical staff), summary of discussion with the patient and relatives or reasons why this was not possible and completion of the mental capacity sections. Action plans had been put in place to improve compliance and re audit was planned.

Are end of life care services caring?

Good

We rated caring as good because:

- Most of the end of life patients and those people close to them we spoke with told us they were treated with kindness and compassion.
- Patients and their relatives told us they had been consulted about treatment and care, this was also evidenced in some of the care plans we reviewed.
- The new cancer resource centre provided a wide range of resources, counselling and support to any person affected by cancer.

However:

- There was a lack of survey or other evidence to show patients' needs were being consistently met.
- There was a lack of detailed written information in care records to show what had been discussed with patients and how they had been included and involved in treatment and care.

Compassionate care

- We spoke with five end of life patients and four relatives of patients. Visitors told us ward staff were always welcoming and helpful. One relative of a patient said the ward staff were "fantastic, from the domestic staff through to the nurses and doctors, nothing is too much trouble".
- Another relative told us how much they had appreciated the support provided from all the ward staff including the ward clerk who had helped with parking charges. This person told us all of the staff had been "wonderful, kind and attentive".
- One ward had a number of patients who had been known to the staff team for a number of years. Staff told us they got to know these patients and their families at greater depth and valued these relationships as they enabled more personalised care. Patients on this ward told us how they greatly appreciated being supported by staff who knew them well. As a consequence we were told that many patients chose to return to the ward for end of life care.
- Volunteers to the chaplaincy and bereavement services provided supportive and compassionate care. Two part

time bereavement service volunteers were trained (Cruse) counsellors (national charity for bereaved people). These volunteers were available to relatives and supported them to use the bereavement service. Two other volunteers supporting the chaplaincy service offered accommodation (at no cost) to visiting relatives of patients, so they could remain close to the hospital. Staff told us these were often relatives of end of life patients.

- We observed staff on the wards we visited were friendly and welcoming. Care and support to patients and visitors was provided with kindness and compassion. Staff told us they were proud of the care they provided to patients. However, we were also told by one relative of a patient that they felt personal care, attention and compassion had been compromised due to a lack of available staff.
- There was no specific end of life Friends and Family audits or other surveys undertaken by the trust to gather patient feedback on care received.

Understanding and involvement of patients and those close to them

- One patient told us they had been happy with the care provided and that all of their physical needs had been met by staff. This person told us their visitors had been able to attend at any time. The patient explained how staff had worked hard to get their pain to manageable levels and they felt they had been listened to and information had been explained well.
- Another patient told us staff always explained what they wanted to do and why. This person described their stay on the ward as a good experience despite staff being extremely busy.
- One relative of a patient told us how all aspects of their relative's prognosis and care had been discussed so that they understood what was happening and why. This person told us that whilst this was desperately sad they felt safe and reassured by staff.
- There was a lack of documented information in patients care plans to show what had been discussed and how patients and those people close to them had been included in discussions and action plans. We looked at 17 care plans and most of these (16) had very limited information. One patients care plan had clear, detailed descriptions of the care discussed, plans of actions and the views of the patient and relatives. We highlighted this to senior staff as a good example of how collaborative and inclusive working with patients had been evidenced.

Emotional support

- Ward staff told us they supported end of life patients and those people close to them as best they could but were aware it was not always possible to give people sufficient time due to other service demands.
- Emotional support was available through the chaplaincy service (including 12 volunteers) was accessible 24 hours a day, seven days a week. Ward staff told us the chaplaincy service were responsive to patient or relatives requests for visits.
- The cancer resource centre employed one (whole time equivalent, WTE) clinical psychologist and one (WTE) counsellor. These two clinicians were able to provide emotional and therapeutic support sessions to cancer patients or to people close to the patient based on individual need.
- The cancer centre had facilitated different types of emotional support services based on response to patient and carer feedback. For example; benefits advisors were available to speak with every day, monthly 'Look Good Feel Better' pampering sessions were offered by specially trained beauticians. The manager told us future support sessions would be planned directly in response to patient feedback and demand.
- During December 2016 a health and wellbeing workshop at the cancer centre had been facilitated and attended by approximately 80 people. The manager told us as well as providing emotional support to attendees, the services had also enabled new social networks and friendships to be established.
- The cancer centre manager told us whilst the service was primarily for anyone affected by cancer, they would always signpost people with non-cancer life limiting conditions to other services which could provide support.
- There were no follow up processes in place to contact relatives following the death of a family member. Relatives were provided with leaflets on the ward and from the bereavement office which signposted to

counselling services in the community. We were shown a new booklet regarding bereavement care services which would be provided to relatives as part of the new end of life care planning process and strategy.

Are end of life care services responsive?

Inadequate

We rated responsive as inadequate because:

- There was a lack of processes in place to evidence if the end of life care provided was responsive to patient's needs and wishes. Ward staff primarily relied on the patient or relatives to initiate and communicate any requests.
- Each patient's personal choice as to where they preferred to receive their end of life care was not routinely monitored and reviewed.
- Staff told us discharge delays were frequent and resulted from a lack of community resources. However, information was not routinely gathered to fully evidence this and ensure all necessary actions to address end of life patient discharge delays had been put in place..
- There was inconsistent feedback and evidence to show if patients spiritual and cultural needs had been reviewed and any needs addressed.
- In some areas there was confusion regarding who had overall responsibility for processing fast track patient discharges through to discharge.

However:

- The cancer resource centre provided a wide range of services, support, training and information based on the needs of patients and people close to patients. The centre also provided training information and information for trust staff and other professionals who provided any services to patients with cancer.

Service planning and delivery to meet the needs of local people

- A cancer resource centre had been built from charitable funds and with the full inclusion of local people at all stages. The service had been designed to offer and provide a wide range of support and information to patients and those people close to them. The manager told us that what was on offer was changeable as it was dependent upon request and demand. For example; therapy rooms were used to combine chemotherapy assessments with a hat, scarf and wig specialist service. In other areas, professionals provided support specifically aimed at teenagers and young people.
- Working in partnership with patients to provide end of life services in the location of their choice was part of national strategy (Leadership Alliance, 2014). The trust did not routinely monitor or audit if end of life patients achieved their preferred place of care.

Meeting people's individual needs

- We saw there were resources and information available to staff on the trusts intranet to support treatment and care provided to patients with learning disability, and for those for whom the English language was not well understood. This included national guidance and easy read patient information and access to an interpreter service.
- The bereavement service had not undertaken any survey of relatives of deceased patients nor had the trust been included in the national "Voices" survey. Therefore there was a lack of ongoing evaluation from people who used the service to evidence if the bereavement service was meeting people's needs.
- There was mixed feedback regarding how end of life patients' spiritual, religious psychological and cultural needs and wishes had been reviewed and actioned. One member of the chaplaincy service and all of the ward staff we spoke with told us if a patient or relative requested a chaplain, one would visit. Other senior trust staff and another chaplain told us wards were routinely visited and patient care discussed with staff.
- There was no written evidence in any of the 17 care plans we reviewed that documented if or how spiritual, psychological or cultural needs or any other personal patient wishes had been discussed or actioned. In some patient care plans, areas had been ticked, in other care plans these sections had been left blank. Therefore there was a lack of consistent evidence to show staff had been responsive to needs.

Access and flow

- There were no dedicated end of life beds at the hospital; patients were admitted where possible to the most appropriate ward related to their condition.
- The trust did not routinely monitor how many end of life patients assessed as suitable for fast track discharge achieved this and left the hospital within 24 hours.

There had been some revision to the fast track discharge processes between wards and the onwards care team. This had resulted in some confusion of who had overall responsibility for completing the process.

- Staff told us that there were frequent delays discharging end of life patients due to a lack of community resources. However, there was no audit evidence to identify the actual cause of delays or to quantify how many end of life patients had been affected. Information was not routinely gathered by the trust to fully evidence the cause of delays and ensure all necessary actions to address end of life patient discharge delays had been put in place..
- The role of the trusts onward care team was to liaise with ward staff, community health and social care services and GPs to facilitate patient transfers and discharges.

Learning from complaints and concerns

- The trust told us between May 2016 and November 2016 there had been 77 patient complaints related to end of life care. The trust told us no themes had been identified and that four of these complaints had led to full investigations by the associated clinical divisions. The trust did not provide any detail regarding the learning and outcomes of these complaints or actions taken as a consequence.
- The end of life facilitator told us they had been working with a family who had submitted a complaint three years ago. A relative of the complainant had been agreeable to being filmed in order to share the families experience for the purpose of staff training. Plans were in place to present the learning from this to staff during 2017.
- There had been previous complaints as a result of delays in the availability of death certificates provided to families. The trust was reviewing alternative arrangements to provide death certificate and minimise delays. This included certificates provided from wards rather than through the bereavement offices. This was being trialled at the time of this inspection.

Are end of life care services well-led?

Inadequate

We rated well-led as inadequate because:

- There was a lack of audit and quality measures to fully evidence quality and risk management issues for end of life patients to maintain and make service improvements.
- There was not an established governance or reporting structure in place.
- There was no routine engagement with patients or those people close to them to gather feedback in order to make service improvements.
- Available funds and training available for the development and sustainability of a skilled workforce throughout the trust had not been fully utilised.
- Leadership of the end of life service was not fully effective and coordinated.
- There was an established pattern of increased referrals to the specialist team but there were no plans in place to ensure the specialist end of life team had the capacity to cope with it.

However:

- The specialist team were held in high regard by staff we spoke with on the wards and other services we visited.

Vision and strategy for this service

- There was a defined strategy which was based on national priorities of care (Leadership Alliance, 2015). The strategy had been developed by the end of life facilitator and discussed within the end of life care meetings. These were facilitated every two months and attended by staff across the trust who had a clinical interest in end of life.
- The end of life strategy and patient care plans had been revised and disseminated to wards via the intranet during December 2016. On the wards we visited staff demonstrated mixed understanding of new care planning tools. If staff attended any end of life meetings or training, they demonstrated an understanding of the aims of the strategy. However, other wards staff had less or no understanding of the strategy. The end of life facilitator was visiting clinical areas to promote the key aims of the strategy.
- There was a lack of planning and training to enable and ensure medical staff understood their roles and responsibilities with regards to the delivery of the revised end of life strategy. The trust end of life policy required consultants to initiate end of life care discussions with appropriate patients. We spoke with two consultants who told us they often had difficulty in

recognising when a patient may be dying and they did not recognise their role in advance care planning. Nursing staff on wards also confirmed these views stating it could be difficult to challenge the appropriateness of continuing active treatments with some doctors. This meant that it was possible that not all end of life patients were being correctly identified or offered the most appropriate treatment and care. We were told the end of life facilitator would be joining medical rounds to promote the end of life strategy.

Governance, risk management and quality measurement

- There was a lack of audit and quality measures to fully evidence quality and risk management issues for end of life patients and services. For example, there were no routine processes in place to evidence the cause of delays in fast track discharge for end of life patients. There was no process in place to benchmark and evaluate how patients were potentially being identified as approaching the last year of life and what subsequent actions had been taken. All of these issues were part of national quality standards (Leadership Alliance, 2014).
- Improvements were required to risk management processes. As staff did not generally recognise or report issues which could be categorised as end of life incidents there was a weak oversight of potential trends and associated actions plans to minimise patient risk. The end of life facilitator had produced a prompt list for generic staff reference but at the time of this inspection there was no evidence this had improved understanding of incidents and risks specifically relating to end of life patients.
- There was also evidence incidents had been reported for end of life patients but had been processed and categorised differently. For example; one end of life patient with complex issues had been reported and managed as 'frail'. Other end of life patient incidents had been categorised as 'delay in treatment' but not specifically related to end of life care. This meant what incident data was captured for end of life patients was likely to have been underestimated. This subsequently reduced opportunities to maximise staff learning and minimise issues reoccurring.
- During 2016 there had been 22 formal complaints related to end of life care. By the end of January 2017 all of these complaints, apart from one had been investigated. From these 21 investigations, four of the complaints were fully upheld and 12 were partially upheld. Information was not provided to evidence how these complaints had been interrogated for learning and quality and service improvements.
- There was no specific end of life risk register and identified risks were held within individual clinical divisions. Records provided by the trust (January 2017) showed there was one end of life risk dated 21 November 2016. This related to a number of identified concerns and inadequate ratings as a result of a previous CQC inspection during January 2016. These included; incomplete documentation, policies and guidelines, lack of training (and evidence of training), management of risk and operational issues, delays to rapid discharge and concerns regarding culture, leadership and patient experience. Eight actions had been put in place to mitigate against these risks and improve patient care. However, these did not cover all of the issues identified. For example, there were no actions identified to monitor and improve rapid discharge processes or to evaluate patient experience.
- During the weekly specialist end of life multidisciplinary meeting we observed each referral was fully discussed and all risk information and appropriate actions were updated on the electronic record during the meeting.
- The executive trust link for end of life told us a new governance structure was in the process of being developed. We were told once this was approved end of life quality and risk management information would be regularly reported through to a trust quality assurance committee.
- We reviewed the trust wide end of life care group meeting minutes (November 2016) which documented discussion regarding how the end of life risk had been graded and that the grading (identified level of risk) should be reduced once the actions had been completed. The minutes noted this would be done using the new trust risk management strategy, which was due within the next few weeks.
- There was a structure for governance reporting for end of life care. This included the submission to the board and trust management committee of a quarterly report on incidents, complaints and compliments. These reports had not been completed during 2016 and we were told this was due to a lack of capacity and prioritising clinical needs.

End of life care

Leadership of the service

- There was clear clinical leadership from the specialist end of life consultant and specialist nurses in respect of meeting the clinical needs of patients and in supporting generic staff. The specialist team were held in high regard by staff we spoke with on the wards and other services we visited.
- The specialist consultant had recently resigned from the trust lead role. The replacement person was invited to take the role and did not have any specialist end of life training, skills or experience. The executive trust lead for end of life care told us they were confident the newly appointed trust lead would be able to deliver the actions related to the end of life strategy. The was no non-executive director for end of life care.
- Improvements were required in order for all staff to fully ensure all end of life practice and the roll out of the new strategy was coordinated and consistent trust wide. The working relationship between the executive and trust leads and the end of life team was not fully collaborative. This could have impacted on the effectiveness and provision of the service.

Culture within the service

- The specialist end of life team was committed to providing high quality treatment and care for patients at all times. This was evident in how patients were spoken with and about, and how general hospital staff praised the service the specialist team provided.
- The specialist team were focused on partnership working with colleagues. There was an emphasis on 'doing with' rather than 'doing for' in order to promote education, increased skill and confidence.
- Most of the staff we spoke with told us they enjoyed working for the trust and that they felt supported by the colleagues and teams they worked within.

Public engagement

- There had been limited engagement with the public, patients or relatives to gain local or national feedback about the end of life service. No surveys had been undertaken for during the past year to ensure that the service provided met patients and their relative's needs. The chaplaincy service told us they collated patient stories to share understanding and feedback with staff but no information was provided following our request, to evidence this.
- There was also no formal or informal follow up contact with bereaved relatives to discuss how care was or should be provided. However, the office was providing comment cards for relatives to complete if they chose to but these had not been evaluated.

Staff engagement

- One of the responsibilities of the end of life facilitator was to produce a newsletter every two months. We saw this had been completed and disseminated across the hospital during September and November 2016. We saw the newsletters provided end of life policy and training updates.

Innovation, improvement and sustainability

- Improvements in the provision and sustainability of a skilled end of life workforce throughout the trust had not been fully utilised. Macmillan continuously funded a three month secondment post for generic staff to work with the specialist end of life team. This was provided to increase skills, experience and knowledge. Each secondee completed an end of life project relevant to their clinical area and where possible took on the end of life link role for their service. This post had not been given priority throughout the trust. The last secondee had been during March to May of 2016 and previous to this the secondment post had been suspended for more than a year.
- We looked at records which showed the rate of referral to the specialist end of life team had been steadily increasing whilst the size of the team had remained static. From April 2013 to March 2014 the number of end of life patients referred was 713, between April 2014 and March 2015, the number was 830. Between April 2016 and November 2016 the number of end life patients referred was 599, and was projected to be 958 by the end of March 2017.
- The specialist team told us they were most effective and responsive to patient needs by working alongside generic hospital staff to provide hands on education, clinical expertise, guidance, information and support.
- There was no succession planning in place, or formal cover arrangement for any long term absences for any of the specialist end of life team. However, the trusts

End of life care

executive lead for end of life care told us they were in discussions with a local hospice to develop a more shared approach between the hospital and community services for the delivery of end of life care.

Outstanding practice and areas for improvement

Outstanding practice

- There was an outstanding commitment to medical simulation training in the emergency department and this extended to the production of detailed and valuable case studies. This provided education for staff, but also awareness of human factors in a busy environment, and how staff might react to those.
- There had been an outstanding response to trauma and stroke patients in the emergency department. The department was among the top hospitals in the country for providing timely and appropriate care.
- There was an outstanding commitment to mandatory training for the nursing staff in the emergency department with three-day sessions held to cover this and other key topics for continuous professional development.
- Despite unprecedented overcrowding, the emergency department was calm and professional during our unannounced inspection.
- MASH up Monday training on Wellington ward – small training sessions on the ward done by the ward sister and other relevant staff. Now extended to something each weekday. Ward sister won a trust pride and achievement award in November 2016 for this.
- Clinical Matron for the cardio-respiratory directorate was nominated for a Nursing Times award for 'Matrons Rounds' – promoting safe, effective, caring, responsive and well led care, January 2016.
- One of the respiratory doctors had organised a respiratory day, for staff, at an external venue that included training, lunch and discussion about respiratory care. The matron said the doctor was very enthusiastic and staff were looking forward to the day.
- The use of an electronic pharmacy system to ensure detailed exchanges of communication to community GP's and pharmacists. This ensured that the community teams were up to date in dose changes, new medicines, discontinued medicines, and those that were to continue but were temporarily stopped.

Areas for improvement

Action the hospital MUST take to improve

- Review, document and implement the governance processes, subcommittee structures and reporting lines to and from the board and ensure this is communicated to staff.
- Review the governance in the emergency department and across medicine to ensure it has evidence that recognises and addresses risks, safety, and quality of care. This needs to include actions from avoidable patient harm, progress with audits, and demonstrable learning and improvements when there are incidents, complaints, and other indications of emerging or existing risks.
- Review and improve governance processes to fully evidence all quality, safety and risk management issues for end of life patients, and ensure these are reported in line with the risk management policy and processes. This needs to include actions from avoidable patient harm, progress with audits, and demonstrable learning and improvements when there are incidents, complaints, and other indications of emerging or existing risks.
- Review and implement the systems and processes for managing corporate, divisional and local risk registers and ensure that all staff are clear about their roles and responsibilities. The risk register must be improved to recognise all risks, particularly clinical risks, and consider where there are gaps in what is reported and how they are reviewed.
- Review the incident reporting systems and processes and provide assurance this is a fair reflection of the risks in the trust at all times. Ensure any categorisation of an incident is accurate in order to ensure learning and appropriate escalation from all incidents, including 'near miss' events. In addition, to ensure that duty of candour is correctly applied in all cases.
- Review how end of life patient care is captured within the trusts incident reporting system to ensure

Outstanding practice and areas for improvement

incidents reported in all categories can adequately identify if they also involve end of life patients, and improve and educate staff trust wide to recognise what end of life issues could or should be reported as an incident.
- Present incident information with more prominence in safety reviews and governance committees with a responsibility for risk, and embed and demonstrate learning and improvement.
- Address timeliness and inconsistencies in the quality of investigation reports for all serious incidents.
- Demonstrate learning across the trust from patient deaths, particularly, but not limited to, any that were unexpected or avoidable.
- Ensure that actions to improve on performance measures are robust, are actioned appropriately and are discussed at the relevant meetings to ensure senior level and board oversight as necessary.
- Ensure a holistic approach to the monitoring of safety and performance data, supported and informed by robust, ongoing clinical audits in all services underpinned by robust action plans to drive improvements.
- Ensure that staff receive appropriate safeguarding training to protect both adults and children.
- Ensure that both nursing and medical staff have appropriate mandatory training to keep people safe.
- Continue to review and put in place measures to address and manage patient access and flow, and ensure patients are appropriately discharged, working closely with system partners to achieve workable solutions to the current barriers, including a review of the effectiveness of system wide GOLD calls and the steps taken in advance of anticipated busy periods to plan for this.
- Ensure that designated leaders have the time and capacity to lead effectively and manage governance within their divisions, departments and teams.
- Review using the emergency department as an access point for medically expected and surgical patients to relieve pressure on the whole system, reduce breaches of patient privacy and dignity, and improve the response to patients.
- Ensure that there is appropriate medical oversight and accountability for neurology patients on Tintagel ward including at weekends.
- Find a workable solution to delays in the administration of medicines to patients in the emergency department, and ensure that medicines in the medical division are stored safely and securely.
- Ensure there is a sustained and effective improvement in the management of sepsis in the emergency department.
- Ensure there is evidence in the emergency department of governance for equipment and the environment, which includes staff competence, cleaning regimes, availability of call bells in all areas, and maintenance being undertaken when required.
- Ensure that resuscitation trolleys in medicine are checked appropriately so they are safe to use.
- Ensure that medical records remain secure and locked away throughout the medical division.

Action the hospital SHOULD take to improve

- Ensure MDT processes improve to discharge patients at appropriate times of day.
- Ensure that complaints are managed in a timely way. Improve systems and processes to show how complaints have been scrutinised for themes and level of impact and what subsequent actions have been taken.
- Improve governance processes to fully evidence all quality and risk management issues for end of life patients, and ensure these are reported in line with the risk management policy and processes.
- Ensure plans are developed to support improvement in culture within the trust.
- Ensure there is sufficient oversight of outcomes for patients.
- In line with national guidance, routinely audit and evidence if patients are achieving their preferred place to receive their end of life care.
- Complete ongoing audit programme and deliver this to evidence quality and progress in of effective end of life services.
- Identify and evidence the cause of any fast track discharge delay of end of life patients from the hospital and complete appropriate action plans to evidence discharge delay improvements.
- Improve processes so all staff are clear who has overall responsibility for processing fast track patient discharges through to discharge.

Outstanding practice and areas for improvement

- Have engagement processes in place in order to routinely gather feedback from end of life patients or those people close to them to make end of life service improvements.
- Ensure senior lead end of life roles and responsibilities are provided by staff who have end of life expertise, skills, knowledge and experience.
- Ensure that staff have appraisals when they are due to meet the trusts target.
- Ensure that staffing levels throughout the medicine division keep people safe. Particularly within cardiology.
- Ensure senior staff on all wards know which nurses have in date syringe driver training and competency to safely set up and monitor equipment.
- Have comprehensive action plans in place to ensure all medical staff have education to fully understand their roles and responsibilities with the end of life strategy and care planning documents.
- Improve staff training and records to show staff have initiated conversations regarding the personal wishes of end of life patients and those people close with them.
- Evidence how end of life patients spiritual and cultural needs have been reviewed and needs addressed.
- Ensure that standards of cleanliness and hygiene are maintained consistently throughout the medicine division. Address any shortcomings with hand hygiene in the emergency department.
- Ensure that work continues to improve the waiting lists in cardiology.
- Undertake a review of the time to carry out ECG tests for patients presenting in the emergency department with chest pain to determine whether improvements have been made.
- Remove any temporary congestion causing obstruction to entry to the resuscitation room in the emergency department, and to the mental health crisis room.
- Ensure there are no breaches in security of the drug cupboard keys in the emergency department.
- Resolve the issues in the emergency department's clinical decision unit around safe management of medicines.
- Look to introduce a risk matrix for the admission of patients with a mental health issue to the clinical decision unit in the emergency department.
- Consider how the nursing staff are placed when there are patients waiting in the corridor in the emergency department to ensure adequate clinical supervision.
- Consider how to get the best out of staff who are asked to help in the emergency department at short notice, and ensure they have good support and guidance.
- Improve cover arrangements for the specialist end of life consultant so this is sufficient at all times with a consultant with a similar level of expertise.
- Review the electronic alert system for doctors to ensure they can prioritise patient care appropriately.
- Ensure appropriate skill mix review of the specialist end of life team and plans in place to meet the increased number of patient referrals.
- Follow best practice guidance and ensure there is sufficient specialist medical and nursing staff to provide a service seven days a week.
- Prioritise the release of ward staff to attend the 3 month continuously funded secondment post staff to work with the specialist end of life team.
- Review the templates on foundation-year doctor rotas with Health Education England to find a solution to the ongoing issue of workload pressures on this group of staff.
- Update the trust website to advise people of the opening times of the hospital pharmacies.
- Make sure patients in the emergency department have something to eat and drink as often as is safe and practical.
- Reflect on our concerns with privacy and dignity for patients waiting in the corridor in the emergency department and look for solutions where some of this will be avoidable.
- Review the design and layout of the clinical decision unit, which has no discrete areas for male and female patients to be accommodated separately.
- Find a solution to the poor response rate by patients to the Friends and Family Test.
- Have systems in place to routinely gather feedback on the end of life service provided from patients or those people close to them. Evidence how this information has been used to inform service improvements.
- Improve ward staff understanding that end of life care extends beyond the last few days and weeks.
- Improve documentation of advance care planning during the last twelve months of life.
- Improve the completion of treatment escalation plans by doctors to ensure full compliance with policy.

Outstanding practice and areas for improvement

- Look at finding a solution to the lack of resources or space in the emergency department for meetings, seminars, education, IT and library resources.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 9(1) The care and treatment of service users must – (a) be appropriate, (b) meet their needs. Due to available bed pressures elsewhere in the hospital, pressures in the wider healthcare economy, and the requirement to receive expected medical and some surgical patients in the emergency department, not all patients were being treated in a timely way. The trust had not met the target to admit, discharge or transfer 95% of patients within four hours from arrival for at least the past two years.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 10(1) Service users must be treated with dignity and respect. 10(2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular – (a) ensuring the privacy and dignity of the service user; Due to overcrowding in the emergency department, patients waiting in the corridor on trolleys were not afforded the privacy and dignity they must have at all times.

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

12(1) Care and treatment must be provided in a safe way for service users.

12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –

(a) assessing the risks to the health and safety of service users of receiving the care or treatment;

(b) doing all that is reasonably practicable to mitigate any such risks;

Incidents that affect the health, safety and welfare of people using services must be reported internally and to relevant external authorities/bodies. They must be reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.

We found multiple incidents which were reported as 'no harm' which should not have been. These incidents included serious harm caused to patients and some which resulted in patient death.

Incidents affecting end of life patients were not always being picked or given sufficient priority.

The emergency department was not yet providing sepsis management that was fully compliant with treatment protocols.

(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

We found that processes to ensure that resuscitation equipment was safe were not being followed. There were multiple occasions where daily and weekly checks had not been completed appropriately putting patients at risk.

The emergency department was not able to demonstrate staff were competent to use equipment. There were incomplete records to show equipment was cleaned as

This section is primarily information for the provider

Requirement notices

required. The patient call bells were sometimes not in the reach of patients, and were either not provided or not within reach in a number of the toilets provided for patients and visitors.

(g) the proper and safe management of medicines;

Staff on The Medical Admissions Unit did not follow the policies and procedure for managing medicines. We found that medicines were not stored securely on this ward

Not all medicines were given at the right time in the emergency department and there was a lack of safe management in all of medicines held in the clinical decision unit in the emergency department.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. We found systems and processes to manage governance at the trust were not clearly articulated and were not documented so that staff could follow them. We were unable to identify clear reporting or subcommittee structures. Governance systems were weak. The trust was in a period of transition to new processes but these were not well articulated and there was confusion about roles and responsibilities. The provider did not operate effectively to reduce the risk to patients who were subject to delayed transfers of care. There were significant numbers of patients requiring transfer out of the hospital within the medicine service. These patients were at risk of physical and mental deterioration, acquiring a pressure ulcer and acquiring a hospital-acquired infection. (2) Without limiting paragraph (1), such systems of processes must enable the registered person, in particular, to-

This section is primarily information for the provider

Requirement notices

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

The provider did not operate effectively to reduce the risk to patients who were subject to delayed transfers of care.

There were significant numbers of patients requiring transfer out of the hospital. These patients were at risk of physical and mental deterioration, acquiring a pressure ulcer and acquiring a hospital-acquired infection.

(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 carrying on of the regulated activity;

The provider did not have sufficient processes in place to enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.

The divisional team and the board did not have sufficient oversight of risks. Risks were not reviewed often enough and significant risks were not always recognised or escalated appropriately. When concerns were escalated to the senior team, staff on the ground said there was limited action to mitigate them.

The provider was not able to demonstrate sufficient evidence through its governance and management of the service that it recognised, addressed and improved risks, safety and quality of care. There was a lack of action around some of the themes emerging from our inspection. This included avoidable patient harm, progress and results from clinical audit, and demonstrable learning from incidents, complaints and other indications of emerging or existing risks.

The emergency department was not providing sufficient evidence through its governance and management of the service that it recognised, addressed and improved risks, safety and quality of care. There was a lack of action around some of the themes emerging from our inspection. This included avoidable patient harm, progress and results from clinical audit, and demonstrable learning from incidents, complaints and other indications of emerging or existing risks.

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Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. At times of overcrowding, there were insufficient numbers of nursing staff in the emergency department to provide safe care at all times. There were not sufficient numbers of staff on wards. This was due to high vacancy rates, difficulties in acquiring additional staffing and redeployment throughout the trust. Both patients and staff were feeling the impact of this. Many staff in the medicine directorate did not have appropriate training in children's safeguarding level one

In medicine we found multiple incidents which were reported as 'no harm' which should not have been. These incidents included serious harm caused to patients and several patient deaths.

In medicine the provider did not have sufficient processes in place to enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.

In medicine the divisional team did not have sufficient oversight of risks. Risks were not reviewed often enough and significant risks were not always recognised. When concerns were escalated to the senior team, staff on the ground said there was limited action to mitigate them.

(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.

We found on the Medical Admissions Unit and on Tintagel Ward there were multiple occasions where patient records were left unlocked and unattended.

This section is primarily information for the provider

Requirement notices

or level two. Consultants employed by the trust did not have appropriate training in infection control, fire safety, health and safety, information governance and manual handling.

Many nursing and medical staff did not have appropriate levels of mandatory training to keep people safe.

There was not adequate specialist cover for neurology patients at the weekends. The nurses did not receive additional training to ensure they had the skills necessary to care for neurology patients safely. The nurses did not have the support they needed to care for these patients safely.