Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Royal Cornwall Hospital

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Date of Inspection: 29 May 2013

Date of Publication: July 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Royal Cornwall Hospitals NHS Trust
Overview of the service	Royal Cornwall Hospital is situated in Truro, Cornwall. It is part of the Royal Cornwall Hospitals Trust (RCHT) which also consists of West Cornwall Hospital (Penzance), St Michael's Hospital (Hayle), Penrice Birthing Unit at St Austell Hospital (provision of approximately 750 beds between them), and RCHT Headquarters who manage community services at other sites throughout Cornwall. This is an acute hospital with a 24 hour emergency department.
Type of services	Acute services with overnight beds Blood and Transplant service Long term conditions services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 29 May 2013, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information given to us by the provider, reviewed information sent to us by other regulators or the Department of Health and were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

The inspection was carried out on 28 and 29 May 2013 with two compliance inspectors, a national professional advisor and an expert by experience. We looked at five outcome areas. In particular; clinical care quality assurance processes, follow up of children's services inspection reports from 2011 and 2012, disabled access and staff support systems.

We spoke with 15 patients and observed staff and patients on a variety of wards and departments including the maternity department, gynaecology department and ward, cardiology wards, trauma wards, gastroenterology wards, children's wards and the dermatology department, which included day surgery. Comments from patients we spoke with were positive and they praised the care, support and treatment they had received. One patient told us "the nurses have got a lot to do, little time to do it and they've got to do the best they can" the same patient also said "the girls here are marvellous and compassionate with each other". On another ward a patient told us "the staff on X are brilliant, though they generally need more staff". A different patient told us "the nurses have a very good attitude.

We spoke to over 50 staff including the medical director, interim nurse executive, head of quality and safety and quality improvement manager, tissue viability consultant nurse, speciality director and governance lead in dermatology, psychiatric liaison nurse, divisional general manager and divisional director of surgery, trauma and orthopaedics, head of learning and organisational development, learning and development nurse, divisional nurse for anaesthetics and theatres, the responsible officer for revalidation, divisional director of women, children and sexual health, child protection named nurse, divisional nurse – head of midwifery, cardiac catheter laboratory manager, coronary care

unit manager, matron for child health, head of estates operations and head of human resources business partners. On the wards and departments we visited we also spoke to nurses, midwives, healthcare assistants and housekeeping staff.

People who used the service were protected from the risk of abuse, because the trust had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

The trust has taken steps to provide care in an environment that was suitably designed and adequately maintained. We found that disabled parking provided could cause difficulties for people with mobility problems due to the distance from the spaces to the pay and display machines.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.
The hospital had appropriate quality assurance processes in place to monitor and improve the services they provided. However a number of the patients we spoke with had not been advised of the process to follow if they had any concerns about treatment or staff.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

When we spoke with patients on different wards and in different areas of the hospital we received a variety of feedback on the quality of care being delivered most of which was positive or very positive. However there were occasions when patients reported negative experiences and we took these into account in our overall judgement of the care and treatment that patients were receiving while they were staying in the hospital.

Three patients on one ward told us there had been less staff on duty over the previous bank holiday weekend. As a result, one patient told us they went to fetch a nurse to assist a person during the night as they had heard a bell ringing for a long time and thought that staff might not answer it. On another ward a patient told us "the staff on X are brilliant, though they generally need more staff". On a third ward we were told "the nurses had a very good attitude. On all other wards and departments we visited patients thought there were enough staff to meet people's needs.
One patient told us "the nurses and health care assistants are amazing, they made me feel really comfortable but the dietician and some of the doctors have no bedside manner they didn't treat me like a human being". This person added they had been seen by another doctor who explained things "brilliantly" to them.

We looked at three sets of medical notes on one ward. They detailed the patients pre admission assessment, examinations once they were admitted to hospital, details about the operation planned, consent forms and post-operative instructions around pain control and instructions about discharge. We were able to speak to one of the patients who told us they knew from before admission how long they would be expected to be in hospital, exactly what operation was to be carried out and the exercises they had to do post-operatively to ensure good recovery and mobility. They said "I have felt fully informed all the way through".

Patients told us the meals were "nice" and "ok". They added that the portions size meant they got enough to eat. Patients told us they got hand wipes to use before they had their

meal. On one ward we saw patients being given their main meal at the same time as a hot sweet. The housekeeping staff told us they had to get "the meal" cleared away in 40 minutes. We told the trust and they assured us they would visit the ward in question to determine why this was happening and to prevent it from happening in the future.
On one ward a patient told us they could not pick from the menu as they had "gastric" problems, they added they had been given vouchers to enable them to use the hospital restaurant where there would be more choices for them.
Four patients told us they were offered "plenty" of drinks. We saw jugs of water on people's bedside tables, within reach of the patients. On one ward we were told you "only had to ask" and they would make you a drink. One patient said there had been a disturbance on the ward overnight meaning a lot of patients were woken up. They said the nurses offered them a hot drink and it was really appreciated. We saw that patients were being supported to receive enough food and drink while they were in hospital.

We did not speak to patients in the cardiac catheter laboratory (CCL) or on the coronary care unit (CCU). The managers and staff told us how these areas operated, including direct access for cardiac patients, bypassing the emergency department. The CCL manager told us the potential for planned operations to be delayed because of emergency admissions was explained to all planned procedure patients, and the unit made use of the translation service where necessary to ensure people understood. On CCL male and female surgical lists were arranged on different days with bed bays allocated to either gender to ensure privacy and dignity. Average stays on CCL were one hour to overnight, with longer admissions transferred to cardiac inpatient units. The CCU was arranged into three open bays (three beds, two beds and three beds) divided by solid walls and curtains, and two single cubicles. The bays were allocated to patient genders, but were fluid as demands dictated. The CCL and CCU were operating appropriately.

The paediatric unit consisted of five ward areas with defined roles, such as Fistral Ward for adolescents from 11 years of age. The ward areas were secure with visitors having to announce themselves to staff to gain access. We were advised by the child health matron that admission questions included age and gender preferences. We saw the hospital school (empty as it was half-term), and we were told about the cyber school and home tutoring service for unwell children and children at home. The paediatric department also employed outreach nurses to help continue advice and treatment after discharge. There was a parent/carer council in development to identify services that might be of use to young people, and the trust were looking at setting up a secure blog on part of their website for children and young patients to access to socialise and ask questions. We saw that Paediatric services were being provided appropriately.

We saw a well organised maternity service. Women were provided with handheld maternity notes and were encouraged to actively participate in their pregnancy care. During our visit to the maternity unit (Day Assessment Unit, antenatal ward, delivery suite and postnatal ward) we saw good team working. The atmosphere on the delivery suite appeared calm. There were particularly good facilities for parents who had suffered the loss of a baby. The staff we spoke with described the culture within the maternity unit as friendly and supportive.
There were a number of specialist midwifery posts including: practice development, risk management, screening, drug & alcohol, named midwife for child protection, diabetes and research. This ensured there were staff trained to deal with a whole range of conditions that women presented with.
There was an agreed staffing level and the unit were continuing to recruit more midwives to meet the expected rise in the birth rate nationally. The maternity service gained Clinical

Negligence Scheme for Trusts (CNST) level 3 in February 2013. This is the highest level and is only achieved after a maternity unit has evidenced that where deficiencies had been identified, appropriate recommendations and action plans had been developed and changes implemented.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the trust had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

The trust responded appropriately to any allegation of abuse.

Reasons for our judgement

We did not receive any patient comments specific to safeguarding, and one patient said to us, "Professionalism, cleanliness and dignity. Any concerns have been dealt with quickly and efficiently. Thank you!"

In a recent CQC thematic review the trust was similar to the national average for Deprivation of Liberty Safeguards (DoLS) reporting. There had been nine DoLS applications, one of which was withdrawn and eight DoLS outcomes reported to CQC since August 2011. We were confident that DoLs is being appropriately used by the trust. Visitors to some of the wards we visited and the maternity unit had to ring a bell to gain access to the area. This ensured staff knew who was on their unit and meant the patients were being kept safe.

We spoke to both the adult and children safeguarding leads for the trust. They both provided specialist advice for staff in the hospital. There were safeguarding policies in place and regular meetings with key staff. The leads met each month to discuss common issues and each reported to the trust's Governance Committee.

We heard that staff had to complete mandatory e-learning about safeguarding adults and children. Training also included the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff confirmed that they and their colleagues were confident they would report any incidents of perceived abuse. Staff also confirmed they had access to training relevant to their jobs, including safeguarding training. We were told all the staff on the paediatric unit were trained to level one and then two in safeguarding when they started their employment, and then level three within their first month. Safeguarding training was then updated annually. Staff told us they routinely looked for signs of abuse and also checked with patients about home circumstances.
There were policies and information packages for staff that gave guidance on their roles and responsibilities in respect of safeguarding adults from harm and abuse. Staff knew where these policies were and could access them. The policies reflected national

legislation requirements and the local multi-agency policy. Staff showed us safeguarding information displayed for staff to refer to.

The managers and staff we spoke with on the cardiac catheter laboratory and the coronary care unit were confident they would identify and report any perceived abuse, and all knew who the key safeguarding staff were in the trust.

We were told all the staff on the paediatric unit were trained to level one and then two in safeguarding when they started their employment, and then level three within their first month. Safeguarding training was then updated annually.

Staff on other wards and departments we visited were aware of the different types of abuse and how to report their concerns. They also had a working knowledge of the Mental Capacity Act 2005 and the associated deprivation of liberty safeguards.

Staff told us they felt confident in seeking advice from their ward managers if they had any safeguarding concerns. Two members of staff said they would bypass the ward manager if they felt they would not deal with the situation. They knew about the whistle-blowing procedure. One ward manager told us "I know who to go to if I have concerns about my immediate management". A department manager told us they would have no concerns about raising issues about anybody working in their unit if they felt it put patients at risk. They added "I am here for the benefit of the patients".
In discussion with staff it was clear some staff on the obstetrics and gynaecology unit were not as confident about whistle-blowing as they should have been. We told the trust about this and they told us they would explore the issue with staff on the unit.
We were confident that the staff working at the hospital were aware of what constituted abuse, and what to do if they suspected that abuse was taking place.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

The trust has taken steps to provide care in an environment that is suitably designed and adequately maintained.

Reasons for our judgement

We visited a trauma ward, orthopaedic ward, gastroenterology ward, cardiology, paediatrics, the dermatology unit and the obstetrics and gynaecology department. This involved walking through communal corridors in the Trelawney wing and the Tower block. We saw that all the areas we visited were clean and tidy. We saw domestic staff going about their jobs in all areas. Prior to our inspection visit we had had concerns raised about the general cleanliness of the hospital and one ward. We found no evidence to support these concerns. One patient told us "they [the domestic staff] are always cleaning".

Prior to our inspection we received comments that the disabled parking was inadequate and access to the physiotherapy department was now difficult as it had been relocated to the first floor of the maternity unit. We asked an expert by experience (this is a person who has personal experience of using or caring for someone who uses this type of care service) who is mobility impaired to park their car and access the physiotherapy department. They reported the disabled parking bays were some distance from the entrance to the unit and the pay and display machines. He added the parking tickets were not transferable between car parks on the site. We had no other comments about the parking arrangements.
We discussed these issues with the trust who recognised difficulty disabled people might have when parking and agreed to improve the disabled parking situation.

The expert by experience told us they had no trouble accessing the physiotherapy department as signage was clear and the passenger lift was close to the department once on the first floor. They added the reception staff had been very helpful.

We saw there were permit parking spaces designated for patients who had to use the hospital on a daily basis. General parking consisted of two car parks near to the main entrance and an overflow car park that could be used if necessary. We saw public transport coming and going during the two days of our inspection. It picked up and dropped people off at the main entrance to the hospital. We found that the general parking and public transport services available at the hospital were adequate to enable access to the services at Treliske.

Two patients on one ward told us "there are inadequate toilet and shower facilities for 29 females, one shower and two hand basins, the shower cubicle is quite small, the curtains inadequate, there's no privacy". Another patient said "there are commodes available, but on one occasion I was told they were all in use and so were all the toilets". We spoke to the trust about this and they assured us they would look into the comments and make sure there was enough equipment for people to use. They told us they would let us know the outcome of their investigations.
We saw that the environment on the gynaecology ward (also used by male urology patients) showed signs of wear and tear and there was some need for some basic maintenance. We brought this to the attention of the trust who told us they would look at the environment. We had not received any complaints from people about the condition of the ward.

We were told the ward was going to be designated as a female only ward from 17 June 2013. This was being achieved as part of the clinical site development plan, which will see an overall increase in capacity. It is anticipated the work will be split into four phases with phase one already underway. This included; the creation of a surgical floor in Trelawney Wing due to be completed by December 2013, improvements and increased capacity in the emergency department (accident and emergency) and environmental improvements taking into account people with a form of dementia which is due to be completed by March 2014.
We were also told of the refurbishment plan in place to increase the capacity of the maternity unit by four beds. This will include a midwife- led unit, which will provide additional choice for women. There were other plans to support the capacity of the maternity unit including a transfer lounge for postnatal women and their babies waiting to return home. These improvements to the facilities offered by the hospital will improve the quality of the services that can be delivered to patients.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

Staff received appropriate professional development.

Staff were able, from time to time, to obtain further relevant qualifications.

Reasons for our judgement

Supervision is a vital tool used between an employer and an employee to capture working practices. It is an opportunity to discuss on-going training and development. Some professions have to show they have had formal supervision sessions in order to maintain their right to practice. We saw from the trust's clinical supervision policy (reviewed January 2013) that for band 7 nurses (usually senior nurse managers) and above supervision was a mandatory requirement as it is for qualified midwives. It was clear from talking to nursing and health care assistants on the wards and departments we visited, that they felt supported by their colleagues and line managers. All staff had personal development reviews (PDR) or annual appraisals.

We spoke to senior ward staff and the interim nurse executive who explained the systems in place for additional supervision, which was identified as a voluntary option for staff, and relied on the individual requesting this support. Records were in place to show how many staff, who had to have mandatory supervision, had received formal supervision.

Staff we spoke with told us about receiving regular informal supervision related to their role. They told us how the supervision on some wards or departments occurred on the ward and was practically based during ward rounds or when delivering patient care. The trust may wish to note that not all supervision was formally recorded, and therefore it was not easy to check the quality and continuity of support to staff in all areas. This was discussed at the time of the inspection. The trust agreed to reflect on their current practice and consider any further steps they could take to ensure frequent and regular supervision is embedded in the culture of the trust.

We spoke to the responsible officer for appraisal and revalidation of medical staff. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis (every 5 years) that they are up to date and fit to practice. Revalidation started in December 2012 and the majority of licensed doctors in the UK will be validated by March 2016. He described how the trust was engaging the medical staff in the revalidation process. Those currently going through the process are screened for complaints against them and any disciplinary issues. They also complete an approved

colleague and patient feedback process. The revalidation process was being carried out appropriately by the trust.

Nurses told us about the training they received each year to meet their registration requirements. This included regular updates of training in core areas such as moving and handling and safeguarding. Nurses also told us they were encouraged and supported to gain extra skills. For example in the dermatology department some nurses had completed training in nurse prescribing and phototherapy (light) treatment and as a result held nurse led clinics for phototherapy treatments and drug monitoring clinics. Other staff such as health care assistants told us about similar training updates to help maintain and improve their knowledge and skills.

All of the staff we spoke to confirmed that they had access to the training available throughout the Royal Cornwall Hospitals trust (RCHT). Staff we spoke with confirmed they had access to appropriate training and did not have to wait long for training if they were new to the hospital. Newly appointed staff had induction training, where they were introduced to staff throughout the hospital and learned more about their role within the organisation. All new staff were expected to become familiar with the relevant policies and procedures to enable them to do their job. The training covered a variety of essential subjects including fire, health and safety, infection control, medical emergency (CPR), moving and handling, safeguarding and other training specific to the department or speciality.
We saw records that showed professional staff, such as nurses and doctors, were properly registered with their governing organisation (Nursing and Midwifery Council, General Medical Council), and that the status of their registration was constantly monitored. We spoke with the responsible medical officer (RMO) for the trust who described the on-going revalidation process for the trusts' medical staff.

On the gynaecology ward, which was also used for male urology patients at the time of the inspection, we were told by staff there was good "team work". We were told if they had empty beds they often had medical patients admitted that staff did not feel so well equipped to support. The chief operating officer and interim nurse executive told us there were plans to ensure all nursing and care workers attended training about the general care of medical patients, either in person or via the e-learning system, They added a team of doctors from the medical division would be responsible for medical patients on wards other than designated medical wards, on a daily basis, to make sure their medical needs were being met. We were told as part of the staff listening events staff were also being asked about their preferences in areas they would like to work in to ensure the workforce was deployed as effectively as possible.
We were told the recent publicised incidents within the obstetrics and gynaecological service had been demanding on current staff. We were told more staff had been recruited to ease pressures and support was in place and on-going to improve the culture and working relations within the departments.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented.

The trust took account of complaints and comments to improve the service.

Patients, their representatives and staff were asked for their views about their care and treatment and they were acted on.

Reasons for our judgement

We received no specific comments from people about assessing and monitoring the quality of service at the trust. Patients we spoke with confirmed that they were asked for their consent to treatment, had opportunities to discuss treatment options and recovery plans and could voice their views about their daily care.

Observation of staff showed that they worked using safe practices for example moving people between departments in beds and wheelchairs, and using manual handling equipment to help people from their bed to a chair. We saw they were very aware of their environment and the type of patients they were supporting. For example they understood the difficulties of people who could move about freely, ensuring there was no equipment in their way. Staff told us, and records confirmed that appropriate and relevant training was available and undertaken, and staff felt supported.

Some of the patients we spoke with had been advised of the process to follow if they had any concerns about treatment or staff. When asked what process they would follow if they had a concern and one patient said I would "talk to the nurse". Another patient said "I would tell one of the nurses and go higher if necessary". However the same patients were not aware of the Patient Advocacy and Liaison Service (PALS) either.
We heard that patients could make their views known via national systems such as NHS Choices or via national and in house inpatient and outpatient surveys. We also heard that the patient experience, such as results of the Department of Health Friends and Family test (F&FT) that asks for feedback from patients about their care and treatment, was used to help inform the trust board of what patients thought of their care and treatment throughout various departments.
We were shown detailed breakdown of the responses and scores. The trust results showed 80% of respondents recorded they would be "extremely likely" to recommend the

ward or emergency department to friends and family. We were told each ward covered by the F&FT had received a report detailing their individual results for each month. We saw the results would also be discussed through the Patient Experience Group and other trust committees as relevant.

In a similar test carried out on staff working at the trust between September and December 2012. Royal Cornwall Hospital Trust was in the lowest 20% of hospitals in the country. The trust showed us the systems they had in place to receive feedback from staff about their confidence in the service. These included staff listening events and sharing the site development plans. We were told by ward staff and the chief operating officer the staff listening events had been well attended and had produced some useful information. Ward staff told us there had also been more executive and senior staff presence on wards, with matron walk rounds and the Chief Executive Officer and board members carrying out visits to the wards and departments. The information we found during our inspection balanced the data received in the 2012 Friends and Family Test.

One ward manager showed us the patient surveys, which were being used prior to the introduction of the Friends & Family Test Survey, that were given out to each patient once they were advised they could be discharged. With an expectation that there should be at least 60 returned in every four week period. They told us there was quite a good level of return. They said the results were sent to the clinical effectiveness team to be analysed. The ward manager said all the results were shared with the ward team to ensure they knew what people thought of their ward and where improvements could be made if necessary.

We spoke with senior staff at the trust who outlined the range of quality monitoring systems in place to review the care and treatment offered across the trust. These included a range of clinical and health and safety audits, monitoring of patient feedback, staff training and reviews of all accidents, incidents and complaints. They outlined the committees in place to monitor risks which included medical advisory, clinical governance, and health and safety committees. We saw minutes of these committees and saw how relevant staff attended all these groups. This meant senior staff were informed about all clinical and non-clinical risks in the hospital. We saw all departments were represented at the various committees and we were told about regular staff meetings held by heads of departments. This showed that staff had opportunities to discuss local issues, identify risks and improvements needed and received feedback about quality and risk.

We saw that all accident/incidents reported were reviewed and no significant trends had been identified. We saw there were a number of ward based audits in place to ensure service provision was kept to a high standard. For example ward based equipment was cleaned regularly and resuscitation trolleys were checked daily to ensure they had the correct equipment on them.

Of the 515 NRLS (National Reporting and Learning System) notifications received from the trust between 01 April 2012 and 18 April 2013 the greatest number had been for the greatest number had been for slips, trips and falls 107 of 515. We saw that pressure sores accounted for 104 of the 515 notifications. We spoke with the tissue viability nurse who described the training staff had in recognition and management of pressure areas and pressure sores. We saw the updated pressure ulcer prevention clinical pathway that described what pressure relieving equipment should be in place, re positioning recommendations and nutritional considerations, when a patient was admitted to hospital or transferred between departments. Ward staff we spoke to were very knowledgeable

about pressure area and pressure sore management. In the patient care plans we looked at on one ward we saw up to date information about pressure areas both pre-operatively and post-operatively and direction to staff about how they should manage the person's pressure areas. Overall we felt that the management and delivery of pressure area care in the hospital met peoples' needs.

Due to an increased demand for emergency department and subsequent admissions to RCHT premises in March and April 2013 (mirrored by the NHS nationally) and an outbreak of Norovirus, causing some wards/bays being to be closed to admissions there were a number of planned operations cancelled. We were told about the "recovery plan" in place to ensure people were not waiting for more than 28 days after their original operation had been cancelled for their operation to then take place. This included extra theatres working on a Saturday to carry out day case surgery and other cancelled operations being rescheduled in relation to their urgency. The Clinical Site Development Plan (CSDP) and discussion with the divisional manager for surgery, trauma and orthopaedics showed that increased numbers of medical beds were soon to become available. This will increase capacity to allow people who were currently waiting to be discharged from the hospital, possibly on a surgical ward, to use those medical beds therefore reducing the number of operations being cancelled because there was no bed available. The trust was also in discussion with the commissioners of care for example the Kernow Clinical Commissioning Group (KCCG) about potential future increased capacity in community hospitals and strategies to prevent unnecessary hospital admissions and to support discharge planning.

The trust reported a high number of complaints in April 2013 with 40 received. They were focussed on the medicine and emergency department, surgery, trauma and orthopaedics and women's, children's and sexual health. We were told this was the period of time the hospital was experiencing an increase in demand and had an outbreak of Norovirus. The complaints were mainly around people being unhappy with their care outcome and lack of communication with patient by medical staff. The complaints investigations will make recommendations for any change of practice required and any issues with medical staff will be reported to the responsible officer for revalidation of medical staff. Records showed that the trust received 319 compliments during April 2013.

We saw that sickness levels within the trust were 4.35% which was above their target of 3.75%. We heard from the head of human resources about how the trust was supporting staff in terms of their health and wellbeing with the expectation that sickness levels would reduce over time. Strategies in place included health and wellbeing champions throughout the hospital to remind staff they have a voice and if they should raise concerns about their wellbeing due to the environment or working culture. For example unexpectedly vacant slots in physiotherapy may be used by staff who may need some treatment or advice that may then support them to return to work. He said there was a lot of work on-going around bullying and harassment and leadership and management styles. This included speaking to managers of areas where sickness levels are low to examine how the wards and departments were managed.

We have been in discussion with the trust prior to this inspection taking place in relation to two Never Events (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers) and one serious untoward incident (SUI) reported to us in March and April 2013. The never events were in orthopaedic surgery (wrong side prosthesis put in place) and dermatology day surgery (wrong scar removed) and the SUI was in the obstetrics and gynaecology unit and involved a non- surgical permanent contraceptive technique. This

was fully reported which showed the trust working with the CQC and was keeping the commission informed of significant events.
The outcome of the SUI showed that some clinicians in the obstetrics and gynaecological department appeared to be unaware of the necessity and importance of a governance framework when introducing new practices. We discussed this with the trust who assured us a training programme for clinicians was being developed and would be rolled out in the near future. They added the revalidation process for medical staff would help to recognise and support staff who were not always following laid down procedures.
At the time of the inspection all three investigations were nearing their conclusions and the final reports would then be shared with the trust board. We saw each event had highlighted areas for improvement. We saw action plans had been developed to change practice, support and inform staff and ensure that the new practice had been embedded by a process of regular audit.

We did not visit the operating theatres during this inspection. We saw from medical notes we looked at on the trauma ward and in the dermatology department that the World Health Organisation surgical safety checklist had been used as required during each operation carried out. Senior members of the surgical division told us that changes had already been made when selecting equipment to ensure it was for the correct side for example in a knee replacement in the form of an additional document to ensure correct side prosthesis had been selected. They also told us they were in discussion with the company that supplied the component parts of the prosthesis to make the left and right markings more clear. The trust told us they would keep us informed of other changes in practice that had been adopted following recommendations made in the final report.

The unit manager in the dermatology department told us they were in discussion about how to ensure patient's consent to the correct scar being excised (removed) when they could not see it as it may be on their back for example. The information technology team were being asked if a photograph could be taken and shown to the patient and then marked when the correct scar had been identified and confirmed as the right one. The department manager told us they were considering the use of body maps to identify to the patient where the scar for example was and identify if it was the correct one to remove. The trust will inform us of the recommendations of the final report. We will check they have been implemented during our next inspection.

The head of quality, safety and compliance told us about the general governance arrangements in place that promoted a culture of reporting incidences and issues, investigating, providing assurances that improvements had been made and an agreed work programme in place that showed what was to be delivered and by when. The board would then look at progress and challenge areas where the agreed plan was not achieved. We saw a governance delivery group had been set up to ensure all issues around governance were captured in one place and moved forward to ensure action plans for example were implemented and achieved. This would allow for trends to be identified and similar incidences from different divisions for example to be linked together. One meeting of this group had taken place and we were told CQC would be sent subsequent minutes to note how the group were developing.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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