Inspection Report

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

CircleReading

100 Drake Way, Reading, RG2 0NE

Tel: 01189226888

Date of Inspections: 20 January 2014
14 January 2014

Date of Publication: February 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Management of medicines	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Circle Hospital (Reading) Limited
Registered Manager	Mr. Adrian Peake
Overview of the service	CircleReading provides a range of inpatient and day patient surgical procedures. The location also provides outpatient therapy, diagnostic and screening services. There are 30 inpatient beds and 20 day case beds.
Type of services	Acute services with overnight beds Diagnostic and/or screening service
Regulated activities	Diagnostic and screening procedures Surgical procedures 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 in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 14 January 2014 and 20 January 2014, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information given to us by the provider, were accompanied by a pharmacist and were accompanied by a specialist advisor.

What people told us and what we found

In January 2014 we received intelligence information regarding the management of medications and the monitoring of the quality of service provision. We completed this responsive inspection to check that the provider was compliant with the two relevant outcomes and that people received safe and well-lead care and treatment.

At this inspection our focus was on systems and processes related to people's safety and the quality of care. We spoke with six people at the inspection, but their feedback did not relate to the outcomes we inspected.

On the first day of the inspection, we looked at the management of medicines with a pharmacist inspector to determine whether people were at risk from unsafe practices or procedures related to medicines. We found that the provider ensured the safety of people who use the service because there were robust systems in place for the management of medicines. Where the provider had identified areas for improvement, plans were already in place to ensure that risks were addressed promptly.

On the second day of the inspection, we looked at the monitoring of the quality of service provision with a specialist advisor to determine whether the location provided safe care and treatment. We found that the provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service. On rare occasions where the quality of care provided was not satisfactory, the provider had identified this and implemented strategies to prevent recurrences of similar situations. We saw evidence of a culture of continual improvement at CircleReading.

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

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had safe and effective arrangements in place for the management of medicines.

Reasons for our judgement

During this inspection we looked at storage of medicines, ordering and supply of medicines and labelling of medicines. We talked to staff and patients. Pharmacy services and medicine supplies were provided by a pharmacy company who were based off site.

Medicines, including controlled drugs, were kept safely and only accessible to staff authorised to handle medicines. All medicines were stored within controlled access automated medication dispensing systems (Pyxis machines) or locked refrigerators. Only trained and authorised staff could access medications. Locked cabinets that contained controlled drugs required two authorised members of staff to gain access. There were appropriate arrangements in place for access to medicines in the event of a power failure. Medicines requiring cold storage were kept in a locked refrigerator and the weekday temperature of the refrigerator was monitored and recorded. Staff knew what action to take if the refrigerator temperature was outside the range for safe storage. Medicines for emergency use were easily accessible and were monitored regularly. Therefore people received medicines that had been stored appropriately and were fit for use.

Appropriate arrangements were in place for obtaining medicines. Stock levels were monitored by the Pyxis machines and pharmacy staff ordered supplies every morning based on the reports generated. Supplies were delivered by an overnight courier and there was evidence of an adequate cold chain distribution system in place. Restocking of the Pyxis machines was completed by the pharmacy technician. Dates of opening on liquids had been recorded but there were no 'date of opening' stickers in use. People brought in their own drugs for continued use but no one was self-administering their medicines. Pharmacists were not involved in medicines reconciliation (checking of people's medication on admission) but people's own drugs were checked by the resident medical officer on admission. Appropriate storage for medicines was provided in people's rooms. Appropriate systems were in place for obtaining, storage and accessibility of intravenous fluids. The provider may find it useful to note that the system for obtaining controlled drugs did not comply with the current legislation..

There were appropriate arrangements in place for supply of medicines and pharmaceutical advice out of hours. There was an electronic and a hard copy of information provided regarding the whereabouts of different medicines within the hospital. If the medicine was not available within the hospital, there was a 24 hour number to call which was operated by the off-site pharmacy company. Therefore medicines were available when people needed them.

Appropriate arrangements were in place for recording the administration of medicines. Medicine charts were screened by a clinical pharmacist each weekday morning from the off site location and supplies provided if required. There were separate charts for patient controlled analgesia, warfarin and insulin. Original pack medicines were appropriately over labelled for people to take home with them. All labels contained the legally required information. The provider may find it useful to note that one antibiotic suspension did not have "Shake well before use" on the label and one buccal tablet was labelled "take" and the instructions "do not swallow or chew" had been covered up by the addition of the over label. In some incidences, medicines were provided directly from the pharmacy to people's homes via secure delivery. Therefore there were systems in place to ensure that people received appropriately labelled medicines as prescribed.

There were appropriate arrangements for checking the safe use of medicines. Staff training on medicine management had been provided by the pharmacy in early 2013.The clinical pharmacist attended the meetings of the medicines management committee where any people's complaints or incidents relating to medicines were reviewed. The hospital had effective arrangements in place to manage the risks associated with medicines.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We saw the provider used a third party pharmacy supplier for the provision of medicines, equipment and some associated staff roles. There was a service level agreement between the pharmacy and provider and this was reviewed at regular intervals. There were also key performance indicators agreed and documented between the two parties. The registered manager explained that the provider and pharmacy company had recently reviewed certain aspects of their agreement and provisions of service to improve the medication-related outcomes for people who use the service. We wrote to the provider to request information about the monitoring of key performance indicators between the two parties. We received information that corroborated what the registered manager had told us about the working relationship of the provider with the pharmacy service.

The location used an electronic incident recording system widely available in the healthcare industry. We saw that incidents were freely recorded by staff from all levels and the data was reviewed by department managers, the registered manager and staff who worked in quality and risk. Staff we spoke with were aware of their responsibilities regarding incident reporting and knew how to use the computer system to input new data. We looked at information that had been entered into the database and saw that when medication incidents occurred, these were satisfactorily captured in the system. Incidents were risk assessed and measures were put in place to prevent recurrence of the same type of incident. Where necessary, this included discussion or consultation with the pharmacy service and changes to practices or procedures. In the event of more serious matters, root cause analyses were undertaken by the provider. However, we noted that no root cause analyses were required for medication management incidents since the location's registration.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. We found that a senior staff member at the location responsible for clinical governance matters maintained a robust system for recording, analysing and prioritising organisational risk, including issues associated with medicines management. The staff member was able to demonstrate that whenever incidents occurred related to medicines, these were recorded, assessed and control

measures put into place to ensure the safety of people who use the service. We saw the staff member was responsible for a comprehensive location risk register which was thorough and up-to-date at the time of our inspection. We saw the location held monthly clinical governance and risk management meetings which were chaired by a medical practitioner with practising privileges. We reviewed the minutes from these which confirmed what we were told by staff about the management of medicines.

The provider's governance system included many sub-committees that held meetings in addition to the clinical governance and risk management meeting. For example, we saw the location had a medicines management committee and resuscitation committee. The provider may find it useful to note that the resuscitation committee did not have meeting minutes documented since April 2013, although we saw safety improvement work had continued outside the meeting agenda. We reviewed the terms of reference for, and multiple sets of minutes from the medicines management meetings. The minutes demonstrated that issues related to medicines management were discussed and captured, and escalated to the clinical governance and risk management meeting where necessary. The latter meeting reviewed each month what had occurred in the sub-committee meetings and discussed any actions or changes that were required. This meant that the provider ensured that risks were adequately identified and addressed without potential omission of issues.

We saw the provider's controlled drugs accountable officer (CDAO) was the registered manager. However, from the minutes we reviewed we saw the registered manager had not attended any of the location's medicines management meetings for 2013. We spoke with the registered manager regarding this. The manager told us that they attended the local intelligence network (LIN) meetings when they were held in the area, and that they had recently attended one. LIN meetings are held to ensure the safe management of controlled drugs following the outcomes of the Shipman inquiry. We saw the CDAO checks were also delegated by the registered manager to another senior member of staff. The provider may find it useful to note that the location's policy identified the manager as the staff member responsible for this duty. The manager informed us that they were made aware of any issues related to controlled drugs by other team members. The registered manager also provided written confirmation they had received appropriate training for their role and responsibility as the CDAO.

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.

✓ **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. 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:

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