Review of compliance

Royal Cornwall Hospitals NHS Trust Royal Cornwall Hospital	
Region:	South West
Location address:	Treliske Priory Road Truro Cornwall TR1 3LJ
Type of service:	Acute services with overnight beds Long term conditions services
Date of Publication:	July 2012
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 services such as a 24 hour accident and emergency department,

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

Our current overall judgement

Royal Cornwall Hospital was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 13 - Staffing
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider.

What people told us

We carried out a responsive review of the Royal Cornwall Hospital on 23 May 2012 between 4pm and 8pm. This followed safeguarding concerns about the care of vulnerable people who may not be able to speak for themselves. We visited Wheal Agar ward (from where the concerns had first been bought to our attention), Carnkie ward, Grenville ward, Phoenix ward, Roskear ward and the Medical Assessment Unit. The inspection team consisted of two compliance inspectors and a specialist nurse.

On Wheal Agar ward we observed people being assisted to stand up and move about appropriately. We saw that people were being offered a choice of meal and an explanation of what the meals were. We also saw staff chatting with people in an adult manner and at eye level with the patient.

One person on Carnkie Ward told us that they had been treated with respect and kindness throughout their 11 day stay. She added that the staff were completely flexible in responding to her needs. This view was reiterated by a patients on Roskear Ward and the Medical Admissions Unit who described the staff as "kind and caring", "brilliant in the night" and "can't speak highly enough" of them.

People, on all the wards we visited, told us that they did not have to wait too long to have the bell answered. This view was supported by our observations. Apart from on Wheal Agar Ward where the provider might like to note that we were told by a visitor that their

relative had had to wait so long for assistance they had soiled themselves already before anybody arrived..

We saw staff on Wheal Agar ward struggling to meet the demands of the patients. Many of the patients needed two staff to help them and others were wandering around with no focus. One person was observed picking up a piece of electronic equipment from the nurse station. This warranted a staff member to quickly go to the lady to take the item off her. The equipment might have been harmful to her or become damaged by her meaning that the equipment would then not be available for other perople to use.

One person on Carnkie Ward told us that the staff had been very supportive to her through a difficult time and that she never felt rushed. Another person told us that the staff had been "excellent" and that they had "no complaints". They added that they had been "fully involved" in their discharge plans and had had lots of information.

Patients we spoke to on the Medical Assessment Unit spoke very highly of the staff. Patients on both Medical Assessment Unit and Roskear ward told us that noise at night was an issue and this coupled with the medicine round sometimes happening at 11.30 pm often prevented them from getting proper rest.

One patient and two visitors on Phoenix ward told us that the "care couldn't be better in a private hospital". They added that "staff are excellent. And they keep us informed every step of the way".

Two patients on Grenville ward told us that they had seen other patients wait for a long time to have their bells answered when they rang for assistance.

People on Carnkie Ward told us that the food was "brilliant". Another person said that what they had chosen they had enjoyed. They were pleased that small portions were available as they did not have big appetite.

When we arrived on Wheal Agar ward it took over five minutes for anybody to answer the bell to let us in. Staff told us that staffing levels go in "peaks and troughs" as often agency staff bought in to help did not always have the relevant skills and experience to look after people with dementia. We were told that the directors of nursing have been very supportive and they were aware that recruitment specifically for Wheal Agar ward was underway.

One relative told us that there were "not enough staff" and whilst they were usually polite and helpful they were "a bit thin on the ground".

Three staff on Carnkie ward told us that due to the high number of intravenous drugs that have to be given they often felt that there were not enough trained nurses on duty. On the day of our inspection they were managing with one less trained nurse due to sickness. Two of the staff said that the ward had recruited two trained nurses with previous relevant experience and felt that once they started the pressures would ease.

One member of staff on Roskear ward told us that she had had concerns about staffing levels in the past. As a result she had made an untoward incident report. These reports are seen by senior staff in the hospital and fed into national patient safety data.

Two patients on Grenville ward told us that the staff were very busy all of the time.

The nurse in charge on Grenville ward told us that he thought they were fully staffed at the moment. He told us that as the ward has a variety of patients, some of whom have dementia, he was the ward dementia lead. He was supported by two health care assistants. We observed him advising a relative about completion of a 'This Is Me' booklet, designed to help staff understand the needs of people who may not be able to speak for themselves and describe their likes and dislikes.

Staff on Phoenix ward told us that staffing numbers go down to four overnight even though the needs of the patients are still high with many of them needing two staff to assist them.

Staff on Wheal Agar ward told us that they had recently met with senior staff regarding poor staffing levels. They told us that they are reassured that this was being actively addressed. They said that they were receiving support and regular visits from the nurse consultant and other senior nursing staff. They said this was to ensure that the skill level and numbers of staff would enable the staff to tailor the care to meet patients individual needs.

On the medical admissions unit staff told us that flexibility of staffing was required to meet the fluctuating demand. They explained that they used an electronic rostering system and had access to bank staff and funding for agency staff if required. They said that new staff had recently been recruited and would be joining the team soon.

The nurse in charge on Carnkie ward told us that the ward had recently gone through a difficult period but there were lots of improvements planned. She felt very positive about the development plan and thought it was realistic and achievable. She added that the need for annual appraisals and regular supervision (one to one) to take place had been added to the plan and were due to start taking place very soon.

We spoke to an assistant practitioner (a role developed from the health care assistant role to provide more complex support to the trained nurses). She told us that they carried out extensive training over a two year period. She added that the role has not been completely defined and so an educator had been appointed for three months to ensure the correct protocols were in place to define what an assistant practitioner can and cannot do. She felt supported by this move and enjoyed the role very much.

Staff on Phoenix ward told us that annual appraisals were taking place. They added that if you physically had to attend training there was no problem being released, but if the training was via e-learning then it was more difficult to get protected time to complete it.

The nurse in charge on Grenville ward told us that their annual appraisals take place. He added that the ward managers had an open door policy and encouraged staff to raise any concerns with them at any time.

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

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider is compliant with this standard.

People's privacy, dignity and independence was being respected.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider is compliant with this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Outcome 05: Food and drink should meet people's individual dietary needs

The provider is compliant with this standard.

People were protected from the risks of inadequate nutrition and dehydration.

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

The provider is not compliant with this standard.

There was not always enough qualified, skilled and experienced staff to meet people's needs.

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

The provider is compliant with this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Actions 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. We will check to make sure that this action has been taken.

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. When we propose to take enforcement action, our decision 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.

Other information

Please see previous reports for more information about previous reviews.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Some of the people that were on Wheal Agar ward had dementia-type illnesses and therefore not everyone was able to tell us about their experiences. To help us to understand the experiences people had we used our SOFI (Short Observational Framework for Inspection) tool. The SOFI tool allowed us to spend time watching what was going on and helped us record how people spent their time, the type of support they got and whether they had positive experiences.

On Wheal Agar ward we observed people being assisted to stand up and move about appropriately. We saw that people were being offered a choice of meal and an explanation of what the meals were. We also saw staff chatting with people in an adult manner and at eye level with the patient.

One health care assistant on Carnkie Ward described flexible routines on the ward that aimed to be patient centred.

One person on Carnkie Ward told us that they had been treated with respect and kindness throughout their 11 day stay. She added that the staff were completely flexible in responding to her needs. This view was reiterated by a patients on Roskear Ward and the Medical Admissions Unit who described the staff as "kind and caring", "brilliant

in the night" and "can't speak highly enough" of them.

People, on all the wards we visited, told us that they did not have to wait too long to have the bell answered. This view was supported by our observations. Apart from on Wheal Agar Ward where the provider might like to note that we were told by a visitor that their relative had had to wait so long for assistance they had soiled themselves already before anybody arrived.

Other evidence
During our visit to the Royal Cornwall Hospital we saw and heard staff interacting with patients in positive and inclusive way. We saw that, although staff were very busy, they treated people in a professional, friendly and respectful way.

On some of the wards we saw a notice by the nurse station with the name of the nurse in charge and names of other staff on duty.

Outside Carnkie ward we saw a notice about the importance of individual privacy. We had to ring a bell before being let onto some of the wards we visited. This was to maintain security for the patients and so that, outside of visiting times, the staff knew who was on the ward apart from the staff on duty.

The provider might like to consider that low staffing levels on some wards may lead to people having to wait for assistance, which can lead to loss of dignity.

Our judgement
The provider is compliant with this standard.

People's privacy, dignity and independence was being respected.

Outcome 04:
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 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We saw staff on Wheal Agar ward struggling to meet the demands of the patients. Many of the patients needed two staff to help them and others were wandering around with no focus. One person was observed picking up a piece of electronic equipment from the nurse station. This warranted a staff member to quickly go to the lady to take the item off her. The equipment might have been harmful to her or become damaged by her meaning that the equipment would then not be available for other perople to use.

One person on Carnkie Ward told us that the staff had been very supportive to her through a difficult time and that she never felt rushed. Another person told us that the staff had been "excellent" and that they had "no complaints". They added that they had been "fully involved" in their discharge plans and had had lots of information.

Patients we spoke to on the Medical Assessment Unit spoke very highly of the staff. Patients on both Medical Assessment Unit and Roskear ward told us that noise at night was an issue and this coupled with the medicine round sometimes happening at 11.30 pm often prevented them from getting proper rest..

One patient and two visitors on Phoenix ward told us that the "care couldn't be better in a private hospital". They added that "staff are excellent. And they keep us informed every step of the way".

Two patients on Grenville ward told us that they had seen other patients wait for a long time to have their bells answered when they rang for assistance.

Other evidence
The two care plans on Carnkie ward and the one we reviewed on Phoenix ward were well organised detailed and had appropriate risk assessments included in them.

We noted a memory box on Grenville ward. This can be used to engage people who may have some form of dementia. The nurse in charge told us that simply showing people magazines with things in them that might interest them can help them settle into the ward environment and put them at their ease.

Our judgement
The provider is compliant with this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People on Carnkie Ward told us that the food was "brilliant". Another person said that what they had chosen they had enjoyed. They were pleased that small portions were available as they did not have big appetite. We saw meals being served to people on individual trays, with serviettes on them. We observed staff helping people to get into the right position to be able to eat their meal or have a drink.

On Wheal Agar Ward we saw one person being asked what they would like as a choice of meal. An explanation was given of what the meal was.

Other evidence
We saw people with drinks and food on all of the wards we visited. They were all within reach.

Staff were seen assisting people appropriately with their meals on Wheal Agar, Carnkie and Phoenix wards. Although on Wheal Agar ward the staff were very busy they did not rush people with their meals/drinks.

Supper service was observed on the medical admissions unit. Temperatures were checked and food served promptly to ensure it remained hot. The housekeeper showed excellent knowledge of those patients that needed assisting and relayed this information to staff serving the meals.

Our judgement
The provider is compliant with this standard.

People were protected from the risks of inadequate nutrition and dehydration.

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

The provider is non-compliant with Outcome 13: Staffing. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
When we arrived on Wheal Agar ward it took over five minutes for anybody to answer the bell to let us in. Staff told us that staffing levels go in "peaks and troughs" as often agency staff bought in to help did not always have the relevant skills and experience to look after people with dementia. We were told that the directors of nursing have been very supportive and they were aware that recruitment specifically for Wheal Agar ward was underway.

One relative told us that there were "not enough staff" and whilst they were usually polite and helpful they were "a bit thin on the ground".

We saw patients wandering around the ward moving items that included electronic equipment from the nurses station. There were polite, but firm interventions from the staff asking them to put things down.

Three staff on Carnkie ward told us that due to the high number of intravenous drugs that have to be given they often felt that there were not enough trained nurses on duty. On the day of our inspection they were managing with one less trained nurse due to sickness. Two of the staff said that the ward had recruited two trained nurses with previous relevant experience and felt that once they started the pressures would ease.

One member of staff on Roskear ward told us that she had had concerns about staffing levels in the past. As a result she had made an untoward incident report. These reports are seen by senior staff in the hospital and fed into national patient safety data.

Two patients on Grenville ward told us that the staff were very busy all of the time.

The nurse in charge on Grenville ward told us that he thought they were fully staffed at the moment. He told us that as the ward has a variety of patients, some of whom have dementia, he was the ward dementia lead. He was supported by two health care assistants. We observed him advising a relative about completion of a 'This Is Me' booklet, designed to help staff understand the needs of people who may not be able to speak for themselves and describe their likes and dislikes.

Staff on Phoenix ward told us that staffing numbers go down to four overnight even though the needs of the patients are still high with many of them needing two staff to assist them.

Staff on Wheal Agar ward told us that they had recently met with senior staff regarding poor staffing levels. They told us that they are reassured that this was being actively addressed. They said that they were receiving support and regular visits from the nurse consultant and other senior nursing staff. They said this was to ensure that the skill level and numbers of staff would enable the staff to tailor the care to meet patients individual needs.

On the medical admissions unit staff told us that flexibility of staffing was required to meet the fluctuating demand. They explained that they used an electronic rostering system and had access to bank staff and funding for agency staff if required. They said that new staff had recently been recruited and would be joining the team soon.

Other evidence
Staff on duty on Wheal Agar ward during our inspection visit consisted of two trained nurses, two care workers and one domestic to look after the needs of 25 people. We were told that some mandatory training booked for that day had had to be cancelled in order to ensure the ward was fully staffed. We observed that the patients on Wheal Agar ward were very demanding of staff time and the staff seemed hard pressed to meet their individual needs.

The Trust told us that following the recent issues on Wheal Agar they had reviewed the staffing and support within the ward environment. They acknowledged that it had been a difficult time for all the staff and that the senior nursing team continued to maintain a regular presence on the ward on a daily basis.

They added that a number of staff remained on maternity leave, sick leave or temporary redeployment pending completion of external and internal investigations. This had challenged the service in maintaining recommended staffing levels for the ward. They told us that short and long-term bank and agency staff cover had been, and continued to be, sought for all vacant shifts. When individual shifts had not been filled, movement of staff from other wards had been employed to assist with maintaining staffing levels at recommended level. They added that the current ward leader was off sick, therefore the clinical matron and divisional nurse were working with the deputy ward sister to provide leadership and support. Additional support and supervision was also being provided via the Consultant Nurse for Older People. A senior clinical nurse was due to take temporary leadership of the ward whilst a substantive post was to be advertised.

On Phoenix ward there were three trained nurse and three care workers looking after 25 people.

We were told that a rapid review of nurse staffing levels and deployment within the whole hospital has been commenced by the Interim Nurse Executive.

Our judgement
The provider is not compliant with this standard.

There was not always enough qualified, skilled and experienced staff to meet people's needs.

Outcome 14:
Supporting staff

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

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
The nurse in charge on Carnkie ward told us that the ward had recently gone through a difficult period but there were lots of improvements planned. She felt very positive about the development plan and thought it was realistic and achievable. She added that the need for annual appraisals and regular supervision (one to one) to take place had been added to the plan and were due to start taking place very soon.

We spoke to an assistant practitioner (a role developed from the health care assistant role to provide more complex support to the trained nurses). She told us that they carried out extensive training over a two year period. She added that the role has not been completely defined and so an educator had been appointed for three months to ensure the correct protocols were in place to define what an assistant practitioner can and cannot do. She felt supported by this move and enjoyed the role very much.

The provider might like to note that staff on Wheal Agar ward told us that they had not had any planned supervision (one to one meetings between a member of staff and their supervisor) for at least the last six months.

Staff on Phoenix ward told us that annual appraisals were taking place. They added that if you physically had to attend training there is no problem being released, but if the training was via e-learning then it was more difficult to get protected time to complete it.

A student nurse we spoke said that their learning contract had been agreed during their first 2 weeks on the ward. They added that they were now in their fourth week on the ward and enjoying the experience, benefiting from regular staff support and

supervision.

The nurse in charge on Grenville ward told us that their annual appraisals take place. He added that the ward managers had an open door policy and encouraged staff to raise any concerns with them at any time. He said that all mandatory training was done and the ward manager was rigid about that. He added that specialist training for the staff group was encouraged and he felt that they had staff with good knowledge of dementia, diabetes and renal conditions.

Staff told us that some mandatory training had been cancelled due to staffing issues during a outbreak of infection but that they were now able to "catch up" with the training programme.

Other evidence
The Trust supplied us with the Grenville development plan following the inspection visit. It included 'projects' on effective rostering, increased compliance in professional development reviews (appraisal) and dementia care.

Our judgement
The provider is compliant with this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There was not always enough qualified, skilled and experienced staff to meet people's needs.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There was not always enough qualified, skilled and experienced staff to meet people's needs.	

The provider must send CQC a report that says what action they are going to take to achieve 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 to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance 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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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

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