Care Quality Commission

Royal Cornwall Hospitals NHS Trust

West Cornwall Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Medical care	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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

We rated the hospital as good for safety

Our key findings were as follows:

- Not all records were complete or up to date meaning patients' needs and levels of care were not always clear to enable staff to meet their needs.
- Action had been taken to ensure medical records were kept confidential by use of lockable trolleys.
- Insufficient numbers of staff were up to date with mandatory training including infection control and resuscitation.
- Staffing levels were managed with bank and agency staff and approval for more nursing posts had been given based on a review of patient dependency and acuity.
- There was evidence of learning and feedback from incidents with staff telling us of a positive culture for reporting incidents.
- The hospital was supported to access the pharmacy to ensure stocks of medications were maintained at sufficient levels through the electronic prescribing system.
- Delays in discharging patients from the hospital was seen to be a concern with recognition that extended stays were not beneficial to patients recovery with a lack of social workers being felt to contribute to these delays.

We saw some outstanding practice including:

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up to date information about patients (for example, details of their current medicine).

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

Importantly, the trust must:

- Ensure that patient records are up to date and completed in full to ensure that all staff caring for the patients have access to all relevant details regarding on-going care.

In addition, the trust should ensure that:

- Substances and chemicals that may be harmful to health are not accessible to patients or visitors.
- All emergency equipment is checked and ready for use in line with trust policy.
- Fridge temperatures are regularly checked in line with trust policy to ensure the safe storage of medicines.
- All relevant staff are up to date with infection control training.
- All relevant staff are up to date with basic life support training.
- Ensure sufficient resources are available enable timely assessment and review of patients for discharge
- Ensure staff have an understanding of duty of candour and when it should be applied
- Ensure staff awareness/training on assessment and treatment tools so that patients needs are fully assessed

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?
Medical care	Good 	The care delivered to patients on the medical wards at West Cornwall Hospital was rated to require improvement. Audits were undertaken to ensure processes and standards of care were followed. Patient confidentiality was maintained by using secure storage systems for records. Observational records were completed; however, there were occasions when the records were incomplete, with care plans missing or assessments not completed within the advised timeframe. A regular programme for auditing records was in place. Patients' needs were assessed using recognised tools; however, these were not always completed in full. Care plans, where available, were found to be not always followed consistently. Some nursing records were partially completed. Some patients had conditions that needed monitoring but no care plan was written for how they should be monitored and how frequently. Other patient records we saw had no details of the nursing assessment or rationale for actions that had been taken. Bank staff were employed where shortages of permanent staff were identified although there were plans to increase the number of permanent staff on the wards. Medications were stored and administered safely, with omissions being audited frequently.

West Cornwall Hospital

Detailed findings

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

Detailed findings

Contents

Background to West Cornwall Hospital

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

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

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

West Cornwall Hospital is one of three acute hospital locations run by the Royal Cornwall Hospitals NHS Trust.

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

Our inspection team

Our inspection team was led by:

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

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

The team included CQC inspectors and specialists including consultants in emergency medicine and general medicine, an emergency department nurse, a critical care nurse, and a medical nurse.

How we carried out this inspection

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

The findings of our previous inspection at West Cornwall Hospital in January 2014 were:

Safe

We found the services at the West Cornwall Hospital to be good. Although some improvements were required as

Detailed findings

patient notes were not always accurate or complete, which could mean that there was not appropriate information available to plan care or judge if a patient's condition was improving or deteriorating.

We inspected the following at West Cornwall Hospital:

- Medical services – Safe

Prior to the inspection we gathered information from other stakeholders including NHS Kernow Clinical Commissioning Group, the Trust Development Authority and Healthwatch Cornwall. As the inspection was unannounced we did not hold a public listening event prior to the onsite visit.

We visited Royal Cornwall Hospital on 3, 4, and 5 June and West Cornwall Hospital on 3 and 4 June 2015. We carried out a further unannounced visit at Royal Cornwall Hospital on 15 June 2015.

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

Facts and data about West Cornwall Hospital

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

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

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

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

The trust scored 7.4/10 on whether patients felt that they waited an acceptable amount of time on the waiting list to be admitted for procedures, which was worse than other trusts. . They scored 8.9/10 for patients not having their admission date changed by the hospital.

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

In the NHS staff survey 2014, 75% of staff in the trust responded that they were satisfied or very satisfied with the support they got from work colleagues. Seventy-nine percent felt that their role made a difference to patients and 59% agreed or strongly agreed that they would recommend the organisation as a place to work.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

1. This was a focussed inspection and ratings have only been stated for the areas inspected at this time.

Medical care (including older people's care)

Safe	Good
Overall	Good

Information about the service

West Cornwall Hospital is one of three acute hospital locations run by Royal Cornwall Hospitals NHS Trust. It provides inpatient and day care treatments and surgery, as well as diagnostic and therapy services and a wide range of outpatient clinics. The hospital has a 24-hour Urgent Care Centre.

Since its registration with the Care Quality Commission, West Cornwall Hospital has been inspected four times: in 2011, 2012, 2013 and 2014. The inspection in January, 2014 found improvements were needed in the safety of patient care. The hospital was required to ensure medical records were being kept up to date, giving appropriate and timely clinical information to the staff caring for patients.

We inspected the safety of West Cornwall Hospital medical unit. The medical unit had 52 inpatient beds for the care of older people, some of whom were living with dementia. The unit also cared for patients who needed to stay in overnight following minor surgery that had been carried out that day.

Summary of findings

The care delivered to patients on the medical wards at West Cornwall Hospital was rated to as good.

Audits were undertaken to ensure processes and standards of care were followed. Patient confidentiality was maintained by using secure storage systems for records.

Bank staff were employed where shortages of permanent staff were identified, and there were plans to increase the number of permanent staff on the wards after agreement had recently been given by the trust board.

Patients' needs were assessed using recognised tools; however, assessments were not always completed in full. Care plans, where available, were found to be not always followed consistently by nursing staff. Inconsistency in record keeping could put patients at risk especially where conditions had been diagnosed but no plan of care was provided. This would leave any professional caring for the patient unsure of actions that needed to be taken and how best to deliver the care. Where records were not signed and dated by the person completing the record, it would be unclear whether the nursing action had been completed and may result in a repeat of the same care being delivered or the patient not receiving care at the most appropriate time for their condition.

Medications were stored and administered safely, with omissions being frequently audited.

Medical care (including older people's care)

Are medical care services safe?

Good

Medical services at West Cornwall Hospital were rated as good.

Patients' needs were assessed using a variety of risk assessment tools according to trust policy. Records were stored in locked cabinets but were accessible to clinical staff for review when necessary. Observational records were completed; however, there were occasions when the records were incomplete, with care plans missing or assessments not completed within the advised timeframe. A regular programme for auditing records was in place. Patients' personal information was kept confidential by using a screen saver on the electronic whiteboard.

Medications were stored in locked trolleys and locked cupboards. Nurses used an electronic system to administer medications which gave frequent prompts to highlight any omissions. Provision was made for medicines to be available for patients who were admitted to the ward outside of pharmacy opening times. Audits were carried out on medicine prescription and administration to monitor safety.

The ward and equipment were clean. Some of the equipment had stickers to identify when it had last been sanitised and other equipment did not. All staff were aware of their roles in maintaining hygiene standards, including the ward's cleaning staff. The nurses used personal protective equipment to prevent contamination from patient to patient. Infection prevention and control policy required staff to cleanse their hands on entry to ward areas. Some staff cleaned their hands on entering the ward areas and some did not. Side rooms were available when it was necessary to isolate patients to prevent the spread of infection. All staff we spoke to were aware of the procedures for enhanced cleaning processes and when they were appropriate. Monthly cleaning audits were carried out jointly by senior nurses and cleaning managers. During our ward visit we observed that some cleaning solutions were left on the side of a sink instead of being locked away.

When there was a need identified for more staff to be on the ward, requests went first to the internal bank nurse system. If no bank staff were available there was a system for matrons to go to outside agency nurses for more staff.

Untoward incidents were reported by staff, who received feedback on their reports. Training for safeguarding of patients was attended by most staff and staff were aware of the procedures for reporting concerns.

Incidents

- Between June 2014 and June 2015 the hospital reported one serious incident involving the medical services at West Cornwall Hospital that required investigation. We found evidence that an investigation by staff independent of the unit was completed. An action plan was produced, including the introduction of a new assessment and treatment escalation tool regarding a patient's needs when being transferred to another area for care. The assessment tool was due to be introduced to practice in June 2015, which was at the time of our visit. The staff were unaware of the new assessment and treatment escalation tool.
- Mortality and Morbidity meetings had previously been held at a trust-wide level with the attendance of ward managers. Hospital-level meetings were due to commence at West Cornwall Hospital in July 2015. Terms of reference had been drawn up which described the plan to include all levels of staff at the meetings in order to learn from incidents and improve care delivery. The first local meeting had not taken place at the time of our visit and we did not discuss it with other staff.
- Duty of Candour legislation has been in place since November 2014 and requires all NHS organisations to disclose and investigate mistakes and offer an apology if the mistake results in a death, severe or moderate level of harm. Three staff we spoke with were aware of the duty of candour and had attended training the previous year. Other staff did not know the term. All the staff we spoke to were able to describe being open and honest with patients and their relatives, demonstrating an awareness of the principles of duty of candour.
- Staff who told us they had reported incidents on the electronic reporting system stated they could request feedback and that they did receive this. One member of staff told us how they had received feedback from the ward manager, regarding an inadequate supply of

protective clothing in varying sizes during an outbreak of norovirus. The staff member told us how there was a positive outcome in a greater supply of clothing to fit all sizes of staff.

Safety thermometer

- The Patient Safety Thermometer provides a quick and simple way of surveying any potential harm to patients and analysing the results, so that staff can measure and monitor local improvements and 'harm free' periods of time. The ward managers told us they regularly completed safety thermometer audits within their department. The results were displayed on the ward using a safety cross. This identified numbers of falls and incidence of pressure ulcers on the ward. For the previous day this had been zero.
- Data obtained from the National NHS Safety Thermometer showed that the number of reported pressure ulcers and falls with the patient experiencing harm showed no rising trend in incidence. This data was for the whole of the medical unit including medical wards at West Cornwall Hospital, for the period from December 2013 to December 2014.
- Between January and May 2015, the Patient Safety Thermometer reported that the number of new pressure ulcers for both wards, varied between 0 and 11. No discernible trend was demonstrated and the majority of the time, the incidence was below the national average.
- The rate of patients being assessed for the risk of venous thrombo-embolism was between 95% and 100%. This would assess whether patients needed any treatment that would prevent a blood clot forming following admission to hospital.

Cleanliness, infection control and hygiene

- There was disinfectant hand wash at each ward entrance, with instructions on how to apply it correctly. On two occasions we observed that nurses entering the ward area did not decontaminate their hands.
- The monthly hand hygiene audits completed between January 2015 and April 2015 showed compliance rising from 80% to 100% for using hand hygiene procedures. The results of the audits were displayed where patients and visitors could see them. We saw a doctor using decontamination procedures between patient contacts.
- The Public Health Observatory reported that between July 2014 and November 2014, the trust as a whole had no incidents of Methicillin Resistant Staphylococcus Aureus (MRSA), seven cases of Clostridium Difficile and nine cases of Methicillin sensitive Staphylococcus Aureus
- There was evidence that action was taken to prevent the spread of infection, which followed the trust policy. All patients were screened for MRSA on admission. The ward was informed of any positive results. The affected patient would then be placed in a side room and provided with antibacterial agents for personal care activities. We saw personal protective equipment (gloves, disposable aprons) being used appropriately by staff before entering the room of a patient who needed to be nursed in isolation. Reports of compliance with protocols were fed back to the hospital infection prevention and control committee meetings, which were held quarterly at Royal Cornwall Hospital. The matron for the medical unit of the trust presented reports on infection rates for West Cornwall Hospital.
- Information on the trust website informed visitors who might have an infection that they should stay away from the hospital to prevent the spread of infection.
- We saw that multi-use equipment looked visibly clean but did not always have a sticker to indicate when it was last decontaminated. For example, two commodes had dates and times of the last clean and three others did not. If they were not decontaminated this could pose a risk of cross-infection to the next person using the equipment.
- Containers used for disposal of sharps should be signed and dated on first use and again when full to ensure they are disposed of in a timely way. Some were used appropriately, being temporarily closed when not in use. However, three were closed and waiting for collection but were unsigned and undated. This is not in line with the waste policy for the trust.
- The Patient-Led Assessments of the Care Environment (PLACE) 2014 scored the hospital at 99% for cleanliness compared to the national average of 97%.
- There was a trust-wide protocol to audit the cleanliness of the wards regularly. Staff told us they conducted joint healthcare and cleaning agency audits of the wards to assess cleanliness and where practice needed improvement. Medical ward two displayed their achievement of 97% in the most recent audit, exceeding the trust's target of 95%.

- Infection control training was part of the mandatory training staff needed to attend yearly. Staff on medical ward one were 81% compliant and on medical ward two 78% compliant with this training.

Environment and equipment

- The system for checking emergency equipment required staff to check the equipment daily, with a more detailed check weekly. They would sign a dedicated book to confirm completion of the check. On medical ward two we observed there were many gaps in the book. For example, the resuscitation equipment had not been confirmed as checked for the previous four days and on 16 other occasions during May 2015. This could pose a risk to patients if there was equipment missing or out of date when needed in an emergency. We informed the ward manager of the observation but were unable to witness any resulting action as we were about to leave the hospital premises.
- We observed risks from unsecured chemicals and substances that are hazardous to health on one of the wards. This was because cleaning material was stored in the sluice, which was not locked and was accessible to patients and visitors to the ward.
- A staff member we spoke with informed us that equipment like a Stand aid, which helps a patient to mobilise, was often not replaced when it became old and unsafe to use. We were also told there was a wait of a week for equipment to be delivered for use on the ward once requested. The result was insufficient equipment to promote the independence and mobility of the patient. Staff told us the trust was investigating the issue.
- Wards had entry doors that could be locked if any patients were prone to wander and pose a risk to their own safety.
- We were shown a bathroom call bell pull having become detached from the ceiling fixing that rendered it unusable and were told that this happened frequently. It had been reported for repair the previous day and a traditional brass bell was being used for patients to summon help. The brass bell was harder to reach and presented a risk for patients with reduced mobility if they needed to call for help.

Medicines

- The trust provided guidance and information to staff in a medicines management policy and supporting policies (for example, self-administration of medicines by competent patients) and standard operating procedures.
- One of the medical wards had a drugs trolley for use when administering medication to patients. It was locked shut and fastened securely to a wall when not in use.
- Medical Ward One was trialling the use of patients' lockers instead of a mobile trolley to store medicines.
- A Registered Nurse showed us how the patients' prescribed medicines were kept in a locked compartment of their locker that was accessible using keys that the qualified nurses kept with them.
- The medicines in the individual lockers could then be taken home by the patient on discharge from the ward.
- A newly implemented electronic medication prescribing system was demonstrated by a Registered Nurse. The nurse described how it linked to other electronic patient records systems, allowing prescriptions to link automatically with the pharmacy, who could ensure the ward had adequate stocks of medicines. The nurse described how allergies were highlighted on the system for the prescriber and the person administering the medicine as a safety check. Omissions of administration of any medicines resulted in reminders on the hand-held screen, for the staff to complete the reason for any omission.
- Fluids for intravenous use were stored safely in locked cupboards.
- The registered nurse on one ward showed us the book for recording when the controlled drugs (CDs) were checked. On this ward they were checked twice a day, morning and evening. All stock was counted and signed for by two members of staff and recorded in the controlled drugs register.
- There was a pharmacy department at West Cornwall Hospital. It also supplied other providers. We were told this could cause problems if the pharmacist was needed to visit a ward but could not leave the pharmacy department.
- There was no pharmacy provision on site at the weekends. The medical wards each had a locked storage cupboard of commonly used medicines. An emergency supply of other medicines was kept on

Medicine One. This meant that if a patient was admitted at the weekend and did not have the medication they needed it might be available in one of the stock cupboards. Should the patient require medicine other than the stock available, the on-call pharmacy service at Royal Cornwall Hospital could be accessed to provide the medication. Staff were positive about the process and no difficulties were reported with the supply.

- There were regular audits relating to missed doses of medication. Each day the electronic records for the previous 48 hours of prescribed and administered medications were analysed by nursing staff. This identified any delayed medications and allowed staff to seek medical advice for appropriate actions. The electronic prescribing and medication administration record allowed the hospital pharmacy department to analyse rates of missed doses and compare results with those of the trust as a whole. This was completed monthly and could identify the specific drug missed and any trends in missed doses. Between December 2014 and May 2015 the two wards had missed dose rates ranging from 7.7% to 12 % for prescribed medication which was below the trust average. We saw meeting notes of the quarterly medicines review for June 2015 where missed doses were discussed and actions identified.
- Both wards had fridges for the storage of drugs that needed to be kept between two and eight degrees Celsius. On medical ward one the temperature was checked daily, with a clear policy on actions needed if the temperature was outside set parameters. The staff member checking the temperature signed and recorded this in a book. On medical ward two, fridge temperatures during May and June were not consistently checked. This could pose a risk to patients if the efficacy of the drug to be administered was compromised by being kept at the wrong temperature. An audit in December 2014 found a lack of compliance with monitoring fridge temperatures on medical ward two and this had been reported at the West Cornwall quarterly pharmacy and medicines management review meeting in June 2015. An action point at this meeting was to put in place a robust process for fridge monitoring. As our visit was on 3 and 4 June 2015, it may have been too early to notice a change in the process.

Records

- A required action from the CQC inspection in January 2014 was to store patient records securely. An audit in February 2015 had identified that notes were being stored securely but were still appropriately accessible to health professionals. On our visit we saw current notes were stored in lockable trolleys. Older notes were stored in another secure area of the ward and were easily accessible if needed.
- Another action required following the January 2014 CQC inspection was to ensure medical records were being kept up to date, giving appropriate and timely clinical information to the staff caring for patients. There was an audit plan in place which included reviewing records and their quality of completion on a monthly basis. Audit results we saw showed that between February and May 2015 compliance ranged between 81% and 100 %. We reviewed 11 individualised care records. The current medical and nursing notes were placed in the same folder. This allowed all professionals involved in the patient's care to view all activities and recommendations for care with ease. The records were in the form of generic care assessments and plans that were designed to be completed on admission and when care needs changed. Of 11 patient records we reviewed we found seven had incomplete nursing actions recorded as follows:
  - Record 1
    - Risk of Falls screening assessment was not signed or dated,
    - Waterlow score reassessment was not completed as frequently as required based on initial risk assessment so did not document any changing condition.
    - Bedrail assessment was completed on admission but no date for review was identified.
    - Nursing assessment not signed or dated
    - Wound care plan not completed for 11 days and should have had more frequent assessment based on wound care assessment.
    - Diabetic condition was found to be monitored but no care plan was written for ongoing care.
    - Difficulty swallowing was written in the evaluation notes but no care plan was written
    - No care plan for pressure ulcer
- Record 2

  - Record of patient vital signs not completed as recommended on assessment.
- Record 3
  - Nursing assessment not signed /dated
  - No rationale given for using bed rails
- Record 4
  - Internal transfer form incomplete
- Record 7
  - Falls risk assessment no completed
- Record 10
  - Pressure risk not reassessed as frequently advised according to original assessment
- Record 11
  - Transfer information incomplete
  - Waterlow assessment incomplete
  - Bedrail assessment incomplete no dates or rationale for using bedrails.
  - Nursing assessment not reviewed when transferred from another hospital.
  - Nutrition care plan partially completed
  - Continence issue identified in the evaluation but no care plan written

- Inconsistency in the completion of care assessments and care plans could compromise patient care. Staff would not be clear on the care already administered and at what frequency of actions were needed.
- Using bedrails when not advised could pose a risk to patients by increasing the risk of falls (for example, if a patient is confused).
- Not having a detailed care plan for a patient's diagnosed need such as diabetes, could result in a lack of monitoring and cause severe harm.
- Incomplete transfer information could result in a delay in accessing test results.
- There were records at the end of patients' beds to record timings and ongoing assessments including Care Rounds. This was a record of care assessment by the nurse, including comfort, pain and movement. These were seen to be dated and signed by the staff.
- Information on the needs of the patients was indicated on an electronic whiteboard behind the nurses' station. The name was displayed but no date of birth, to protect patient identity. The board was in an area to which patients and visitors had access but we saw a screensaver that came into operation after a short time, which protected patient privacy

Safeguarding

- Safeguarding training was included in the mandatory training. In April 2015 a high percentage of between 97% and 100% of staff were recorded as being up to date with their adult safeguarding training. All staff were expected to complete level three for adult safeguarding training (for all frontline managers or senior clinicians) and for children's safeguarding, level two (designed for staff who have any contact with children, young people and/or parents/carers of children). The training records showed that between 69% and 84% staff had completed their children's level two safeguarding training. This ensured that most staff had an awareness of safeguarding risks to adults, children and families.
- Staff could name the safeguarding lead for the trust and could describe how they would report a safeguarding concern or seek advice if they were unsure.
- We were told the electronic system for recording incidents had a section for reporting safeguarding issues.
- Between June 2014 and May 2015 (the hospital, excluding urgent care locations) reported eight safeguarding adults incidents using the electronic reporting system.

Mandatory training

- A programme of mandatory training was in operation for all staff. This programme included moving and handling, safeguarding, infection control, fire safety, health and safety. It was required to be updated annually.
- Staff told us mandatory training completion was monitored at annual staff appraisals and at trust level.
- The trust held records showing that in April 2015, 80% of staff had completed mandatory training.
- On 31 May 2015, 74.1% of staff for the medical unit at West Cornwall Hospital had completed basic life support training.

Assessing and responding to patient risk

- Risk assessments regarding moving and handling were in place for patients. An assessment was completed for patients on admission regarding potential risks for venous thromboembolism (VTE). The NHS Safety Thermometer indicated that between 93% and 100% of patients on medical wards at West Cornwall Hospital were assessed and appropriately treated to prevent developing VTE.

Medical care (including older people's care)

- We saw how a nurse helped a patient who was unsteady on his feet, from falling by observing when they wanted to mobilise and supporting them appropriately to stay safe.
- The medical wards used the national early warning score (NEWS) to record patients' vital signs. It would indicate when a patient was becoming unwell and further advice or action was required. When the recorded observations of heart rate, respiration rate and blood pressure indicated a risk to the patient by being in amber or red areas on the recording chart, further advice should be sought. A bright sticker in the patient records and a phone call to the doctor highlighted the escalated need for medical review.
- We saw notes of senior management meetings where the risk register for the hospital was reviewed. The two medical wards had no risks on the register for the period of January to March 2015.
- A system to report incidents was in place which staff were aware of and knew how to use. Risks were discussed at monthly Risk management meetings for the trust as a whole and actions were documented. An incident had been reported using the electronic reporting system regarding delayed discharges of older patients. Senior nurses described potential risks to older patients of staying in hospital for extended periods. At the time of our visit seven patients were delayed as they were waiting for a social worker's review and six were waiting for an occupational therapist to review their needs. These were patients who no longer needed the medical services of the wards. We were told that when there was more social worker provision there were fewer delayed discharges.

Nursing staffing

- The medical unit used an acuity tool to identify staffing levels needed for the ward at any one time. We saw records monitoring planned and actual staffing levels which were available on the trust and NHS Choices websites. The staffing levels we saw for the month of May 2015 showed the actual nursing staff working on medical ward one was more than was planned by 186 hours. Medical ward two had fewer staff actually working than was planned by 106 hours. The records showed that where wards were short of staff for the level of care the patients needed, bank staff were used. The planned and actual staffing for the day was displayed on the ward where patients and staff could see it. The rotas we saw had three registered nurses with four health care assistants working the early shift, three registered nurses and three health care assistants for the late shift and two registered nurses with two health care assistants at night. Ward managers told us they reviewed the needs of the patients and staffing levels several times a day and were able to adjust staffing levels if the needs increased. For example, if a patient needed more nursing observation in order to keep them safe. The staff told us they were busy but any absences due to sickness were filled with bank nurses. If there were no bank staff available there was a process for requesting agency staff. The medical ward managers told us they had been a recent review of staffing needs following concerns that staff were very busy on the unit. They had used an acuity and dependency tool which had identified a need for greater numbers of staff on the wards. We were told this had resulted in greater finance for the wards to employ extra staff. The ward managers were disusing the grades of staff they would need to staff the wards in the best way for better patient care

Medical staffing

- The medical staff at West Cornwall Hospital told us junior doctors, supported by senior house officers provided medical cover and support to the wards. There was no registrar level resident at the hospital but a registrar could be contacted at the Royal Cornwall Hospital for advice if needed. A medical consultant completed ward rounds daily from Monday to Friday and was available for support on the telephone at weekends. We were told the junior doctors were reluctant to call a consultant at the weekend, although other support was available. The trust employed general practitioners who were on a rota to offer medical support at the weekend.
- We were told there was no replacement for junior doctors when they were on annual leave or sick, reducing the number of doctors available. This would increase the workload of the doctors left on the wards to cover any absences.

Major incident awareness and training

- The trust had a major incident policy that included the role of West Cornwall Hospital, detailing the levels of seriousness and the actions that could be taken. This included, for example, winter pressures on the trust and national emergencies. Part of the continuity plan is to

build on existing links with volunteer and community sectors. Following a heightened state of alert when services were undergoing very high demand, at a debrief meeting held 11 May 2015 West Cornwall Hospital was stated to be managing this aspect well. The involvement of community and volunteer groups would help an organisation to be prepared should a major incident occur.

Outstanding practice and areas for improvement

Outstanding practice

The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients (for example, details of their current medicine).

Areas for improvement

Action the hospital MUST take to improve

The hospital must:

- Ensure that patient records are up to date, accurate completed in full to ensure that staff caring for the patients have access to all relevant details regarding on-going care.

Action the hospital SHOULD take to improve

The hospital should ensure that:

- Substances and chemicals that may be harmful to health are not accessible to patients or visitors.
- All emergency equipment is checked and ready for use in line with trust policy.
- Fridge temperatures are regularly checked in line with trust policy to ensure the safe storage of medicines.
- All relevant staff are up to date with infection control training.
- All relevant staff are up to date with basic life support training.
- Ensure sufficient resources are available to enable timely assessment and review of patients for discharge
- Ensure staff have an understanding of duty of candour and when it should be applied
- Ensure staff awareness/training on assessment and treatment tools so that patients needs are fully assessed

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Of the 11 records we reviewed, three of the risk assessments for developing pressure ulcers and of falling were incomplete. On two occasions grade two pressure ulcers had been recorded on the assessment tool but one of these patients had no care plan advising the appropriate treatment. Another record advised daily reassessment of risk but we could only find a recording of this after five days. Any professional caring for the patient would not have had up to date information to promote healing of the pressure ulcers. One patient had a chart to monitor diabetes but there was no care plan informing staff of the actions required to ensure safe management of the condition and no other mention of diabetes in the record.