Inspection Report

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

The James Cook University Hospital

Marton Road, Middlesbrough, TS4 3AF Tel: 01642850850

Date of Inspection: 05 March 2013

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

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	South Tees Hospitals NHS Foundation Trust
Overview of the service	James Cook is an acute hospital that provides a wide range of services including neurosciences, renal medicine, spinal injuries, major trauma, cardiothoracic, vascular surgery and cancer services. There is an accident and emergency department in the hospital which has been designated major trauma centre for the southern half of the northern region and has a dedicated 24-hour acute admissions unit.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning 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 5 March 2013, 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, talked with staff and reviewed information sent to us by local groups of people in the community or voluntary sector. We talked with local groups of people in the community or voluntary sector.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

During this inspection we focused on how patients mental health and physical health needs were met and focused on clinical areas that were more likely to be providing medical and nursing care to patients with these needs. We went to the Accident and Emergency department, the Emergency Admission's Units, ward 24 and 33 and the neurosciences outpatients department. We also looked at how the Trust dealt with complaints.

We spoke with 18 patients and nine relatives from across these departments. Some of the patients were not able to discuss their experiences so we observed how these people's needs were met. Patients and relatives told us that they found the staff always treated them with respect and thought the care they received was of a very high standard. All said both doctors and nurses ensured they understood their plan of care.

We observed that staff across the departments ensured people's dignity was maintained. We found that staff and the Trust understood the process for obtaining patients' consent; what to do when people lacked capacity; or were placing themselves at risk. We also found that complaint procedures were used effectively.

People said, "I went to the outpatients department where everything was explained to me in great detail", "The staff were brilliant when looking after me. When I needed help with washing they made sure that they kept me covered with sheets and towels" and "They encouraged me to do what I could and helped me when 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

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

During the inspection of the James Cook University Hospital we spent time in the Accident and Emergency department, the Emergency Admission's Units, ward 24 and 33, as well as the neurosciences outpatients department. Across all clinical areas, departments and wards, we spoke with 18 patients, nine relatives, and 22 staff of varying disciplines, including different grades of medical and nursing staff, health care assistants, occupational therapists and ancillary staff.

We spent time observing the interaction between staff and patients in all the areas we visited and also had a look around each department. We saw that on the main wards single sex bays were used but in the Emergency Admissions Units and the high dependency unit within neurosurgery there was a combination of single sex and multi sex bays as well as a number of single rooms. The reason for the multi sex bays was because of the unknown nature of the admissions. As such, it was not possible to predict who would need to use the service therefore difficult to segregate into single sex accommodation. We did, however, find that this situation was well managed, with curtains being pulled around beds when consultations were taking place or care was being delivered.

The people we spoke with told us that staff were excellent. People told us, "I went to the outpatients department where everything was explained to me in great detail. The staff in both outpatients and on the ward are fantastic", " I would give the staff 10 out of 10, they are always good, "The care here is absolutely brilliant, they tell you everything that is going on" and "We came in via ambulance and there was no waiting, very good care provided. It has been busy but the staff deal with that really well". All the patients spoken with told us that they were given full and clear explanations of their procedures.

We observed care practices within all clinical areas and wards and found staff attended to people's needs in a timely fashion. We saw that throughout all interactions people were treated with respect and their dignity was maintained. We observed staff sitting beside

people planning and discussing their care. We saw that in all the clinical areas we visited signs were attached to curtains when personal care or private conversations were being conducted to alert others so no one was disturbed.

The patients we spoke with on the outpatients department told us that they were provided with a very flexible service. The people who were using the emergency admissions unit either in the walk-in patients' section or day admission ward also said that they found the service was flexible and they were able to readily discuss their proposed care. People said, "The staff have been super today. I got my appointment date wrong and they still fitted me in. I have had every kindness", "They always respect my dignity and shut the door when I'm being examined. I have never felt embarrassed" and "I come in every few weeks; they treat you well and update you. I know what is happening".

Staff spoken with discussed how they ensured that patients were treated with dignity and respect. They discussed the importance of ensuring patients were given choices, that they give clear explanations and ask permission when providing care. One member of staff said, "Whether it is a mixed sex or single gender bay, we always make sure the curtains are pulled around and that people are covered." They gave an example of how they had ensured the dignity of a patient who was restless and agitated.

We discussed equality and diversity with all the staff we spoke with during our visit. We found staff had a solid understanding of how to meet the needs of people from various cultural backgrounds. We also found that staff readily had access to interpreters and multi-lingual literature. Staff gave examples of how they met the diverse needs of people, which included dietary preferences. They also spoke of people's religious beliefs and how this could impact upon treatment, for example, if someone was unable to have blood products. We also saw this detailed within patients hospital records. One member of staff discussed how they met religious needs of people at the end of their life. They said that for certain religions, this would mean the relatives of the deceased rather then the nursing staff performing 'last offices'. People's diversity, values and human rights were respected.

We looked at the records of 11 patients and saw that a range of assessments had been completed, including an activity of daily living assessment. This detailed information about people's lifestyles and preferences. We also saw that a range of risk assessments had also been completed. We found that there were detailed nursing notes which recorded the medical and nursing care that had been carried out and included information about the person's condition and responses to treatment. We also saw that where patients expressed a specific need, such as being in pain, this was responded to and pain relief was provided. We also saw that the 'Patient Safety Checklists' had regularly been completed. These records were completed on a two hourly basis and asked patient questions about their comfort, their pain levels and whether they wanted a drink or something to eat. People expressed their views and were involved in making decisions about their care and treatment.

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 lacked the capacity to consent, the provider had acted in accordance with legal requirements.

Reasons for our judgement

Patients told us that they had been fully consulted about their treatment options, including any possible side effects. One patient said, "I have been fully involved in my treatment and have definitely been given sufficient information and I have also had regular contact with the McMillan Nurse." Another said, "The treatment has been discussed all the way, have explained clearly and thoroughly including the side effects." They also confirmed that they were aware of their future treatment and discharge plans.

Within the neurology outpatient department the team leader confirmed that treatment plans and options were discussed with people and that they had the opportunity to ask further questions. They said that people were given time to consider their options and to discuss the best plan for them. If going ahead with specific treatment they would then attend for a pre admission assessment, where treatment plans would be explained again and people would then consent to treatment. They confirmed that consent would be further obtained once admitted to the ward and just prior to surgery. We found that in all the other departments similar processes were in place. Before people received any care or treatment they were asked for their consent.

We talked with staff about people's ability to make decisions and how they decided if the person could make informed decisions about their treatment. We spoke with these staff about the actions they needed to take when someone lacked capacity or due to mental health needs were placing themselves or others at risk. We also spoke with senior management staff and the clinical lead for safeguarding about the way the Trust ensured the Mental Health Act 1983 (amended 2007) and Mental Capacity Act 2005 were used. We found that all could readily discuss how they assisted people to make decisions and what to do when people could not make a decision about their treatment. We found that staff routinely assessed whether people had capacity to make decisions also they were very clear about when they might need to use the Mental Health Act 1983 (amended 2007).
The senior management staff and the clinical lead for safeguarding outlined how they had ensured all staff received training around the Mental Health Act 1983 (amended 2007) and Mental Capacity Act 2005. The clinical lead had completed training with over 200 staff during the first part of 2013 and intended to ensure all staff completed these sessions.

Senior staff and the lead informed us that the courses on Mental Health Act and Mental Capacity Act was now mandatory training for the Trust.

We discussed the Mental Capacity Act 2005 in detail with staff. We found they understood what actions they needed to take to assess someone's capacity. Where people had been placing themselves at risk and staff needed to control large parts of their decisions, staff had appropriately applied for a Deprivation of Liberty Safeguard Authorisation (DoLS) and this was regularly reviewed by the supervisory body (the local authority). We found that where people did not have the capacity to consent, the provider had acted in accordance with legal requirements.
From the 11 patient records reviewed, we found that they contained, where appropriate, assessments of the person's capacity to make their own decisions. We also found that where 'best interest decisions' had been made by staff on behalf of patient the records accurately reflected all of the information needed to uphold these decisions. We also centrally reviewed the notes of 10 people who had been under a section of the Mental Health Act whilst admitted to the hospital and found all of the required documents were completed.

We saw a range of information on display within clinical areas, which included information about patient and relative involvement, the ward routine and privacy and dignity information. We also saw information and leaflets were available to provide people with additional support, these included information about the 'Carer Support Network' and information about 'Long Term Neurological Conditions'. The provider might wish to note that during our visits to the clinical areas we could not see on display any posters or find information about what local advocacy services were available.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available and comments and complaints people made were responded to appropriately. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

As part of our inspection we looked at the way the Trust dealt with complaints, concerns and compliments. We spoke with staff from the complaints team, patient safety team and staff who worked on wards and clinical areas. The Trust told us that information about how to make complaints was available to patients, and that leaflets describing the process were easily accessible for patients on all wards. We saw that information about 'Patient Advice and Liaison Service (PALS), was on display throughout the hospital and leaflets about 'privacy and dignity' also detailed how to make a complaint. However, the provider might wish to note that at ward and department level clear 'how to make complaints' posters or leaflets were not available. Patients spoken with were not aware of the complaints procedure, however said that if they were unhappy they would have no hesitation in speaking out. People spoke with were keen to praise and compliment all of the departments and wards we visited.

People said, "Outpatients have been very good. The appointments are always on time and they give you an appointment to suit your needs", "The staff are brilliant. It's twice they have saved me. They are always there if you need them or call for help" and "If I had any concerns I would speak to the staff". A relative spoken with was also very complimentary about care and treatment. We saw comment cards in use throughout the hospital for people to fill in and comment on their care. Also we heard that the Trust had been nine out of over 100 bids to successfully win monies to complete a patient voice project. We looked at one of the videos this team had completed with patients and their relatives. We found the people spoke frankly about their experiences and we were shown the action plans staff had completed to improve areas of practice identified in these discussions.

Staff on ward 33 told us about the work they had completed following a review of their service to improve how they met the needs of people with dementia. We heard that the staff nurse leading this work had won several national awards. We were shown all of the initiatives they had implemented following their review of the clinical area such as providing a wide range of activities to support people to feel less confused by being in hospital. The staff we spoke with from across all the wards and departments were knowledgeable and confident in making and dealing with complaints. They told us that they had received training in handling complaints. Staff told us that they usually try and

resolve complaints first if they can and, if this is not successful, they escalated them.

We saw that the Trust had procedures in place to deal with complaints and concerns received. Senior staff described the complaints procedure to us. We saw that complaints were acknowledged within the appropriate timescales. We looked at the complaints records held and looked in detail at the investigations, and how they were responded to and resolved. There was clear evidence that appropriate people were involved in investigations, statements had been obtained and facts gathered before a response was made. Where different services were involved in delivering care or treatment the Trust took appropriate action to co-ordinate the investigation across the departments so a full response could be provided to the person raising the complaint.

We saw that where there was a need for an apology by the Trust, this was made and where people requested explanations, these were offered in an open and honest way. Complaints were responded to within the specified timescales. We found that patient's complaints were fully investigated and resolved where possible to their satisfaction.

We found that information from complaints was reported to the medical director, the Trust board and two committees were in place to put measure into place around learning from complaints and patient experience. The Chief Executive also has a blog called the Grapevine which staff can access and we were told that this had10000 hits per month. On this blog she posted every month, information about practice development; lessons learned; and the outcome of any initiatives being implemented such as Essence of Care. She found that this medium provides a forum, which assists the Trust to get key messages across.

We discussed how information from complaints was fed back to front line staff and used to make improvements in the service. The staff we spoke with were able to tell us how information from complaints not only influenced improvements in practice but also helped the Trust decide where other pieces of work needed to be carried out. For example, if a number of complaints were received for a particular ward or about a specific issue, then questionnaires or audits were carried out as a way to indentify issues and make improvements. Where appropriate, the nature of complaints was discussed and reflected upon by staff and managers as a way of improving services. The information from these discussions was always fed back anonymously and information about any complaints made was never recorded in people's medical records. Staff at ward level also confirmed this. They told us that complaints are fed back and discussed at ward meetings and that action plans are put in place if they are needed. Therefore, people had their comments listened to and acted on, without the fear that they would be discriminated against for making a complaint.

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.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk