Bodmin Dialysis Unit

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

Bodmin Dialysis Unit is operated by Fresenius Medical Care Renal Services Limited. The treats NHS patients on behalf of the Royal Cornwall Hospital NHS Trust. The service has 14 dialysis stations (two in side rooms) for patients and operate two sessions daily. The service is open six days a week and can operate 168 individual sessions weekly. The unit has a current caseload of 47 patients. The service also accepts patients for dialysis who holiday in the region.

Dialysis units offer services, which replicate the functions of the kidneys for patients with advanced chronic kidney disease. Dialysis is used to provide artificial replacement for lost kidney function.

The service is a nurse led unit which provides outpatient satellite dialysis provision to patients.

We inspected the dialysis service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 6 June 2017, along with an unannounced visit to the hospital on 16 June 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we do not rate

We regulate dialysis but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There was a clear incident reporting process Staff received feedback from incidents they reported. Organisation wide learning from incidents was recognised and implemented.
- Staff were fully compliant with mandatory training and safeguarding training and there was a reliable system to monitor this. There was a comprehensive training programme to ensure trained nurses were competent to carry out their role.
- There were systems and process in place to safely manage medicines and to ensure regular servicing and maintenance of equipment was in place. .
- Staff demonstrated good practice with infection, prevention and control processes.
- There were safe nursing staff levels to ensure safe and effective patient care.
- There were business continuity policies and procedures to follow in case of a power failure or issues with the water supply.
- Pain was assessed and managed well and patient's hydration and nutritional needs were monitored and managed well.
- There was good multidisciplinary working and strong communication links with the nephrology consultants from the referring trust.
- Staff had access to information about patients which enabled effective care and treatment, including access to NHS patient record computer systems. Informed consent was sought and documented prior to commencement of treatment.

Summary of findings

- Staff took the time to interact with patients and had a good rapport with them. Patients said staff were kind and helpful and generally spoke very highly of the unit.
- Staff understood the impact of the treatment on patient's emotional wellbeing and actively supported patients.
- Patients had access to entertainment during their haemodialysis session.
- There was a system to monitor and deal with complaints. There had been three complaints at the unit in the 12 months prior to the inspection, none had been upheld.
- Leaders had the skills and experience to lead and staff spoke highly of the unit manager and senior management team telling us they were visible and approachable.
- There was an effective systematic governance system and programme of audit which was shared with the consultants and contracting team.

However, we also found the following issues that the service provider needs to improve:

- Not all care plans had been regularly reviewed, in line with organisational policy, to ensure the welfare and safety of the patients who attended the unit.
- Staff were not aware of the visions and values of the organisation.

Edward Baker
Deputy Chief Inspector

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis Services		We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Bodmin Dialysis Unit

Services we looked at:
Dialysis Services

Summary of this inspection

Background to Bodmin Dialysis Unit

Bodmin Dialysis Unit is operated by Fresenius Medical Care Renal Services Limited. The service opened in 2003. It is an independent healthcare unit in Bodmin, providing haemodialysis services for the communities of Bodmin, on behalf of the Royal Cornwall Hospitals NHS Trust. The unit also accepts patient referrals from outside this area.

The unit has had a registered manager in post since 2016 and is registered for the regulated activity:

Treatment of disease disorder and injury.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Mandy Norton and one other CQC inspector.

Information about Bodmin Dialysis Unit

The haemodialysis unit is registered to provide the following regulated activities:

- Treatment of disease, disorder and injury.

During the inspection, we visited Bodmin Dialysis Unit. We spoke with seven staff including registered nurses and a technician and we spoke with nine patients. During our inspection we reviewed nine sets of patient records.

There were no special reviews or investigations of the service on-going by the CQC at any time during the 12 months before this inspection.

The unit has a service level agreement with the Royal Cornwall Hospital NHS trust (RCHT) for the provision of outpatient satellite haemodialysis to patients. The unit is nurse led, with clinical supervision being provided by a consultant nephrologist from RCHT.

Activity

- In the 12 months prior to our inspection the unit carried out 5793 haemodialysis sessions. This figure also included haemodialysis sessions for holidaymakers in the area.
- The unit provided haemodialysis for both adult male and female patients from 18 years of age. The unit opened six days a week and carried out up to 28 haemodialysis sessions daily, two sessions in the morning and two sessions in the afternoon.
- The unit employed 8 registered nurses, working both full time and part time contracts. The unit also had its own bank staff and a two consultant nephrologists providing medical support.

Track record on safety:

In the last 12 months there had been:

- No never events
- Three clinical incidents
- No serious incidents
- No incidences of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (C.diff)
- There had been three complaints in the 12 months prior to our inspection.

Summary of this inspection

Services accredited by a national body:

- ISO accredited 9001 Integrated Management System 2008.
- OHSAS 18001 H&S system

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Maintenance of medical equipment
- Cleaning services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following areas of good practice:

- There was a clear incident reporting process Staff received feedback from incidents they reported. Organisation wide learning from incidents was recognised and implemented.
- Staff were fully compliant with mandatory training and safeguarding training and there was a reliable system to monitor this.
- There were systems and process in place to safely manage medicines.
- Staff demonstrated good practice with infection, prevention and control processes.
- There were safe nursing staff levels to ensure safe and effective patient care.
- There were good working relationships between the unit and the consultant nephrologist who was responsible for patients' treatment.
- The unit had clear processes in place to ensure regular servicing and maintenance of equipment.
- There were business continuity policies and procedures to follow in case of a power failure or issues with the water supply.

However, we also found the following issues that the service provider needs to improve:

- Not all care plans had been regularly reviewed, in line with organisational policy, to ensure the welfare and safety of the patients who attended the unit.

Are services effective?

We found the following areas of good practice:

- Policies and procedures reflected current evidence-based guidance including the Renal Association guidelines.
- There was a comprehensive training programme to ensure trained nurses were competent to carry out their role at the haemodialysis unit.
- Pain was assessed and managed well.
- Patient's hydration and nutritional needs were monitored and managed well.
- Staff worked well as a team to deliver effective care to patients.
- There was good multidisciplinary working and strong communication links with the nephrology consultants from Royal Cornwall Hospitals NHS trust.

Summary of this inspection

- Staff had access to information about patients which enabled effective care and treatment, including access to NHS patient record computer systems.
- Informed consent was sought and documented prior to commencement of treatment

Are services caring?

We found the following areas of good practice:

- Patients were treated with dignity, compassion and respect.
- Privacy and dignity was respected in all aspects of care.
- Staff took the time to interact with patients and had a good rapport with them. Patients said staff were kind and helpful.
- Patients spoke very highly of the unit, the staff and the care they received.
- Staff communicated with patients so they understood the treatment they received and were encouraged to ask questions.
- Staff understood the impact of the treatment on patient's emotional wellbeing and actively supported patients.

Are services responsive?

We found the following areas of good practice:

- Services were planned and delivered to meet individual patient needs and improve quality of life.
- Patients had access to entertainment during their haemodialysis session.
- Patients were supported to arrange haemodialysis at their holiday destination.
- Patients were supported to achieve home dialysis if it was appropriate for the patient.
- Patients were fully assessed prior to being accepted as patients of the unit.
- There was no waiting list for patients to attend the unit.
- There was a system to monitor and deal with complaints. There had been three complaints at the unit in the 12 months prior to the inspection, none had been upheld.

Are services well-led?

We found the following areas of good practice:

- Leaders had the skills and experience to lead and staff spoke highly of the unit manager and senior management team telling us they were visible and approachable.
- There were processes in place for unit managers to meet with other unit managers to ensure they did not work in isolation and shared good practice ideas and information.

Summary of this inspection

- There was an effective governance system to support the delivery of good quality care.
- There was an effective systematic programme of audit which was shared with the consultants and contracting team.
- The unit valued feedback from patients and carried out an annual employee survey.
- There was a replacement programme for the dialysis machines, in line with the Renal Association guidelines.
- The organisation had a vision and a set of values. The values were displayed in the unit.

However:

- Staff were not aware of the values of the organisation, although we observed them using the values as they went about their work.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dialysis Services	N/A	N/A	N/A	N/A	N/A	N/A

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Incidents

- Staff were aware of their responsibilities to raise concerns, record safety incidents and near misses and report them.
- There was a policy and system in place to report incidents and staff we spoke with were able to provide us with examples of incidents and near misses they would report. Staff knew how to use the electronic reporting system. The system allowed for head nurses and senior managers to have an overview of all incidents reported and identify trends at local units and organisation wide.
- There had been no never events or serious incidents at the Bodmin dialysis unit in the 12 months prior to our inspection. Serious incidents can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.
- There has been three incidents reported in the 12 months prior to the inspection. There was no comparison with other units run by the organisation to assess if this was higher or lower than other units. The unit manager said that incidents were discussed during managers meetings and any learning shared.
- The unit received and acted upon relevant safety alerts from the Medicines and Healthcare Products Regulatory Agency. Information was sent to the unit via email from head office. If an alert was relevant to the Bodmin unit, the clinic manager took the necessary action and report back to head office.
- Staff demonstrated an understanding of their duty of candour responsibilities. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. There was a Fresenius Medical Care policy relating to duty of candour, which outlined actions to be taken when something went wrong it was also described in the clinical incident policy. All staff had completed training in duty of candour and the steps to follow when something goes wrong. Staff had no specific examples of when the process had been used.

Mandatory training

- Staff completed mandatory training in the safety systems, processes and practices annually. Training was divided into categories such as emergency training, nursing skills and reassessment of competencies. Mandatory training included fire training, manual handling, food safety, infection control and health and safety. The safety training also included prevention of healthcare associated infections, sharps management, waste management, medicines management, records management, risk assessment, planned preventative maintenance, incident reporting, accidents and near misses, root cause analysis and management of emergencies.

- Mandatory training was a combination of classroom and e-learning modules carried out either annually, two or three yearly. Staff were issued with a training matrix which outlined what training was required and how often.
- Training records were maintained centrally, submitted to the unit manager monthly and also to the operational manager. This ensured oversight of mandatory training to ensure all staff remained up to date and could safely carry out their role at the unit.
- At the time of the inspection all staff were 100% compliant with their mandatory training.
- Basic life support training was undertaken annually to ensure staff had the confidence to deal with emergencies at the unit. Staff completed an e-learning training module in basic life support and automated external defibrillator training to ensure they understood their role and responsibilities in the event of an emergency situation like this occurring at the unit. Staff were 100% compliant with this training.

Safeguarding

- The organisation required staff to attend both safeguarding adults and children training and all staff were 100% compliant with this training. Safeguarding adults and children training was completed every three years via and e-learning module. The level of safeguarding training staff had to attain was not specified.
- There were systems and processes reflecting relevant safeguarding legislation to safeguard adults. All staff we spoke with understood their responsibility to report safeguarding incidents. Staff reported safeguarding issues to the local authority.
- The safeguarding lead for the unit was the registered manager. The safeguarding leads for the organisation were members of the senior management team who were trained to level three in both child and adult safeguarding.
- There had not been any safeguarding alerts made by staff working at the unit.

Cleanliness, infection control and hygiene

- Staff adhered to infection, prevention and control policies and procedures. We observed good use of personal protective equipment (equipment which protected the user from health and safety risks at work including disposable aprons, disposable gloves and full face visors) and hand washing. Staff were bare below the elbow to ensure effective and thorough cleaning of their hands between patients.
- There was good access to personal protective equipment around the unit and to hand washing sinks at each side of the unit. Staff and patients had access to antibacterial hand gel at each dialysis station.
- We observed good hand hygiene practices. Staff were aware of the latest hand hygiene audit and where to find the results. However hand hygiene audit results for January to May 2017 showed an average of 76% compliance. Monthly compliance varied and ranged from 76% to 100%. The area most frequently identified with poor compliance over the four month period was not washing hands for long enough and moving between patients without washing hands. An action plan had been put in place to address the results of the audits. Actions included discussing results at team meetings, reminding staff of the '5 moments of hand hygiene' and displaying the results on the staff and patient information boards.
- The premises were visibly clean, tidy and free from clutter, and there was sufficient space for staff to access patients from both sides of their chair.
- The flooring in the unit had no visible damage and visibly clean. It was made of a hardwearing material and extended up the wall, which allowed for effective cleaning and decontamination.
- Curtains separating the dialysis station were changed six monthly in line with company guidance. Staff at the unit changed the curtains and the next change was due in October 2017. Curtains in the consulting rooms were changed annually in line with company policy and were due to be changed in September 2017. Staff told us if the curtains were contaminated they would be changed immediately to remove any risks of cross infection to patients. This ensured patients were protected from harm due to good infection, prevention and control practices.
- The reclining chairs in the clinic were made of a wipe clean material. They were visibly clean and in good condition at the time of our inspection. We observed

the nurses cleaning the chairs, pillows and pressure cushions with disinfectant wipes before and after the haemodialysis session, and we saw this was recorded on the daily cleaning rotas, which were all completed and up to date. Nurses also cleaned the trolleys used to set up the dialysis equipment between each patient use.

- There had been no episodes of methicillin-resistant Staphylococcus aureus(MRSA) and no episodes of methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia at the unit in the past year. There had been no reported cases of Clostridium difficile (C. diff). Patients were screened for MRSA and other blood borne viruses every three months in line with company policy.
- There were guidelines to ensure patients attending the unit for holiday haemodialysis were screened for blood borne viruses (BBV). The unit required proof, which was requested four weeks prior to the patient attending the unit. Nurses reviewed the information provided to ensure suitability of the patient to receive haemodialysis at the unit.
- Patients on their return to the unit from a holiday would also be screened for BBV. They would have their treatment in an isolation room with a dedicated machine, not used by any other patients, until the results of the screening were received.
- The organisation had an infection control lead who staff could contact for advice. They had visited the unit in February 2017 to carry out an unannounced infection prevention and control audit. This was part of the organisations routine audit of infection control practices at all their units. This audit made a few minor recommendations. Staff said they were easy to contact when or if they needed advice.
- Staff used recommended aseptic techniques to attach patients to their dialysis machines in line with their hygiene, infection, prevention and control policy. This was completed through either the insertion of large bore needles into an arteriovenous fistula, graft or central line. Arteriovenous fistulas are an abnormal connection or passageway between an artery and a vein created through vascular surgery specifically for haemodialysis. Grafts are artificial veins inserted for haemodialysis, and central lines are larger cannulas that are inserted for long periods for haemodialysis.
- Staff received training in aseptic non-touch technique (ANTT) for the management of haemodialysis vascular access. Staff at the unit had completed competencies in the use of ANTT and the management of vascular access. Staff told us and we saw evidence in staff files to demonstrate compliance. We saw staff using good ANTT techniques during our visit.
- Water used for dialysis was specially treated to reduce the risk of contamination in patients. There was a water treatment room, which was monitored by Fresenius Medical Care technicians. The technicians monitored the water plant and identified any issues with supply, effectiveness of treatment or leaks. Staff had telephone contact numbers to log concerns or report emergencies with the water plant.
- Nursing staff monitored the water supply and water testing was completed daily, in line with company policy, to ensure that water used during dialysis was free from contaminants. We saw the record log that recorded the testing and the results. Staff were aware of the processes for obtaining samples, and actions to take if results showed some contaminants. There had been no reported incidents of contamination. We saw that weekly checks covered chlorine levels, hardness of the water and tests for bacterial contaminants. The water treatment plant was maintained and monitored by Fresenius Medical Care technicians. Any maintenance and actions taken were clearly recorded on the visit sheets.
- Staff completed daily tap flushing to ensure water used for hand washing was free from contaminants and bacteria. These checks formed part of the daily cleaning tasks, and records we looked at confirmed this was consistently carried out. This was in line with company policy for prevention of legionella (a severe form of pneumonia) and pseudomonas (infection caused by bacteria).
- During our unannounced visit a contractor was visiting to assess a panel, under one of the hand washing sinks, which had swollen due to liquid soap and water

dripping from the sink down onto it. This had happened before and the panel had been replaced. The panel, when wet, could be an infection control risk. No permanent solution had yet been agreed.

Environment and equipment

- The Department of Health 2013 Health Building Note: Satellite Dialysis Unit had been used to ensure the facilities at the unit were suitable for the treatment being carried out.
- The toilet facilities were set up to enable safe and easy access for patients with mobility problems and disabilities. The two toilets had raised toilet seats with arms, hand rails and an emergency call bell in case patients were in need of help.
- The layout of the unit helped staff to maintain the safety and privacy of the patients receiving haemodialysis. The unit had curtains around each station which were used when required. All patients faced in the same direction and were able to look out of the windows of the unit. One patient told us their privacy was maintained due to the each station being surrounded by the haemodialysis machine which other patients could not see past. There was sufficient space around the dialysis chairs to enable staff to gain rapid access in case of an emergency.
- The environment and equipment met patients' needs. The centre provided 14 dialysis stations, two of which were side rooms. Dialysis stations were set up in a row with two bays and a central nurse's station. Each bay had access to a hand-washing sink and each dialysis station had access to its own clinical waste bin.
- Each dialysis station had a reclining chair, pressure cushion, dialysis machine, nurse call bell, table, and television with remote control. This provided patients with their own individual environment and direct access to the nurses on duty at the unit.
- The unit had emergency equipment in case of medical emergencies and in accordance with national guidance (Resuscitation Council, 2015). This included automated defibrillators, which staff were trained to use. The complications, clinical reactions and other clinical event pathways policy outlined what to do in the event of an emergency.
- The resuscitation trolley was checked daily by staff and the records we saw were complete, apart from three omissions, between January and May 2017. We also checked stock held on the trolley which was in date. The trolley also held an anaphylaxis kit (anaphylaxis is an extreme and severe allergic reaction) which was sealed and tamper evident. The resuscitation trolley was stored in the main treatment area for ease of access.
- Sharps bins were stored in line with the National Institute of Health and Care Excellence (NICE) guidelines, Healthcare Associated Infections: Prevention and Control in Primary and Community Care (CG139). Sharps bins were attached to the leg of the table situated at each station. The sharps bins remained temporarily closed at all times due to the flap mechanism on the sharps bin. The sharps bins were dated and not overfilled in accordance with guidance.
- The stock room appeared clean and tidy with shelving for all equipment. Stock was delivered weekly and staff told us they held an extra week's supply in case of emergencies. It was not possible for the unit to hold any more stock due to limited storage capacity. There were adequate supplies to ensure that the service could continue if a weekly stock delivery was delayed.
- All dialysis machines and sets used at the unit were single set use and were CE marked (CE marking defines how the equipment met the health, safety and environmental requirements of the European Union). All single use equipment was labelled accordingly, and disposed of after use. The batch numbers of the single use sets were not recorded.
- The unit had a contingency plan to ensure they had access to consumables to enable continuity of the service for patients, if they were unable to obtain the necessary equipment required for haemodialysis. Small consumables were ordered on a weekly basis and staff always ensured the unit maintained one week's additional supply in case of emergencies. The unit could also order stock in an emergency which could be delivered within 24 hours. This option was costly but available for emergencies to ensure a continuation of the haemodialysis service.

- The unit held a backup set of weighing scales in case the main scales failed. Scales are an integral part of a patient's haemodialysis session because they determine how much fluid needs to be removed during a haemodialysis session.
- All staff were trained to use the dialysis machines in use at Bodmin. This was covered as part of the competencies staff completed when they started their employment at the unit. Each station contained the same model of haemodialysis machine. This ensured all staff were competent and could safely use the machines and equipment provided at the unit to keep patients safe.
- We saw that there was adequate equipment to enable regular servicing of machines and equipment and maintain a full service. The unit held three spare dialysis machines in case of a machine breakdown. All dialysis machines were maintained according to guidance by Fresenius Medical Care Technicians. The technicians attended the centre at regular intervals to complete routine servicing. All equipment checked was logged with a record sent to the centre manager and head office detailing works completed.
- Maintenance of the dialysis machines and chairs was scheduled and monitored using the dialysis machine maintenance/calibration plan; this detailed the dialysis machines by model type and serial number along with the scheduled date of maintenance by technicians. The additional dialysis related equipment was calibrated and maintained under contract by the manufactures of the equipment or by specialist maintenance/ or calibration service providers. All the equipment testing and servicing logs were within the specified dates.
- Alarms, on the dialysis machines, sounded for a variety of reasons, including, sensitivity to patient's movement, blood flow changes, or leaks in the filters. We saw the alarms were used appropriately and not overridden by staff or patients; when alarms went off we saw nursing staff check the patients and the lines before cancelling the alarms.
- In January 2017 Fresenius brought Facilities Management to manage maintenance work of the haemodialysis machines and equipment. A dedicated Fresenius management team, an experienced Fresenius Management manager and two helpdesk coordinators provided the clinic with both reactive and planned preventative maintenance work. We saw evidence of staff in the clinic logging a call with the help desk regarding facilities issues. The call was allocated a job number and priority. The Fresenius Management helpdesk ensured a contractor was requested to attend the clinic to resolve the issue as per the priority level. The calls were also documented in the clinic diary.
- Staff were aware of the escalation process for the reporting of faulty equipment to ensure patients did not experience delays or had sessions cancelled. Staff were familiar with and showed us the procedure they followed to report equipment failure.
- The facilities management team carried out electrical testing work at the unit as part of the planned and preventative maintenance (PPM) schedule. Electrical testing of equipment was also monitored during the annual Health and Safety audit.
- The unit maintained a register to demonstrate all equipment had been tested and was in date. We saw the auxiliary maintenance/calibration plan 2017 that showed the dates the next tests on equipment were due.
- Five out of 25 completed comment cards mentioned how cold the building was at times. Staff said this was an on-going issue for some patients and they had tried to help by adjusting the heating, providing blankets and encouraging patients to bring in their own blankets also. The ambient temperature of the unit was 25 degrees Celsius. During dialysis, patient's blood flows through the dialysing machine, when wastes and toxins are removed, the purified blood is then returned back into the patient's body. When the blood is outside the patient's body, it is cooled and when it is returned into the body, it will make the patient to feel cold. The patient also has to remain quite still during dialysis treatment which also leads to them feeling the cold.

Medicine Management

- The unit had processes in place for the safe management of medicines and staff were compliant with the medicines management policy. Patients attending would receive prescribed medicines for

their dialysis treatment only. On-going oral medicines prescribed by the patients lead consultant were administered by nursing staff at the end of the haemodialysis session. If a patient had prescribed medication for other reasons they self- administered those at home as required.

- Medicines were stored in a clean utility room, away from the main treatment area. This was secured with a keypad access door. Both the medicines fridge and cupboard remained locked and the nurse in charge held the access key.
- Prescribed fluids were stored on pallets, in a clean and secure store room, which meant they were raised off the floor which is considered good practice.
- Medicines were collected and stored in a locked medicines trolley during the day, which remained locked and on the haemodialysis unit. This was to enable the nurses on the unit easy and timely access to the medications required for haemodialysis sessions. These medications would be returned to the medicines store at the end of each day.
- There were a small number of medicines routinely used during haemodialysis, for example anti-coagulation and intravenous fluids. The centre also had a small stock of regular medicines such as erythropoietin (a subcutaneous injection required by renal patients to help with red blood cell production). Controlled drugs (requiring extra security of storage and administration) were not used or available on site.
- Nursing staff completed weekly medicine stock level checks when the amount of and expiry dates of medicines were checked. Stock was also rotated during the weekly stock check.
- The unit had a service level agreement with the local acute NHS trust for the supply of haemodialysis specific medication for patients attending the unit and the company also provided some medication to the unit as required. Medication was prescribed by the patient's lead consultant nephrologist, in line with individual patient requirements. Original prescriptions were stored in the patient written record. All eight patient records we looked at contained up to date prescriptions.
- Staff ensured the safe administration of intravenous medication to patients in line with guidance from the Nursing and Midwifery Council (2015). We observed two nurses checking the anticoagulant provided was in date and correct for the patient. We also observed the nurses formally identify the patient's date of birth against the anticoagulant prior to administration. Staff recorded the lot number of intravenous anticoagulant used, in the patient's electronic record. We saw the system would not let staff complete the record unless the lot number had been added. Therefore, if a medication alert was issued about a particular medication, staff would know if a patient had been administered this particular batch of medication.
- Staff adhered to the Nursing and Midwifery Council's (2015) standards for medicines management. Staff could administer boluses (a single dose of a drug or other substance given over a short period of time) of fluids intravenously if patients dropped their blood pressure during dialysis treatment and other methods of managing a drop in blood pressure had failed. Patients were prescribed fluids by the lead consultant to be used in the event this situation arose.
- Safe prescribing and review of medications was undertaken for patients on haemodialysis by the patient's lead consultant during the monthly quality assurance meeting or at the patient's quarterly follow-up appointment. Staff told us they could raise any medication queries directly with the patient's lead consultants. We saw that prescription charts were clearly written, showed no gaps or omissions and were reviewed every three months. They added that they had developed routines to make sure prescriptions were received and no patients had been without their treatments as a result.
- The unit had arrangements for pharmacist support to gain additional advice relating to dialysis medication. The nurses at the unit could liaise with the pharmacy at the referring trust. Alternatively, the unit also had access to a pharmacist employed by the organisation, who was based at head office.
- Staff took appropriate actions if patients showed signs of infections. Staff phoned the consultant nephrologist to obtain a verbal prescription for antibiotics. The prescription was also sent electronically and staff wrote it as a 'stat dose' on a paper prescription chart.

This was checked by two nurses to ensure the right medication, the right dose and route of administration. The consultant signed the prescription (paper format) at the next opportunity and ideally within 24 to 48 hours.

- The unit did not liaise directly with the patients GP. Any communication with the patients GP regarding medication or dietary changes were communicated via the lead consultant for the patient.

Records

- Patient care records were mostly written, managed and stored in a way which kept patients safe.
- The unit used a combination of paper and electronic records. Nurses at the unit used an electronic record system to input patient data pre, during and post haemodialysis sessions for individual patients'. The unit also maintained paper records that included the initial admission documentation, haemodialysis prescription, patient next of kin contact information, and GP details. There were also nursing assessments, medication charts, and patient consent forms.
- Records were kept at the unit until a patient stopped dialysing, at which point the records were archived and remained in a locked room at the unit. All patients' paper records were kept in a locked cabinet overnight to ensure patient confidentiality.
- On receipt of new patient transfer documentation there was a mandatory requirement to document on a dedicated section of the transfer form to acknowledge data quality confirmation checks had been undertaken to ensure patient safety. This ensured that data provided reflected accurate patient information and was crosschecked between paper records and the local NHS trust. If the data was not of good enough quality then the staff approached the staff at the referring unit for additional information.
- Staff inputted information about the patient's dialysis session and all observations on both the electronic and paper records. Day sheets detailed dialysis sessions by date, time and the number of the machine used during the session. This meant that any changes in treatment, any problems occurring during the session and any treatment changes could be identified. Information was also inputted electronically to enable the unit to produce a monthly overview of the treatment performance and outcomes for patients attending the unit. We saw handwritten records and they were complete, legible and up to date.
- Documentation audits were carried out on a monthly basis. A number of different sets of records were selected each month. Twenty seven aspects of documentation were looked at each time; (for example legibility, signature, clear prescription, care plan in place). We saw the May 2017 audit results. Twelve sets of notes had been reviewed. There were a number of minor omissions. The document was signed to say the omissions had been dealt with.
- Consultants managing patients who attended the unit were able to access the patient's record and blood results via the local NHS trust computer system. All nurses were also able to access the patient's full NHS record via this system.
- Staff at the unit had to access patient's NHS clinic letters which ensured they remained fully informed and up to date about the patient and their needs. Following patients' outpatient appointments, the unit was copied into the letter, written by the consultant, which contained information about medical history, current medications and the outcome of the appointment, including changes made to the care and treatment of the patient. This ensured staff had access to the most up to date information about the patient, necessary to provide safe care and treatment.
- There was a system to ensure safe monitoring of records for patients that self-needled and dialysed. There was one patient at the unit who self-dialysed. The nursing staff continued to record all of the patient's observations pre, during and post dialysis sessions and also monitored the patient throughout haemodialysis sessions.

Assessing and responding to patient risk

- Effective systems were not always in place to assess and manage patient risks. Staff did not regularly review care plans to ensure the welfare and safety of the patients who attended the unit. Reviews enable staff to identify any deterioration or changes in patients' physical condition. Staff completed two care plans: mobility and pressure care. The mobility care

plan was completed on the patient's initial session and according to the organisations guidelines was not required to be updated unless the patient's general health or mobility status declined, the patient fell or following any hospital admission. We saw evidence of a care plan being reviewed following a patient's recent hospital admission and change in mobility status. However, guidelines for the skin integrity scale (a tool which gives an estimated risk for the development of a pressure sore in a given patient) care plan stated patients should be reassessed six monthly or immediately after hospital admission, falls, surgery or a new diagnosis. The guidelines also stated for any scores greater than 10 should be reassessed monthly until all nursing measures were in place. Of the eight records we reviewed, only two patients had received reassessment of their care plan in line with guidelines. Other care plans we reviewed showed patients with a score greater than 10 which had not have the specified reviews.

- Some patients had not received routine six monthly care plan reviews. We raised this with staff at the unit who told us things had been challenging to keep on top of when the unit had two trained nurse vacancies in 2016. These posts had been filled since February 2017and the unit was now running with the required staffing levels.
- There was a formal assessment of a patient's identity prior to being connected to the haemodialysis machines. Each patient held their own card which recorded information about the patient which was inserted into the dialysis machine to help the nurses set up the haemodialysis session and remained in the machine throughout the session. On inserting the card into the haemodialysis machine the machine required staff to check the date of birth of the patient. Staff had to confirm, on the machine, they had undertaken this process prior to setting up patients for their treatment.
- Patients had clinical observations recorded prior to commencing treatment. This included blood pressure, pulse rate and temperature. The nurse reviewed any variances prior to commencing haemodialysis, to ensure the patient was fit for the session. Where necessary the nursing staff consulted with the patient's consultant or on call renal registrar for clarification.
- There was a daily handover to ensure all staff were aware of the continuing needs of the patients from the previous day and the current day. Nurses used a communication book during their shift to ensure important information was handed over to the staff the following day. The handover allowed nurses on shift to follow up any outstanding actions for the current day and previous day patients. Staff signed in the book to show actions had been taken.
- Nursing staff recorded patients' observations on a patient's paper day sheet at the beginning and end of haemodialysis' sessions. This information was also entered into the patient's electronic records. Nurses also recorded electronically any other incident or treatment variances to the individual patient's dialysis session. We saw one patient request to stop their haemodialysis session 30 minutes prior to the end of treatment which was recorded electronically. We observed the treatment variance report completed regarding the incident and the actions taken at the time of the incident, for example explaining the risks of ending the session early, to the patient. This was then sent for review by the clinic manager.
- Patients were monitored throughout their haemodialysis session. Nurses recorded a patient's weight, temperature, blood glucose levels and blood pressure prior to treatment. Nurses reviewed any variances prior to commencing haemodialysis, to ensure the patient was fit for the session. Where necessary nursing staff consulted with the consultant or on call renal registrar for clarification. Patient observations, for example blood pressure was more closely monitored at regular intervals if the nurse had concerns the patient was slightly outside of their normal parameters. However, the service did not use an early warning system to alert staff if a patient who was deteriorating.
- Patients' blood pressures were recorded pre, mid and post haemodialysis session. Alarm settings on the haemodialysis machine were adapted to each patient, allowing any variance to the patients' normal readings to be highlighted to nursing staff. We saw a patient with low blood pressure prior to their treatment, and nurses explained they reduced the blood pressure reading interval to allow more frequent monitoring of the patient's blood pressure to ensure their safety.

- A risk to patients during their haemodialysis session was dropping blood pressure. Staff told us they would respond to this by elevating the patients legs and reducing the amount of fluid being taken off to the lowest amount possible, to enable a 10 minute break for the patient, to help the blood pressure rise.
- The nurses provided us with an example of multidisciplinary working to ensure effective management of a vulnerable patient. The clinic manager had concerns a patient's temporary package of care following a surgical intervention was due to finish before the patient had been reviewed by the consultant carrying out the procedure. The concerns were raised with the nurse social worker based at the local acute NHS trust who ensured the care package continued until the patient's follow up appointment at the hospital.
- The unit had a policy for 'complications, reactions and other clinical events pathways.' This included simple algorithms for staff to refer to in a variety of scenarios to guide treatment and clinical decision making. The policy contained flow charts outlining procedures to follow in specific circumstances, for example, if a patient had an adverse drug reaction, acquired a bacteraemia (presence of bacteria in the bloodstream) or Clostridium difficile, suffered a cardiac arrest or death in the unit or a data protection breach occurred. The flow chart had been produced in conjunction with the lead consultant based at the local NHS acute trust for the unit.
- Staff had training in how to recognise and manage suspected sepsis. If sepsis was suspected the staff would contact the lead consultant for advice. If it was an emergency situation the staff would call an ambulance to take the patient to the local NHS trust, which was also the referring trust, where they would be assessed.
- All staff were trained in basic life support.
- The unit had a procedure to ensure patients who self-needled and dialysed were safe to do so and ensured risks were mitigated. The unit had a competency assessment for patients who dialysed themselves to complete prior to doing this independently. We saw a completed record at the unit which assessed the patient carrying out the haemodialysis process from beginning to end. The unit requirement was that patients had to be observed three times and signed off to be competent prior to carrying out their treatment independently. The one patient who self-dialysed at the unit had been assessed according to company policy and the competency document was held in the patient's paper record. Staff continued to monitor the patients and recorded their observations and continually monitored the patient throughout their treatment to ensure their safety.
- There was an escalation policy for a patient who required an immediate review. If it was an emergency situation staff called 999 and the patient was transferred to the emergency department at the local NHS trust. If an immediate review was required staff called the renal team at the local NHS trust who would advise if the patient needed to attend the renal unit for review. Staff said the renal team were always contactable and made quick informed decisions about how to manage patients who needed to be reviewed.

Staffing

- The unit based it staffing levels on guidance set out by the Renal Workforce Planning Group 2002, the service level agreement set out with the local trust and patient dependency. The unit used one nurse to four patients, however, the contract for the unit did not include any healthcare assistants to support nurses at the unit.
- The unit used a bespoke electronic system to ensure compliance with agreed staffing levels. The electronic staff rota was completed eight weeks in advance by the clinic manager and approved by the regional business manager. This method of planning ensured all shifts were covered for the specific week and made sure staffing levels were safe for the patients attending the unit.
- The team at the haemodialysis unit consisted of eight registered nurses, two team lead registered nurses, one deputy clinic manager, one clinic manager and one clerical member of staff. There had been vacancies for two registered nurses between April 2016 and January 2017. This had created a period of low morale amongst staff due to increased work pressures

because of the vacancies. After an active and creative recruitment drive the two posts were filled in February 2017. At the time of our inspection there were no staff vacancies at the unit. An area head nurse had also been appointed in 2016, in line with changes to the organisations management structure.

- The unit had a plan to cover for any absences such as annual leave or sickness. The unit looked to fill the shift with a permanent member of staff from the unit. If this was not an option, the unit would look to cover the shift using bank staff and then Fresenius Medical care approved agency nurses. The organisation's requirements for agency staff were that they had renal experience or a renal qualification. The unit manager also tried to ensure continuity of agency staff if required to work at the unit to minimise disruption to patients. In the last three months, between January and March 2017, 48 shifts had been covered by bank members of staff; no agency staff had been used.
- Bank and agency staff underwent a comprehensive induction programme prior to working at the unit, which helped to minimise disruption to patients and the running of the unit. This consisted of a training shift and a competency assessment which ensured the member of staff was as competent in their role and procedures as the permanent members of staff. Agency staff were required to undertake a health and safety temporary worker induction checklist, which included familiarisation with emergency equipment and were also provided with company policies and work instructions to ensure they understood what was expected whilst they were working at the unit.
- Staff at the unit had access to link nurses for advice and support for patients who had problems with falls or pressure ulcers via the local NHS trust.
- The unit did not employ doctors and medical support and advice was provided by the consultant nephrologists at the local NHS acute trust. The unit had a process to escalate any concerns or issues to the patient's consultant if required.
- There was a cover plan in place in the event of absence of the patient's lead consultant. The local acute NHS trust sent a rota of the consultants and registrars on duty each month which nurses at the unit could contact if the lead consultant for the unit was not available. This information was stored in a file on the main unit. The nurses would call directly to the local NHS acute hospital and the switchboard would put them in contact with the consultant or registrar covering for the lead consultant.

Major incident awareness and training

- The unit had an emergency preparedness plan (EPP) for the unit which provided plans for the prevention and management of emergency situations. Staff were aware of the emergency preparedness plan and participated in site evacuation drills to ensure their familiarity with procedures. The emergency preparedness plan provided prevention plans for fire, loss of electricity and loss of computer systems and data. The plan also addressed other situations which could arise for example, service failure, fire or minor and major water leaks. The EPP defined the roles and responsibilities of the staff during an emergency situation and key contact details. This was available to staff on the unit in both paper form and electronically.
- Staff told us the dialysis machines had a 15 minute battery back-up so in the event of a power cut, the patient's own blood could be recirculated and returned to them. Patients were aware of what to do in an emergency and had their own individual evacuation plans.
- Each patient had their own individual patient emergency evacuation plan which ensured each patient had been assessed to determine what help they would require in the event that the unit needed to be evacuated. The patients physical ability was documented along with the support required from a member of the nursing team to ensure their safety. This form was kept in the patient's paper record and was completed at the patient's initial visit to the haemodialysis unit.
- In the event of adverse weather meaning patients and /or staff would have difficulty getting to the unit patients would be contacted and directed another unit in the area for their treatment or be assessed to decide if their treatment could wait until later that day or the next day.

Are dialysis services effective?

(for example, treatment is effective)

Evidence-based care and treatment

- Current evidence based guidance, best practice and legislation was used to develop how services, care and treatment were delivered. The unit had been incorporated into the organisations 'NephroCare standard for good dialysis care.'
- Patients care needs were assessed and their care planned and mostly delivered in line with evidence based guidance, which was monitored to ensure compliance. The unit was monitored by the local acute NHS trust and the consultant nephrologist leading the patients' care and treatment. Data was collected at the unit on a monthly basis. A monthly quality assurance meeting was held with the lead consultant to monitor patients' blood results, progress and general condition. Any changes to treatment parameters were led by the lead consultant and co-ordinated by the clinic manager. Changes made to dialysis prescriptions and medications at this meeting ensured quality and standards were mostly maintained in line with evidence based guidelines.
- Patients were assessed using risk assessment tools based on national guidelines and standards. This included skin integrity assessments using the Waterlow scale. Patients with a central venous catheter (a catheter which provides access to the patient's bloodstream to enable haemodialysis treatment to take place.) were monitored using an assessment tool score in line with the local acute NHS trust policy. The tool was a unique visual tool, which used pictures and a scoring system to assess levels of infection in different skin colours. Nurses recorded the score at each session in the patient's electronic record. The records we reviewed had the scores recorded for each session.
- Staff at the unit followed National Institute of Health and Care Excellence Quality Statement (QS72) statements 8 (2015):'Haemodialysis access – monitoring and maintaining vascular access.' Every three months the unit used an electronic machine to review a patient's vascular access to ensure the access was well functioning to optimise treatment for haemodialysis patients. The results were recorded in the patient's paper record. A result outside a target range was then escalated to the lead consultant for review.
- The unit did not facilitate peritoneal dialysis (which is a type of dialysis that uses the peritoneum in a person's abdomen as the membrane through which fluid and dissolved substances are exchanged with the blood. It is used to remove excess fluid, correct electrolyte problems, and remove toxins in those with kidney failure).
- The unit had an accreditation in Integrated Management Systems (ISO 9001) 2008. This accreditation ensured all policies and procedures supported the most current best practice and evidence based guidelines. This accreditation was reviewed annually to ensure compliance with this standard.

Pain relief

- Patients' pain was managed effectively. Some patients administered a numbing cream (local anaesthetic), prescribed by their consultant, 45 minutes prior to their session to help with the pain and discomfort of needling. Needling is the process of inserting wide bore dialysis needles into the arteriovenous fistula or graft.
- The local analgesia (numbing cream) was prescribed as a 'to be administered as necessary medication', which meant it could be used each time the patient visited the unit.

Nutrition and hydration

- Patients' hydration and nutritional needs were managed effectively.
- The dietician visited the unit every two weeks, to hold clinics, they would see patients in between if necessary. Staff said the dieticians were always available for telephone advice and support.
- All patients had nutritional assessments (Malnutrition Universal Screening Tool) completed and we saw these had been reviewed in line with the organisations policy.
- Patients in renal failure require a strict diet and fluid restriction to maintain a healthy lifestyle. Patients and

staff at the unit had access to specialist dietary support and advice from the local acute NHS trust linked with the unit. The dietician attended the unit twice a month and also attended the monthly quality assurance meetings to provide support and input with the patients dietary care and treatment.

- Patients weighed themselves on arrival to the unit at each visit. This was to identify the additional fluid weight that needed to be removed during the dialysis session. This varied from patient to patient. The patient's weight was recorded onto their individual card which was then inserted into the haemodialysis machine and supported nursing staff to determine the treatment required.
- Patients had access to food and drinks whilst undergoing their treatment. The nurses provided patients with tea, biscuits, cake and a choice of sandwiches during their haemodialysis session. Some patients also chose to bring their own food into the unit to eat during their session. Patients we spoke with spoke highly of the sandwiches at the unit.

Patient Outcomes

- The centre did not directly contribute data to the UK Renal Registry, as the centre's data was uploaded to the national database from the local NHS trust. The Renal Registry is part of the Renal Association who collected, analysed and reported on data from renal centres in the UK, as mandated by the NHS National Service Specification. The registry also provided access to a clinical database, which could be used in renal research. The registry provided an annual report for the unit detailing the quality of care and treatment provided for patients by the unit. Comparisons could be made with other haemodialysis units to compare performance.
- Patients were monitored in accordance with best practice guidelines. The unit monitored patient outcomes on a monthly basis. These outcomes consisted of blood results, vital signs, target weights and nutritional status, as per a pre-defined schedule by the lead consultant. These were audited monthly to ensure effectiveness of the haemodialysis treatment being provided. The results identified any actions which needed to be taken to improve the effectiveness of treatment for patients and improve their outcomes for example amended dietary advice or target weight.
- The unit reported on performance measures, such as patient observations, haemodialysis access specific data, infection control interventions and treatment variance. The unit monitored risk and performance through their monthly reports, which were reviewed by the area head nurse, alongside the clinic manager to identify and address any areas for improvement. The data was also used to benchmark patient outcomes against other clinics run by the organisation. A monthly report detailing the unit's achievement of the Renal Association Standards was also sent to the lead consultant at the local NHS acute trust to provide feedback on the unit's performance and patient outcomes. The unit achieved their targets for a number of outcomes in April 2017: vascular access management - 87%, nutritional management - 89% and phosphate levels – 87%.
- Single pool Kt/V (number used to quantify haemodialysis adequacy – clearance, time, volume) outcomes were measured. In March 2017 dialysis adequacy management showed effective weekly treatment time was 63.83% against a target of 70%, infusion or blood volume was 89.36% against a target of 70% and Kt/V was 48.94% against a target of 70%. Where the results had fallen below targets action plans were in place and monitored to ensure improvement was achieved.
- There had been eight unplanned transfers of patients from the unit to the local NHS acute trust in the 12 months prior to the inspection. These were for a variety of clinical reasons and for reasons of patient safety. This was about the same compared to other units of a similar size that we held data for.

Competent staff

- Staff had the right skills, qualifications and knowledge to carry out their role. There was a comprehensive training programme available for nurses. Staff were required to complete a set of clinical competencies applicable to their role to ensure they could competently carry out all the aspects of their role and responsibilities.

- Staff were competent in aspects of their role in order to effectively manage patients at the unit for example aseptic non-touch technique annual update. Staff performed annual self-assessments of competence. This followed company guidance and was intended to highlight training and development needs to discuss in annual appraisals. We saw evidence in staff files of completion of annual competency declarations.
- The organisation supported trained nurses to gain a recognised renal nursing qualification. Two nurses had the qualification and two more staff were due to start the course.
- Staff had received performance appraisals within the last year, where discussions had taken place about performance and career development. Data submitted showed 100% compliance with annual appraisals.
- Staff at the unit were clear about their role and for what they were accountable. The unit manager had recently introduced lead roles for staff for example infection control, diabetes and training.
- New staff members had a supernumerary period followed by a six month probation period in which a competency programme was completed. There were regular reviews during this period to assess progress. Once past their probationary period staff embedded their learning with the help of a mentor. The organisation had a Training and Education Progression Plan that in the first 12 months of a staff member's employment covered: a supernumerary period, a probationary period, supervised practice and a consolidation of knowledge and skills phase. Staff were also encouraged to complete a renal training programme to enhance their skills.
- New members of staff joining the unit were provided with support until they were competent and were able to carry out their role proficiently. A new member of staff was allocated two mentors (trained nurses already working at the unit), who provided support with completing training and competencies during the supernumerary period. The duration of the supernumerary period was dependent upon the individual nurse and reviews were carried out at one, three and six months after joining the unit. This enabled managers to monitor progress with development and training.
- All staff had received a performance appraisal within the last year where discussions had taken place about performance and career development. Staff set goals to enable career progression and were encouraged to develop in line with the patient and service needs. Appraisals contained learning requirements and actions were clearly documented. Staff felt listened to during their appraisals and supported to achieve their learning objectives.
- Staff also had access to the Fresenius Medical Care learning centre. Staff showed us the variety of courses available and said they were supported to undertake training that was relevant to their role.
- Nursing staff had support to complete their revalidation. All trained nurses had had their professional registration status checked by the unit manager in the 12 months prior to the inspection.
- Staff had an understanding of the principles of the medicines used during dialysis. All staff were assessed annually for medications administration and understanding.
- The organisation had an internal performance management system used to manage staff that were not performing to expected standards. This included supervised practice and one to one support and/or additional training.
- All staff received training on the recognition and management of sepsis.

Multidisciplinary working

- The lead consultant was closely involved with patients and was kept up to date with the patient's conditions including their blood results. The staff took blood samples from the patients and these were sent to the local acute trust to be analysed. The patient's lead consultant reviewed the patient's blood results and made the necessary changes to an individual patient's treatment to ensure the effectiveness of the treatment. Changes to treatments were implemented at the patient's next haemodialysis session.

- Patients were reviewed as part of a multidisciplinary team meeting every three months to ensure they were receiving the most
- Dieticians, physiotherapists and the anaemia nurse from the referring trust were involved with the care and treatment of patients attending the unit for dialysis as necessary. If the nurses at the unit had any concerns about a patient's nutritional status or weight, they contacted the dietician with their concerns. If required the consultant then made a referral to the health care professional most suited to manage the patient's needs.
- Access to psychology or counselling services was via a referral from the patient's consultant.
- The consultant nephrologist at the local acute NHS trust, which held the contract for the Bodmin haemodialysis unit, had overall responsibility for the patients care. The nurses told us on the whole there was effective communication and multidisciplinary working, which enabled efficient patient centred care.

Access to information

- All of the information needed to deliver effective care and treatment to patients was available to all staff involved in their care in a timely manner. The unit were sent the most recent clinic letters following a patient's appointment with the consultant. This enabled staff at the unit to keep up to date with the patient, their condition and any other concerns or issues arising from their review with the consultant.
- Staff at the unit, the patient's lead consultant and the anaemia nurse at the local acute NHS trust had access to the most recent blood results for the patients. Following review of the blood results, the anaemia nurse made changes to the patient's anaemia medication, if required, to optimise treatment for patients. These changes were explained to the patients and the changes implemented at their next haemodialysis session. At the time of our inspection, the anaemia nurse was unwell and the consultant had taken over this role.
- Patients were provided with a print out of the analysis of their monthly blood results which were explained to them by the manager of the unit. The paper record provided to them provided the target range in which the results should sit, their result and then a prepopulated explanation of the implications and causes of the blood results outside of target range. Patients told us they found this explanation very useful and also told us the nurses would also come and discuss their monthly blood results with them to provide further clarity and enable them to ask questions.
- Some patients wore red rubber bracelets on the arm which had their fistula to alert other medical staff not to use that arm for blood tests or to check blood pressure in the event of a medical emergency. The bracelet helped to maintain the patency of the fistula used to cannulate for dialysis treatment.

Consent, Mental Capacity Act and Deprivation of Liberty

- Consent was sought from patients at the initial appointment prior to treatment. We observed documented written consent forms for treatment which were completed at the patient's initial appointment. At the time of obtaining patient consent, the clinic manager discussed haemodialysis treatment and the risks with the patient. These risks were also documented on the consent form signed by the patient. Consent forms were kept in each patient's paper record. This was in line with the units consent policy. All nine records we looked at contained consent information.
- Staff understood and felt confident with the relevant consent and decision making requirements and guidance, including the Mental Capacity Act 2005. Staff had training on the Mental Capacity Act 2005 and understood the associated Deprivation of Liberty Safeguards (DoLS). There were systems in place for patients who did not have capacity to make a decision relating to consent. One staff member was attending a study day about the Mental Capacity Act and was looking forward to having a more in depth knowledge of the subject.
- Patients were not asked for their verbal consent prior to receiving care and treatment at the unit at each visit as the fact they had attended the unit implied consent.

- Staff at the unit took the time to explain to patients about the treatment provided to ensure patients understanding and ability to provide informed consent for care and treatment.
- There were arrangements available, if necessary, for patients whose first language was not English to ensure they could provide informed consent for care and treatment.

Are dialysis services caring?

Compassionate care

- Staff interacted with patients in a respectful and considerate manner. We observed interactions between staff and the patients. Staff remained courteous and polite during all interactions with patients.
- Staff treated patients with kindness, dignity, compassion and respect. Patients we spoke with during the inspection were complimentary of the care and treatment they received at the unit. Quotes from patients we spoke with included, "excellent," and "I cannot fault anything."
- We received 25 completed comment cards they were overwhelmingly positive with comments as follows: "nurses are excellent in every way", the centre is "first class", "faultless in my experience", "staff are caring and treat me with respect and dignity" and "the staff are always caring and look after me really well".
- In the latest annual Patient Satisfaction Survey 92% of patients were likely to recommend the unit to their friends and family if in need of dialysis.
- Patient's privacy and dignity was maintained at the unit. There were curtains between each station which could be drawn at patient's request. One patient told us how their privacy and dignity had been maintained when the nurses were using the central venous catheter for treatment.
- Staff demonstrated a supportive attitude to patients at the unit. We observed staff checking regularly to ensure the patient was alright and how attentive staff were when patients needed support to transfer, mobilise or have their belongings carried to the reception area for them.
- Staff at the unit quickly built up a rapport with patients who attended the unit for treatment and interacted with patients in a respectful manner. Staff put patients at ease and communicated with them like friends, although maintained a professional distance. We overheard staff asking about the patient and their family and following up on conversations from the previous sessions without prompting. For example one nurse asked how a patient's family member had done in their driving test. Patients told us, "the unit is a very friendly place; we get on well like a family."
- We saw staff were responsive to all patients' needs, including calls for help and alarms on dialysis machines. All staff were compassionate and attentive.
- Nursing staff maintained patients comfort through the use of additional pillows, pressure relieving aids and if necessary a hospital bed. Pillows at the unit were not covered with linen, but with disposable pillow cases. Staff at the unit told us they had no facility to access linen or have this laundered. Patients we spoke with said they did not mind and this is what they had always been used to.
- Staff offered blankets to patients, who felt cold during their treatment and some patients bought their own blankets in with them. Patients also dressed appropriately for the temperature. The temperature was regulated to try to make it more comfortable for those that felt the cold. Staff had explained to patients that increasing the temperature of the unit may cause some patients have a drop in blood pressure.

Understanding and involvement of patients and those close to them

- Staff communicated with patients to ensure they understood their care and treatment. Patients told us the nurses would always explain what was happening with their care and treatment and would identify any changes set out by the patients lead consultant. Patients told us they felt comfortable to ask questions about their care and treatment to the nurses. We heard staff explaining to patient about their individual treatment and involving them in their care from the start to the end of the session.

- Nurses ensured patients understood their kidney condition and how this related to other medical problems they may have which impacted upon the life choices made by patients.
- Patients felt informed about their blood results and were given the opportunity to discuss any treatment changes made by the consultant. Patients were provided with a printed sheet of their monthly blood results. The nurses discussed the meaning of the results with each individual patient and any changes to their treatment which the consultant had made following the blood results.

- Staff understood the importance of involving family members and close relatives as partners in patients' care. One patient we spoke with told us how their partner in the past had approached staff with questions regarding their care and treatment. The patient told us the staff were always helpful to their partner.

  There were processes in place to ensure a patient new to dialysis was provided with information to ensure their understanding of the nature and purpose of the treatment, the effects, the risks and benefits and any post procedure instructions. A new patient at the unit was provided with a named nurse who discussed important aspects of haemodialysis treatment specifically for the individual with the patient at their first session. The unit also provided a patient guide produced by Fresenius Medical Care. The guide contained information about haemodialysis treatment, vascular access, infection control and dietary advice amongst other subjects. The booklet was very generic and provided an overview of important information. However, the clinic manager told us the unit was in the process of developing a welcome pack for patients with contained local information and was specific to Bodmin Dialysis Unit.

  - Patients had on-going education provided by the nurses to ensure they and their family were able to make informed choices about the future of their treatment.
  - Patients were given information about changes to their medication by the consultant, which was followed up by nursing staff during treatment sessions.
  - Patients were given the opportunity to discuss treatment changes. Patients we spoke with told us the nurses took the time to explain things about their care and treatment to them at each dialysis session and felt comfortable to ask questions.

  Emotional support

  - Staff recognised the broader emotional wellbeing of the patients under their care. One patient had recently received a new diagnosis. The patient told us the staff provided them with the hug they needed and told us how they had been very supportive since the diagnosis.
  - Nurse's sign-posted patients to where they could gain support about their condition and the reception area had a variety of information leaflets for patients to take away to access help and support if they wanted to.
  - We were given an example of where a member of staff had gone the extra mile to support a patient. The patient required further intervention before a review appointment with a consultant from another speciality at the local acute NHS trust. The nurse not only arranged the intervention required, but managed to arrange this for the same day as the patients dialysis session at the hospital on the same site as the unit, to reduce the travelling time and time spent in a hospital environment for the patient which could impact upon a patients quality of life.
  - Staff understood the impact on a patient's condition, care and treatment and how this affected their family and relatives.
  - Staff had access to social work and a renal specialist nurse, at the local NHS trust, for support for patients if required.
  - Psychological support or counselling for patients who attended the unit for treatment could be accessed via the local acute trust. If the nurses at the unit had concerns about the psychological wellbeing of a patient, they would make contact with the lead consultant for the patient to discuss their concerns. It was the responsibility of the lead consultant to make a referral.

- Staff recognised the need and ensured access to palliative care and bereavement support if necessary

Dialysis Services

Are dialysis services responsive to people's needs?
(for example, to feedback?)

Meeting the needs of local people

- Dialysis services were commissioned by NHS England. The contract for the unit was set up in 2003 and the service specification was defined by the acute NHS Hospital trust renal team in conjunction with the requirements and needs of the local community. Not having to travel long distances has been shown to help improve a dialysis patient's quality of life. Patients were referred to the unit by the local NHS trust.
- Information about the needs of the local population was used to inform the planning and development of the dialysis service. This included information from the consultant about how many stable patients could be treated at the local unit.
- The dialysis service reflected the needs of the population served and provided flexibility and choice for patient care. Patients were able to access the unit six days a week and had the choice of either the morning or an afternoon session to receive their treatment.
- The local trust and commissioners were involved in the initial planning of the dialysis service provision.
- There was not a transport user group at the dialysis unit. The unit manager said most patients were happy for the staff to contact the local trust who commissioned the passenger transport service or the passenger transport service themselves to discuss individual patient needs when problem arose. It was an issue sometimes and in the past staff had had to wait with patients after their designated closing time until the transport had arrived. The unit manager said the situation had improved recently.
- The building met most of the core elements of provision for dialysis patients. (Department of Health Renal care Health Building Note 07-01: Satellite dialysis unit). This included level access and dedicated parking facilities. There was space for transport services to drop off and collect patients.

Access and flow

- Patients were assessed for their appropriateness to attend the centre by the renal team based at the local NHS trust. Patients with acute kidney disease were treated at the local NHS trust and only chronic, long-term dialysis patients were referred to the unit for treatment.
- Patients could access dialysis care and treatment at a time to suit them. A convenient time for their haemodialysis was discussed between the patient and their consultant. The unit had, up to the time of our inspection, been able to accommodate patients' needs in this respect.
- At the time of our inspection, there was no waiting list for patients requiring haemodialysis at the unit and there was a surplus of capacity at the unit to accommodate any new patients. The unit was running at 89% of its total capacity in December 2016, January and February 2017.
- We saw that patients' dialysis treatment started as soon as they arrived at the unit. Patients started to weight themselves and were shown to their stations once their weights had been recorded.
- The service had a process to prioritise care and treatment for people with the most urgent needs. In the event of an emergency where patients were unable to dialyse at the unit, patients' monthly blood results reviewed and patients would be managed in order of priority, according to their blood results. The unit would liaise with the local NHS trust to secure a station for dialysis for patients. The unit would ensure all patients received their dialysis. There had been no cancellations of treatment at the Bodmin dialysis unit in the 12 months prior to our inspection.

Service planning and delivery to meet the needs of individual people

- The Royal Cornwall Hospitals NHS Trust commissioned Fresenius Medical Care to provide haemodialysis treatment to service users in and around the Bodmin area at the Bodmin dialysis unit.
- Services were planned to account for the needs of different people. The unit had two side rooms which

were allocated if there was a requirement for a patient to be treated in isolation, for example due to infection. The unit also had 12 stations available for patients in the main treatment area.

- Services were planned to take into account for the needs of different people, to enable them to access care and treatment. Admission criteria was set out, so all patients irrespective of age, gender, race, religion, belief or sexual orientation could access the services. Patients were required to be haemodynamically stable and required medical approval, from their lead consultant, for their suitability to have haemodialysis at the unit.
- The unit had arrangements available to patients attending the unit who had mobility difficulties. There was access to a hoist, dialysis specific chairs, pressure relieving mattresses, a bed for patients who could not dialyse in a chair and single rooms for isolation if required. The patients had been assessed as safe to receive dialysis at a satellite unit.
- Staff at the unit had access to advice about falls or pressure ulcers via the local acute NHS trust. If staff had any concerns, they would contact the lead consultant for the unit. The consultant would then make the final decision and make a referral to the most appropriate team within the acute trust.
- The service was able to support people with protected characteristics under the Equality Act 2010. There was access to translation services, written information could be provided in large print, braille or in alternative languages. There was level access to the building which was all on one floor. Toilets were accessible to wheelchair users and had grab rails in place. They also had emergency call bells to use if help was required.
- The unit had access to translation services via the local NHS acute trust. There had been no requirement for the unit to use this service.
- There had been no appointments cancelled or treatments delayed between January 2016 and January 2017. The unit had no waiting list.
- Patients had access to entertainment or activities during their haemodialysis session. Each station had its own individual television, a call bell and individual lights. Patients could access the Wi-Fi at the unit to access the internet via laptops and other personal electronic devices if required.
- There were provisions to ensure patient comfort during their treatment. Staff offered patients pillows for their session and ensured patients were comfortable and their privacy respected throughout the session. Patients were also provided with a drink and a choice of biscuits or sandwiches during their session. Patients told us the unit was as comfortable as it could be for the treatment it was providing and provided positive feedback about the sandwiches and snacks provided.
- Services were planned and organised so patients could participate in their own care if they chose to do so. The unit had a comprehensive competency checklist where patients who self haemodialysed had to be observed three times and signed off as competent at each stage of the pre, during and post session requirements. This provided patients with the ability to be independent and promoted quality of life for patients. We observed a completed competency checklist for the one patient who self-dialysed at the unit. The nurses also continued to record the patients observations and continued to monitor the patient and offer support throughout the session
- The unit had a specific procedure to follow when patients booked to receive treatment at the dialysis centre during their holiday in the area. Fresenius Medical Care required specific information about a patient four weeks prior to them attending for haemodialysis at the unit. We observed a nurse from the unit reviewing the paperwork for a potential patient attending the unit. The nurse was not fully clear about the information provided by the patient's regular unit and telephoned the nurse at the parent unit to clarify the information provided. Once the nurses at the unit were happy with the information received about the patient, they were then able to attend treatment sessions during their holiday. The unit also provided each holiday patient with an electronic card and information would be recorded in line with the unit's requirements.

- Staff helped arrange attendance at other units, for patients who attended the Bodmin unit and wanted to go on holiday. Staff liaised with the staff at the alternative unit and provided details of the patient's current treatment and health status of the patient.

Learning from complaints and concerns

- People using the service knew how to make a complaint and told us they would raise any concerns with the clinical staff. The complaints procedure was made available to all patients at unit and information about how to make a complaint was displayed in the reception area at the unit.
- There was a comprehensive complaints procedure to ensure all complaints were handled effectively and confidently. The organisation told us they were committed to handling complaints using the 4Cs (compliments, comments, concerns and complaints) in a sympathetic and understanding way. The procedure ensured complainants received a timely response, acknowledgement in two working days and a full response in 20 working days. The complaints policy also outlined the stages the complaint would go through if a complainant was unhappy with their first response.
- The unit had received three complaints in the 12 months prior to our inspection. They were all investigated using the organisations formal complaints procedure and not upheld.
- Learning from complaints was disseminated to staff via regular team meetings or via emails/memos from the unit manager or head of nursing.
- Most of the complaints in the 12 months prior to the inspection had related to transport issues. As a result of this staff had made a decision to prioritise patients who used ambulance transport, for their dialysis treatment, as this appeared to minimise their waiting time to be picked up following their treatment.

Are dialysis services well-led?

Leadership and culture of service

- Leaders were visible, approachable and supportive. Nurses at the unit knew the senior management team well and reported their presence at the units from time to time. The area head of nursing visited the unit regularly. If they were not available staff had details of who to contact in their absence. Staff told us they would not hesitate to pick up the telephone to contact the senior management team if they had a concern or an issue and felt the team were very approachable and supportive.
- The senior management team and manager of the unit of the unit maintained a strong working relationship with the local NHS trust, to ensure the safety and well-being of the patients attending haemodialysis at the unit. The clinic manager and nursing staff met with the lead consultants from the local NHS acute trust on a monthly basis to discuss and review patients and make changes to care and treatment as required to optimise haemodialysis for patients.
- We spoke with one of the consultants who said they had a longstanding and good working relationship with the staff at the unit. They said they between regular established meetings and clinics held at the unit they also spoke to the staff regularly on the phone about patients and any concerns or questions they may have. They added they also met with lead clinicians and managers from Fresenius Medical Care and attended contract meetings with the local CCG to discuss the unit and the services they were able to offer.
- Staff felt respected and valued the clinical manager working on the treatment unit floor to support them.
- There was a friendly and supportive culture at the unit. Staff told us they worked well together and supported each other.

Vision and strategy for this core service

- There was a clear vision and set of values for the dialysis unit. The values of the unit focused on quality, honest, integrity, innovation, improvement, respect and dignity.
- There was also a realistic strategy for the organisation and the unit for achieving the priorities of the unit and good quality care. The strategy was to develop and expand as an organisation, developing treatment by creating a future for dialysis patients.

- Staff at the haemodialysis unit were not aware of the vision and values of the organisation. Although they displayed a number of the values as we observed them during our visits to the unit.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of good quality care. At a local level this involved the area head nurse monitoring the unit against the organisations key performance indicators. The reviews provided open discussion and action plans to ensure continuous improvement. These action plans were fed into unit team meetings and monthly meetings with the nephrologists.
- The consultant involved with patients attending the unit was involved in monthly quality assurance patient review meetings and was part of the strategic management of the commissioning arrangements.
- There were effective processes to feedback from quality meetings and contract reviews to all staff. There were regular staff meetings, which were minuted. The minutes were displayed in the unit so staff who were not able to attend meetings could read what had been discussed.
- There were systems and process to identify record and manage risks and mitigating actions. The unit manager showed us the organisational risk register (split into three defined areas: clinical, operational and technical) which had identified the need for a local Workforce Race Equality Standard report and had sepsis training and management as a 'red' risk and detailed actions being taken to ensure staff had polices and guidance to follow in the case of suspected sepsis. The risk registers were reviewed monthly to ensure actions were being monitored. There was a local risk register that detailed issues specific to Bodmin dialysis unit for example the pot holes on the approach road to the unit. At unit level risks were reviewed on a monthly basis by the Quality Assurance and Risk Manager, for the organisation, and presented to the Integrated Governance Committee for agreement and inclusion in the master register if necessary. The unit manager told us they were having training on risk register so they could better understand the process.
- There was a systematic programme of clinical and internal audit used to monitor quality and identify where actions needed to be taken. We saw the December 2016 audit report. There were 33 positive and/or best practice aspects and 15 minor non-conformities. Minor non-conformities included documentation not being completed as required and there was no formal system in place to monitor the progress of objectives set for the unit.
- There were clear systems and processes to ensure effective working arrangements with partners and third party providers in the form of regular meetings and on-going dialogue.

Public and staff engagement

- Patient's views and experiences were gathered and acted on to shape and improve services. The Fresenius Patient Group had been involved with the development of the patient satisfaction survey and every year patients were asked to complete a patient satisfaction questionnaire. The most recent survey was completed in 2016. The unit had displayed the results of the survey in the reception area along with a list of actions they had taken from the survey. For example, 62% of patients had said the environment was comfortable. The staff at the unit had started to monitor the temperature at the unit to make it more comfortable for patients, 65% of patients had said the chairs were comfortable. The unit had purchased pressure relieving cushions and had demonstrated again to patients how to use the automatic chair adjustment control to ensure their optimum comfort. Also, only 73% of patients said they had received a welcome induction. Staff were at the time of our inspection working on a local introduction leaflet for patients and were also providing patients with a Fresenius Medical Care welcome pack and assigning each patient a names nurse and point of contact at the unit.
- The unit was about to produce quarterly newsletters for patients and their relatives attending the unit. The newsletters would provide information for patients about health and safety and other general information for example changes to staff members, relevant diary dates and upcoming celebrations.

- There were bird feeders outside the unit that could be seen by most patients during their treatment. Staff told us that the patients collectively paid for the food and filled the feeders. Staff added that patients also tended and provided plants for the small garden are in front of the unit.
- Every year the unit staff organised a summer party held on the grassed area in front of the unit. It was held on a Sunday when the unit was closed and all patients had the opportunity to attend.
- Patients felt welcomed and respected by staff at the unit.
- Patients were regularly engaged in planning their care and treatment in their discussions with their consultant and the nursing staff during treatment.
- One patient had been appointed to the Fresenius Patient Board where they were able to represent the patient group.
- Staff felt engaged with the service and felt their views were reflected in the planning and delivery of services and shaping the culture.
- The organisation carried out an annual employee satisfaction survey. The last one was carried out in 2016 when the unit was experiencing staff shortages. For example 67% of staff said they had put themselves under pressure to come to work, 39% of staff felt it (the unit) was not a safe environment to do their job and only 29% of staff felt able to do their job to a standard they were personally please with. The results reflected how staff felt at the time. The manager and the organisation kept staff informed about progress in recruiting new staff and had continued to tell staff how much they were appreciated during this difficult time. However 100% of staff indicated they had clear plans, goals and objectives for their job, 100% indicated they knew what their responsibilities were at work and 100% of staff were happy with the support they got from their work colleagues and regional management team. It is hoped the 2017 staff survey will bring more positive results as the unit is now fully staffed.

Innovation, improvement and sustainability

- There was a system to ensure the phased replacement of older haemodialysis machines. The organisation had a replacement programme for their haemodialysis machines in line with the Renal Association guidelines. The recommendation for machine replacement was either every 7 years, or after 45,000 hours of use. An asset register was maintained at head office and technicians recorded the machines usage during the annual service or when attending to the machine to repair any faults.
- There were initiatives in place for green nephrology and sustainability that monitored number of waste bags disposed of.

Outstanding practice and areas for improvement

Outstanding practice

- Patients were provided with a print out of the analysis of their monthly blood results which were explained to them by the manager of the unit. The paper record provided to them provided the target range in which the results should sit, their result and then a prepopulated explanation of the implications and causes of the blood results outside of target range. Patients told us they found this explanation very useful and also told us the nurses would also come and discuss their monthly blood results with them to provide further clarity and enable them to ask questions.
- Staff recognised the broader emotional wellbeing of the patients under their care. One patient had recently received a new diagnosis. The patient told us the staff provided them with the hug they needed and told us how they had been very supportive since the diagnosis. We were also given an example of where a member of staff had gone the extra mile to support a patient. The patient required further intervention before a review appointment with a consultant from another speciality at the local acute NHS trust. The nurse not only arranged the intervention required, but managed to arrange this for the same day as the patients dialysis session at the hospital on the same site as the unit, to reduce the travelling time and time spent in a hospital environment for the patient which could impact upon a patients quality of life.
- Patient engagement was such that patients paid for bird food and filled the feeders so that all patients could enjoy watching the birds, patients also tended and paid for the plants for the small garden area in front of the unit. The staff held a summer party on the grassed area at the unit each summer. It was held on a Sunday, when the unit was closed, to ensure all patients had a chance to attend and mix with each other. It was said to be well attended.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure care plans were regularly reviewed, in line with organisational policy.
- The provider should ensure there are policies and procedures available to support staff in recognising and managing sepsis.
- The provider should ensure staff are aware of the visions and values of the organisation.