Inspection Report

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

William Harvey Hospital

Kennington Road, Willesborough, Ashford, TN24 0LZ

Tel: 01227886308

Date of Inspection: 29 November 2012

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Consent to care and treatment	✓ Met this standard

Details about this location

Registered Provider	East Kent Hospitals University NHS Foundation Trust
Overview of the service	William Harvey hospital is one of five hospital sites managed by East Kent Hospitals University NHS Foundation Trust. This is an acute hospital providing services to the general population of around 720,500 people in the South East Kent area.
Type of services	Acute services with overnight beds Blood and Transplant service Community healthcare service
Regulated activities	Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely 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

We carried out this inspection to check whether William Harvey Hospital had taken action to meet the following essential standards:

- Consent to care and treatment

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 November 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

This inspection included visits to the following wards: Cambridge K, L and M1, the Clinical Decisions Unit (Male and Female) and Richard Stevens Stroke Unit. We observed and talked with eight patients on the wards and spoke to 14 staff of different levels, including ward managers and junior Drs. We focused on patients in the wards who had reduced mental capacity and needed additional support to understand their treatments and care in the hospital, for example people who had dementia or learning disabilities. Patients told us that they felt well supported by the staff and we observed polite, unrushed interactions between patients and staff when people were being helped to make a decision.

All the staff we spoke to were aware of their responsibilities to support people to make decisions about their care and treatment, if they had reduced capacity and had direct access to the guidance and policies to follow. The trust had increased the level of training and support provided so that staff were able to obtain further advice if needed.

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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

There was a clear procedure for explaining treatment options and for people to give consent for these. The arrangements to support people to make decisions about their treatment were based on legislation and best practice. Mental Capacity Assessments (MCAs) were carried out and patients were given support to make a decision if they had reduced capacity. Consent forms were used for all procedures. This included minor procedures to ensure the patient was enabled to make their own decisions where possible. If the patient was assessed as being unable to make these decisions, then a best interest meeting was held, with the person's family or representatives involvement. People who were able to talk to us told us that the doctors and nurses had spent time with them and had explained their care and treatment so that they understood and were able to agree.

Assessments to determine the level of support patients needed to make decisions and consent to treatments were carried out by a team of professionals. Individual needs meetings were organised for patients who needed MCAs and their support was discussed and agreed. Staff explained that MCAs were conducted as part of the team assessment. The team included: consultants, doctors, nurses, social workers, occupational therapists, physiotherapists and other health professionals. On some of the wards these assessments were carried out as part of the discharge planning because patients were too ill to be assessed prior to that. This meant that patients' needs were assessed by different professionals and they were given the support they needed.

Staff spoke confidently about how they carried out the assessments so that they could support people to make decisions and consent to treatment. They said if they needed assistance there were link nurses who had specialist knowledge who could provide advice and support for people making difficult decisions. All the staff we talked to at all levels were able to show us how to access the information and forms for assessing and supporting people who needed to be considered with regard to the Mental Capacity Act 2005.

The Trust had completed a training needs analysis and there was a training and support

system in place to increase the confidence and competency of staff in assessing mental capacity. Training about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had been organised into categories depending on the different roles and the level of the staff. A programme of external training for consultants, doctors and clinical staff had started which provided more in depth knowledge to support staff to make the assessments and decisions needed when people had limited or no capacity. In addition to this, 60 staff, comprising of medical, nursing and therapy staff, had completed a "train the trainer" course run by Social Services in the last six months. This meant that staff would be trained quicker and there were support systems in place for the staff who had not received the training.

The Trust had responded to the need for increased support for people with dementia in hospital. They had expanded their safeguarding team so that there was at least one member of the team based in each hospital to provide direct support and advice. A dementia matron had been employed. In addition to this each ward had a link nurse who had training in dementia awareness and was able to give advice regarding mental capacity. We saw 'This is Me' care plans used for people with dementia. This gave a clear picture of the person's specific communication needs and preferences. There were posters in the corridors giving information to raise awareness of dementia.

There were communication aids to help people understand and express themselves on the wards. The Trust had introduced some pocket sized booklets of cards, which contained flow charts and quick reference guides to assist the staff. These included pathways using the Mental Capacity Act. We saw these booklets pinned up on the main notice boards in Cambridge K and the Richard Stevens Stroke Unit. These were accessible for staff to quickly refer to if they needed. The learning disability liaison nurse was on hand if a person with a learning disability was admitted into the hospital and needed additional support with their communication and to understand their treatments.

There was a policy in place to guide staff if a deprivation of liberty safeguard needed to be considered to make sure this would only be used in the person's best interest. Staff we spoke to said they had not had to make any of these applications but should this become necessary they were able to locate the guidance on their electronic information system.

The policy for 'Do Not Actively Resuscitate' (DNAR) had been updated. There were clear guidelines for staff regarding their responsibilities for this decision to be made in consultation with the person (where possible), their advocates and health professionals to make the decision in the person's best interest.

We spoke with a junior doctor who told us that her consultants encouraged her to assess the mental capacity of each patient during the medical assessment process. The decision not to provide resuscitation was always discussed with the patient, and where the patient was unable to make this decision, the family would also be involved.

The Trust carried out spot checks of MCA assessments and DNAR orders every three months to make sure they were being completed correctly and that people were being given the support they needed. They also carried out a detailed annual audit, as part of their quality monitoring. From this they considered any further improvements that were needed to the make sure people were given appropriate support to make decisions regarding consent to care and treatment.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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