# Inspection Report

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

# Spire Clare Park Hospital

Crondall Lane, Crondall, Nr Farnham, GU10 5XX

Tel: 01252850216

Date of Inspection: 21 August 2013

Date of Publication: September 2013

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

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|---|---|
| **Consent to care and treatment** | ✓ Met this standard |
| **Care and welfare of people who use services** | ✓ Met this standard |
| **Cleanliness and infection control** | ✓ Met this standard |
| **Requirements relating to workers** | ✓ Met this standard |
| **Complaints** | ✓ Met this standard |

## Details about this location

| | |
|---|---|
| Registered Provider | Classic Hospitals Limited |
| Registered Manager | Dr. Penny Pontet-Piccolomini |
| Overview of the service | Spire Clare Park Hospital is located in a rural location near Farnham in Surrey. The hospital is registered to provide acute overnight accommodation for up to 38 in-patients including children aged 3 and over. The Hospital comprises of two wards, a high dependency ward with two beds, two operating theatres, one minor operating theatre and a sterile services department. Outpatient facilities include treatment rooms and a physiotherapy department. |
| Type of service | Acute services with overnight beds |
| Regulated activities | Diagnostic and screening procedures<br>Management of supply of blood and blood derived products<br>Services in slimming clinics<br>Surgical procedures<br>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 21 August 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 and talked with staff.

### What people told us and what we found

People we spoke with told us the care at the hospital was good. One person said "Its exceptional here I have been in on a number of occasions and I can't find fault." Another person spoken with told us "The care here is first class, I have not been anywhere better."

Infection control practices at the hospital were good and the hospital was clean and hygienic.

Staff recruitment procedures were robust and people were cared for by staff who were fit, appropriately qualified and were physically and mentally able to do their job.

The hospital had systems in place to deal with comments and complaints.

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.

### Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

We reviewed six people's records and talked to staff about how they gained people's consent to their treatment. We also spoke with people about how their consent to treatment had been sought.

We noted in people's records that they had signed their pre admission and admission documents. We also noted that consent forms for surgical procedures had been signed by people on the day of their procedures. People spoken with told us the consultant and anaesthetist saw them prior to their procedure to get their agreement to their treatment. One person told us "X came to see me just before my operation; X explained the procedure and asked me to sign the consent form". This meant people where they were able, gave valid consent to the treatment they received.

Whilst reviewing the complaints received at the hospital we noted one member of staff's witnesses statement alluded to the person not being able to retain the information they had been given. They believed that perhaps the person did not understand or retain the information they had been given. We looked in detail at the pre admission, admission documents and care pathways there was no reference to a person's capacity or lack of capacity in any of the documents. This meant that the hospital assessments and care pathways did not ask staff to consider if a person had capacity to make decisions regarding their treatment. We discussed this with senior managers at the time. They informed us this issue would escalated to the clinical governance team for discussion.

We were shown three different types of consent forms. One was for people who were able to give their consent, one was for adults who were unable to give their consent and one was for parental agreement to investigation or treatment for a child or young person. The consent forms gave clear guidance for staff as to when they had to use a particular form.

Staff spoken with were clear as to when the forms should be used and completed. This meant staff knew the circumstances in which written consent must be taken and the way written consent was documented.

We spoke with nursing staff, senior managers and the RMO about how they gained people's consent. All were clear about their responsibilities to ensure that people were given sufficient information about their treatment prior to them signing the consent form. They also talked about the requirement to ensure they had signed parental agreement to children's treatment. One member of staff talked to us about an occasion whereby the person scheduled for a surgical procedure and refused to have the treatment at the last minute. They told us this person was an adult who was unable to consent and that their parent had signed on their behalf. They went on to explain the person returned the following morning and agreed to the procedure. This meant staff knew how to respond to the decisions people made and respected their human rights.

We talked to senior managers about training staff had had regarding the Mental Capacity Act 2005 (MCA). They told us this training had been included in the hospitals training programme since April 2013 and some staff had undertaken this training. We looked at the training records and saw that 13 of the 37 ward staff and three of the 13 outpatient staff had undertaken this training. Senior managers told us all clinical staff were expected to undertake the training. They also told us the MCA was discussed as part of the on-going safeguarding training and during staff clinical training sessions held monthly. Staff spoken with confirmed what we had been told, one said "Whilst I haven't received specific training around the MCA it is covered during our regular safeguarding training and clinical meetings." This meant there was arrangements in place to ensure all staff had an understanding of how a person's mental capacity could impact on their treatment.

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

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

## Our judgement

The provider was meeting this standard.

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

## Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care pathway.

We reviewed six pre admission and admission assessment records and care pathways during our visit. We saw that information included demographic details such as address, name and age, as well as details of the general practitioner and other important contacts. Personal information was then recorded, for example, medical information, allergies, medication needs, weight, home situation, mobility, work and relationships. This meant that staff had a range of information to guide them in delivering the required care and treatment. People we spoke with told us the care at the hospital was good. One person said "Its exceptional here, I have been in on a number of occasions and I can't find fault." Another person spoken with told us "The care here is first class; I have not been anywhere better."

We saw from the assessments that treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. For example, we saw from the records reviewed that there were risk assessments in place for such matters as deep vein thrombosis (DVT), this is the formation of a blood clot (thrombus) in a deep vein, predominantly in the legs. In addition risks assessments were in place regarding falls, manual handling and the risks to people of developing a pressure ulcer. The information helped staff to manage such risks safely and effectively. For example, staff said they made sure the person could mobilise safely based on the risks.

We asked staff how they ensured that the treatment and welfare needs of people were met. They explained that the assessments identified specific needs and that they followed these in the care pathways. Clinical staff spoken with demonstrated a good of understanding of people's treatments, surgical procedures and post-operative care. Clinical staff also talked about the on-going monitoring of their clinical competencies for example, pain management, safe transfusion of blood, intravenous medicines and aseptic dressings. They told us these helped them to ensure best practice and good outcomes for people following their treatment or surgical procedures.

There were arrangements in place to deal with foreseeable emergencies.
We spoke with the Resident Medical Officer (RMO) RMOs typically work primarily with the surgical inpatients, conducting regular ward rounds and ensuring that all patients are making progress following their surgical procedures. We spoke with the RMO on duty, they told us "If I was concerned about a patient I would contact the responsible consultant to seek their advice." They also talked about occasions whereby people who required further medical interventions that could not be provided at the hospital had been transferred to local NHS hospitals for treatment.

We also noted each ward and department had resuscitation equipment and emergency medicines to hand in the event of an emergency. This equipment and medicines had been regularly checked to ensure they was fit for purpose. Staff talked to us about the resuscitation training they had received and records we looked at confirmed what we had been told.

**Cleanliness and infection control** ✓ Met this standard

**People should be cared for in a clean environment and protected from the risk of infection**

## Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

## Reasons for our judgement

There were effective systems in place to reduce the risk and spread of infection.

We spoke with senior managers and the infection control lead in the hospital. The senior managers told us that regular audits of infection control rates had been undertaken. We saw evidence that seven incidences of infection had been reported since the beginning of 2013. Furthermore we saw that a Root Cause Analysis (RCA) had been undertaken. (RCA) is a method of problem solving that tries to identify the root causes of faults or problems that cause operating events. RCA practice tries to solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. The analysis carried out at the hospital determined that five of the incidences could be related to hospital acquired infections. In addition the analysis was able to identify which surgical treatments resulted in an infection. We were told these issues had been discussed at the infection control committee meetings held on a three monthly basis. We saw evidence that the findings of the analysis had been brought to the attention of the clinicians concerned.

The infection control lead told they used 'Care Bundles' to monitor various aspects of the care pathway. Simply put, a care bundle is a set of three to five evidence-based practices—interventions supported by research—that when used together cause significant improvement in patient outcomes. They told us as part of these interventions, daily audits were taken on the insertion sites of peripheral venous catheters/cannula (PVC) because of the risk of insertion-site infection. A peripheral venous catheter/cannula is a small, flexible tube placed into a peripheral vein in order to administer medication or fluids. We saw evidence that these checks were in place and staff spoken with confirmed what we had been told and what we saw. In addition we also noted 'Care Bundles' were also in place to monitor and minimise the instances of infections in people who had had a urinary catheter inserted. We were told the hospital worked in close collaboration with the microbiology department at the local NHS hospital trust. This meant the hospital worked with other providers to ensure best practice and to minimise the risks of people acquiring an infection as a result of treatment or surgical procedures carried out at the hospital.

The provider told us systems were in place to manage and monitor the prevention and control of infection. This was seen to be the case when we visited including weekly cleaning checks, regular cleaning and hand washing audits. In addition we found audits had been undertaken regarding sharps boxes, spot checks had also been carried on staff with regard to their infection control and prevention practices. The senior managers told us there was an infection control risk assessment audit in place and we looked at the document. We found it was up to date and relevant.

Staff told us they had been trained to manage infection control and the staff training records confirmed this. We were also told clinical staff had to undertake regular competency checks regarding their knowledge regarding infection control. We looked at records of the competency checks and they confirmed what we had been told.

People were cared for in a clean, hygienic environment. We looked at a number of areas of the hospital, including wards, people's rooms, the physiotherapist and outpatient departments. All areas which were seen appeared clean and smelt fresh, and staff were carrying out housekeeping duties during our visit. We saw that there were suitable supplies of equipment, hand washing soaps and sanitising gels. Staff were wearing personal protective equipment, including gloves and aprons, to protect against the spread of infection.  When we spoke with people they told us the wards appeared clean and they had observed housekeeping staff working to maintain cleanliness. People said staff always wore protective gloves when they carried out care and they had observed staff washing their hands prior to care being given. One of the people we spoke with said "The place is spotless, they are always cleaning it."

**Requirements relating to workers** ✓ Met this standard

**People should be cared for by staff who are properly qualified and able to do their job**

## Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

## Reasons for our judgement

There were effective recruitment and selections processes in place and appropriate checks were undertaken before staff began work.

We looked at the recruitment records for eight staff including consultants, nurses, physiotherapists and ancillary staff. We found that the files had the information required to ensure that people were fit to work at the hospital. For example records included a health declaration, a full employment history, a current Disclosure and Baring Service check (DBS) previously known as
Criminal Records Bureau (CRB) check. We also noted previous employer references had been received and checked.

We saw completed application forms and records of staff interviews for the nurses and physiotherapists. The application form and record of interviews showed the applicant's previous experience, qualifications, training and skills necessary for the role applied for. We noted nurses and physiotherapists had been required to undergo written competency exams prior to them being employed and starting work. Nurses spoken with on the day confirmed what we had been seen.

We noted that where required, staff had provided evidence of their registration with the relevant professional regulator or professional body. All of the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and physiotherapist professional body pin numbers were current.

This meant people's health and welfare needs were met by staff that had been properly vetted and were fit to do their jobs

**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. Comments and complaints people made were responded to appropriately.

## Reasons for our judgement

People were made aware of the complaints system.

People spoken with told us they felt confident to make a complaint should they require to do so. One person said "I have been in here a number of times and never needed to complain, but I would be happy to talk to any of the staff here." Another person said "Oh yes I noticed there was a notice about how to make a complaint in handbook provided in my room." We asked senior managers if there were any processes in place whereby people could make a complaint without the need to ask at the reception desk. We were told people could access the complaints process on the organisations website if they wished and that this could be done anonymously. We were also told people were provided with a feedback questionnaire before discharge whereby they could raise any concerns before they left the hospital. This meant the provider had ensured there were processes in place for people who had treatment in the wards to make their complaint anonymously. However we looked around all of the areas of the hospital including wards, the outpatients department, the physiotherapy department and the reception area. We could not see any evidence of the hospital's complaints procedures being displayed anywhere. This meant people who visited the various departments would not have known about the complaints procedure. We spoke with staff in these departments, they told us if people or visitors wished to make a complaint they would be advised about the complaints procedure. Senior managers told us there should have been a leaflet titled 'Talk to us' in all areas of the hospital whereby people could take it away and use it if need be. We were unable to locate a copy of this leaflet. The provider may find it useful to note a well-publicised complaint process and procedure reflects established principles of good complaint handling.

We spoke with nurses, administration staff and the RMO. All staff spoken with demonstrated a good understanding of their responsibilities regarding people's complaints. One nurse said "I have never had a patient complain, but if they did, I would direct them to the complaints procedures and report it to senior managers." This meant that staff were fully aware of the organisations complaints procedures.

People's complaints were fully investigated and resolved, where possible, to their

satisfaction.

We looked at the complaints log and saw that eight complaints had been reported since the beginning of 2013. We noted all of the complaints had been managed in accordance with the procedures and the hospital had taken appropriate action to resolve the complaint to the persons' satisfaction. This meant that people could be confident that their complaints were managed appropriately.

## About CQC inspections

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

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

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

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

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

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

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

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

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

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

## How we define our judgements

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

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

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| ✓ **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.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete. |
| ✖ **Enforcement action taken** | If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people. |

## How we define our judgements (continued)

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

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

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

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

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

## Glossary of terms we use in this report

### Essential standard

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

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| 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

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