Review of compliance

Royal Cornwall Hospitals Trust **Royal Cornwall Hospital**	
Region:	South West
Location address:	Royal Cornwall Hospital Treliske Truro Cornwall TR1 3LJ
Type of service:	Acute Hospital registered for the following regulated activities: Treatment of disease, disorder or injury Assessment or medical treatment of persons detained under the Mental Health Act 1983 Surgical procedures Diagnostic or screening procedures Management of supply of blood and blood derived products etc. Maternity and midwifery services Termination of pregnancies

	Family planning.
Publication date:	July 2011
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 Michaels 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 services such as a 24 hour accident and emergency department, maternity unit, outpatient services, imaging and laboratory facilities. The hospital serves a local population of around 450,000 which is often doubled by holiday makers during the busiest times of the year.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Royal Cornwall Hospital was not meeting one or more essential standards. Improvements were needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Royal Cornwall Hospital had made improvements in relation to:

- Care and welfare of people who use services
- Safety, availability and suitability of equipment
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision

How we carried out this review

The review was carried out to find out what action the hospital had taken following our visit in May 2011 where we found unsafe practices within the theatre departments at the hospital.

This site visit took place on 14 July 2011 and was unannounced. The visit consisted of going to four operating theatres situated in different locations within Royal Cornwall Hospital.

We met with staff including anaesthetists, health care assistants, operating department practitioners, registered nurses, registered midwives, and surgeons. We met the Chief Executive, Medical Director and the Director of Nursing, amongst other heads of department at the end of the site visit.
Our visit consisted of speaking with staff, looking at records and observing theatre practices.

What people told us

Because we were reviewing practice in the operating theatres we did not speak to many people who use the service.

What we found about the standards we reviewed and how well Royal Cornwall Hospital was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

Safety check-lists are being consistently completed and used effectively in the operating theatres at the Royal Cornwall Hospital.

- Overall, we found that Royal Cornwall Hospital was meeting this essential standard.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

Equipment is provided in sufficient quantities and was being used properly.

- Overall, we found that Royal Cornwall Hospital was meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The staff working in all of the theatres had a range of skills and experience.

There is not always sufficient numbers of appropriate staff which could sometimes put the safety of patients at risk.

- Overall, we found that the Royal Cornwall Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Improvements in terms of training and staff support systems are in place to improve the safety for patients undergoing surgery.

- Overall, we found that the Royal Cornwall Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Improvements in the systems in place for monitoring and preventing problems means that patients receiving surgery are at reduced risk of receiving unsafe care and treatment.

- Overall, we found that Royal Cornwall Hospital was meeting this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within **14** days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns, we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

Royal Cornwall Hospital has introduced a standardised surgical safety checklist written by the World Health Organisation (WHO) and recommended by the National Patient Safety Agency (NPSA). The surgical safety checklist consists of safety checks done at various stages of the person's journey through theatre. The WHO state that these checks should be clear, formal and read out loud.

During our site visit we saw 12 examples where surgical safety checks were being carried out in a satisfactory and consistent way within operating theatres at the hospital.

Staff told us that since undergoing training on how to use the checklist and introducing the full checklist they feel more confident, have got to know their teams better and are more able to challenge and ask questions.

Our observations saw that staff were following the WHO guidelines and checklist and as a result core checks are completed and communicated to all team members.

All twelve 'sign in', 'time out' and 'sign out' checks were carried out using a formal

process, they were clear and comprehensive. They included discussion about specialist equipment in use, pressure area care and post operative requirements. All the members of the team were written on a whiteboard and all equipment in use along with the patients name and procedure to be carried out were detailed on a second whiteboard. This was updated as more equipment was used during the operation.

The way swabs were collected and counted was consistent across the different theatres we saw.

Our judgement

Patients are at reduced risk because important safety check-lists are consistently being completed and used effectively in the operating theatres at Royal Cornwall Hospital.

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant with outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us

We saw that equipment in use was appropriate and in good condition. We were told that an equipment audit took place in May 2011 following our last visit and unsuitable or damaged equipment was removed from service.

Our judgement

Equipment is provided in sufficient quantities and was being used properly.

Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us

Although each theatre we visited during the site visit was fully staffed we were told that sometimes there are still staff shortages mostly due to sickness levels. We were told that a number of bank staff are working full time in the theatres whilst recruiting and restructuring are ongoing.

The Trust informed us this was being addressed as part of the longer term plan.

Staff told us that morale and team work has improved with the formal introduction of the WHO checklist and ongoing training and support opportunities. Some staff said they have specific areas/specialities that they like to work in but move between theatres as the duty rota requires.

In one theatre site we saw that administration support was in place to answer telephones phones, answer general queries and to ensure people signed in and out of the department.

Our judgement

The safety of patients is sometimes put at risk due to reduced staffing levels and the ongoing skill mix review and job evaluation exercise.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are minor concerns with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us

We found that staff we spoke to were now aware of the 'never events' that led to changes being put in place and understood there had been a theatre safety issue.

Staff told us that introduction of the checklist and the associated training programme had 'been real change which has added important value'.

Other staff added that they have had supervision sessions and 'departmental and individual meetings' which have made staff feel more valued. They added that suggestions about future local adaptations of the WHO checklist to make it more suitable for specific theatres had been well received.

Other evidence

Formal training for all grades of staff within the operating theatre departments in relation to the implementation and use of the WHO checklist and how that can prevent 'never events' occurring has taken place, for a large percentage of staff, and is ongoing for those who have not yet been able to attend.

The Trust informed us that the support mechanisms in place for staff and ongoing training will be ongoing as part of the longer term plan.

Our judgement

The improvements in education, consistency of approach and communication has created an environment where safety is much improved and best practice can develop.

There has not yet been sufficient time to demonstrate effectiveness over time.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:

- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There provider is compliant with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us

Staff told us they were aware that people had been into theatres to watch the surgical safety checks taking place and knew this was part of a larger audit. We were told that once completed the WHO checklist is currently sent for auditing.

One member of staff said ‘there has been a lot of change but it has been for the better’.

Other evidence

Since the last inspection the Care Quality Commission have been regularly given updated versions of the comprehensive action plan developed as a result of the concerns highlighted. We have also been given minutes of the twice weekly ‘Theatre Safety Assurance Group’ meetings. These show development of systems in place to monitor the quality of services and progression of training and development. The Trust have worked closely with the Cornwall & Isles of Scilly Primary Care Trust (who commission a lot of services from the hospital), another local hospital Trust and an external consultant commissioned to look in depth at the practices across all of the theatres. They have accepted all recommendations made and have incorporated these

into the ongoing action plan.

We were told that monitoring would be ongoing and used as a template to make changes in other parts of the hospital.

Our judgement

Although patients can be confident that systems have been introduced to monitor the quality of the service they receive, these have not had sufficient time to demonstrate effectiveness over time.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Surgical procedures	22	13
	Why we have concerns: The safety of patients is sometimes put at risk due to reduced staffing levels and the ongoing skill mix review and job evaluation exercise.	
Surgical procedures	**23**	14
	Why we have concerns: The improvements in education, consistency of approach and communication has created an environment where safety is much improved and best practice can develop. There has not yet been sufficient time to demonstrate effectiveness over time.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within **14** days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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