

North Wandsworth Dialysis Unit







Quality Report

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Date of inspection visit: 10 January 2020
Date of publication: 03/03/2020

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

Ratings

Overall rating for this location		Good	
Are services safe?	Requires improvement		
Are services effective?	Good		
Are services caring?	Good		
Are services responsive?	Good		
Are services well-led?	Good		

Overall summary

North Wandsworth Dialysis Unit is operated by Fresenius Medical Care Renal Services Limited. The unit has 16 dialysis stations in the main area and two side rooms with two machines which is 18 stations in total. The service provides dialysis services for people over the age of 18; it does not provide treatment for children.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 10 January 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

Summary of findings

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 rate

We rated it as **Good** overall.

- Staff kept patients safe from harm and abuse. Risks were assessed, monitored and managed appropriately.
- Care and treatment records were accurate, stored securely and provided comprehensive details of care and treatment.
- Staff recognised incidents and knew how to report them. Managers investigated incidents and made improvements to the service.
- Staff had the appropriate skills, training, knowledge and experience to deliver effective care and treatment.
- Staff delivered care and treatment in line with evidence-based practice.
- Staff involved patients and carers in decisions about their care and treatment.

- Staff cared for patients with compassion, treating them with dignity and respect. Staff truly respected and valued patients as individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional service.
- The service was proactive in meeting the needs of people from their whole community. The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care.
- There was an open and transparent culture, with engaged and experienced leadership.

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

- The storage of equipment did not always keep people safe. We found wheelchair stored in toilets and the domestic fridge freezer used for storage of blood samples was not appropriate for its usage.
- Staff did not follow best practice in relation to infection prevention and control. Waste bins were overfilled and falling from its stand in most areas.
- During the inspection, we found there was no process for identifying whether equipment was clean or when it was last cleaned. There was no evidence of the use of "I am clean" green label used at the centre. Following the inspection, the provider told us that any infrequently used equipment was labelled with a "I am clean" green label.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London)

Summary of findings

Our judgements about each of the main services

Service

Dialysis services

Rating Summary of each main service

North Wandsworth Dialysis Unit was opened by Fresenius in 2010. The unit provides haemodialysis to patients with chronic kidney disease, under the care of a consultant at the local NHS Trust. The unit is open Monday to Saturday, providing dialysis to adult patients who live in North Wandsworth and surrounding areas.

Good



- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staff had access to a robust training and competency programme to ensure they had the skills required to provide good quality care.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service planned and provided services in a way that met the needs of local people. The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. The facilities and premises were appropriate for the services that were delivered.
- There was compassionate, inclusive and effective leadership at all levels. There was a strategy, and supporting plans, aligned with the wider health economy that were stretching, challenging and innovative, while remaining achievable. There was a demonstrated commitment to system-wide collaboration and leadership.
- Staff felt positive and proud to work in the organisation. The culture centred on the needs and

Summary of findings

experience of people who used services. Staff told us that they felt pride in the organisation and the work that is carried out to ensure patients received good quality care.

Summary of findings

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Good



North Wandsworth Dialysis Unit

Services we looked at

Dialysis services

Summary of this inspection

Background to North Wandsworth Dialysis Unit

North Wandsworth Dialysis Unit is operated by Fresenius Medical Care Renal Services Limited. The service opened on 16 February 2010 and provides haemodialysis to patients from the local NHS trust. The local NHS trust provides the renal multidisciplinary team (MDT) with two consultant nephrologists visiting the service once at a time on a monthly basis.

The service's registered manager has been in post since January 2018. The registered manager was available for the unannounced inspections.

The Care Quality Commission previously inspected the unit in June 2017. We did not rate the service in that inspection, however there were requirement notices served to the provider. On this inspection, we noted that previous requirement notices from the 2017 inspection had been addressed by the provider.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about North Wandsworth Dialysis Unit

Fresenius Medical Care Renal Services Limited is contracted to provide dialysis for local patients under the care of the local NHS trust nephrologists. All patients attending North Wandsworth Dialysis Unit receive care from a named consultant at the NHS Trust, who remains responsible for the patient. There are on average 56,000 treatments sessions delivered a year.

North Wandsworth Dialysis Unit have close links with the trust to provide seamless care between the two services. To achieve this, the service has support from the NHS trust to provide medical cover, satellite haemodialysis unit coordinator support, pharmacy support, and regular contact with a dietitian. This team attend the centre regularly and assess patients in preparation for monthly quality assurance meetings.

North Wandsworth Dialysis Unit's main dialysis area is on the first floor, accessed via a lift and stairs. The unit has one to four staff to patient ratio and a skill mix of 70% nurse: 30% dialysis assistant per shift. The dialysis unit is a 'standalone' dialysis unit. It provides treatment and care to adults only and the service runs over six days, Monday to Saturday with no overnight facilities.

There are three treatment sessions of patients dialysed from Monday to Saturday. These are 6.45am to 12 noon; 12 noon to 6pm; and 6.30pm to 11.30pm.

During the inspection, we spoke with five staff including registered nurses, a healthcare assistant and reception staff. We spoke with nine patients and reviewed ten (10) sets of patient records and associated documents.

The unit is registered to provide the following regulated activity:

- Treatment of disease, disorder, or injury.

Track record on safety in the previous year:

- No never events
- One incidence of MRSA.
- No incidences of Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of Clostridium difficile (C diff)
- No incidences of E-Coli
- No deaths or no serious injury notifications.

Summary of this inspection

- Seven complaints.

Services provided at the unit under service level agreement:

- Water supply
- Hospital emergency service
- Fire safety
- Building maintenance
- Waste management (domestic and clinical waste)
- 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?

Are services safe?

We rated it as **Requires improvement** because:

- The storage of equipment did not always keep people safe. We found that equipment was stored in dirty utility room and other areas of the service which was not in line with good practice.
- The domestic fridge freezer used for storage of blood samples was not appropriate for its usage.
- Staff did not follow best practice in relation to infection prevention and control. Waste bins were overfilled and falling from its stand in the dirty utility room.
- Sharps bins were closed and kept in the dirty utility room without being labelled, signed and dated.
- During the inspection, we found there was no process for identifying whether equipment was clean or when it was last cleaned. There was no evidence of the use of “I am clean” green label used at the centre.
- Following the inspection, the provider told us that any infrequently used equipment was labelled with a “I am clean” green label.
- The sink area was not clean and well kept. There were re-usable gloves in the dirty utility room which were as worn out and not fit for purpose.

However:

- Mandatory training was comprehensive and more than 98% of all staff groups completed it.
- We saw staff observing ‘bare below the elbow’ guidance and using protective equipment appropriately. There was access to hand sanitizing gel for staff and patients at the entrance to the unit.
- Staff completed and updated risk assessments for each patient during their visit.
- Staff kept detailed records of patients’ care and treatment. Records were clear, up to date and easily available and accessible to staff providing care. Care plans were person centred and recorded patients’ needs, preferences and choices.
- Staff knew how to protect patients from abuse and worked well with other services to do so. They knew how to escalate any concerns to senior staff in line with the organisation’s safeguarding policy.

Requires improvement



Summary of this inspection

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and feedback.

Are services effective?

Are services effective?

Good



We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their nutritional needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to manage pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared and benchmarked their results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different specialties worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Are services caring?

Are services caring?

Good



We rated it as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients and their families and carers told us that staff went over and above what they expected.
- Staff provided emotional support to patients to minimise their distress.

Summary of this inspection

- Staff involved patients and those close to them in decisions about their care and treatment. Staff were innovative in their approach to ensure people who used the service had their requests met where possible.
- Staff involved patients and those close to them in decisions about their care and treatment. It was clear from speaking to patients and staff, and from care records, that care and treatment was provided collaboratively. Patients or those close to them had significant control and input and their choices were respected where it was possible to do so.
- Patients told us they could ask any questions and were supported when upset.
- Feedback, thank you cards and regular questionnaires confirmed that patients and those close to them valued the services and emotional support offered by the service.

Are services responsive?

Are services responsive?

Good



We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of local people. Services were focussed on the needs of those using them.
- The service took account of patients' individual needs. Care plans were tailored to capture people's choices and preferences. These were comprehensive, and person-centred.
- People could access the service when they needed it. Waiting times from referral to treatment were in line with Fresenius Standards.
- People's individual needs and preferences were central to the delivery of tailored services. The service was flexible and provided informed choice and ensured continuity of care.
- There were clear processes for staff to manage complaints and concerns and staff at all levels in the organisation were engaged with improving services as the result of complaints.

Are services well-led?

Are services well-led?

Good








We rated it as **Good** because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

Summary of this inspection

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

Dialysis services

Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are dialysis services safe?

Requires improvement 

We rated it as **requires improvement**.

Mandatory training

The service provided mandatory training in key skills, including resuscitation training, to all staff and made sure everyone completed it.

Mandatory training included subjects such as infection control, health and safety, fire safety, information governance and safeguarding. All staff were trained in sepsis recognition. We saw staff compliance of mandatory training ranged between 95% to 100%. The service target for mandatory training was 95%. All nursing had undertaken basic and intermediate life support training for adults.

Mandatory training was provided annually to staff through a mix of both classroom and online sessions. Training was monitored by the clinic manager on a monthly basis through an automated training report.

All staff had access to an online training system. The system gave the registered manager an overview of performance and gave prompts to staff, when they were due to re-take or refresh their training. The manager could also see mandatory training performance. Staff in the unit are allocated training shifts when they have training due.

Mandatory training records were monitored by the Flexibank administrators, to ensure training was up to date. If training lapsed, staff were suspended from shift allocation until evidence of completion was received.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

The service had a detailed safeguarding policy that clearly set out accountability and responsibility for identifying and reporting safeguarding concerns. This included information relating to female genital mutilation, child abuse and radicalisation. The clinic manager was the safeguarding lead for the unit. The safeguarding lead for the company is the nursing manager for governance. We were told the area head nurse had been trained to safeguarding vulnerable adults' level three and was the safeguarding lead for the company. The head nurse visited the clinic monthly to provide safeguarding supervision to staff and could easily be contactable when needed at the clinic for safeguarding advice.

Nursing and dialysis assistant staff received training specific for their role on how to recognise and report abuse. This included training on the safeguarding vulnerable adults and children to level two and three. There were no services delivered for persons under the age of 18 years. However, staff received safeguarding training for children as the provider recognised that staff may come in to contact with children, parents and carers in the course of their work.

Dialysis services

At the time of our inspection, all staff had completed safeguarding adult and children level two training. The staff we spoke with were able to tell us how they would recognise and report potential abuse, which was in line with local and national safeguarding procedures. Staff had access to a member of the safeguarding team at the local NHS trust or other suitably trained member of staff, 24 hours a day, seven-days a week.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding contact numbers were displayed on the unit.

Staff received training on equality, diversity and human rights as part of their induction. All staff had completed this training.

Cleanliness, infection control and hygiene

The service did not control infection risk well. However, staff used equipment and measures to protect patients, themselves and others from infection.

We saw an overfilled waste bin in the dirty utility room and the waste bins were not tied up properly to the stand. The dirty utility room was not cleaned properly and was littered with cardboard boxes and water containers. The sink area was not clean and well kept. There re-usable gloves in the dirty utility room were worn out and breaking apart.

All staff we saw in the unit were bare below the elbows to prevent the spread of infections in accordance with national guidance. Hand cleansing gel was available at the main entrance of the unit and in all areas of the unit. We spoke with patients who told us they saw staff clean their hands before their treatment. Nursing staff received infection prevention and control training as part of their mandatory training package. We saw that 100% of staff had completed this training.

All staff were trained and used an aseptic non-touch technique when accessing patients' fistulas (a fistula provides easy and reliable access to a patient's bloodstream for dialysis) and dialysis lines. This minimised infection transmission between patients. We saw staff washed their hands between patients; handwashing sinks were located by each dialysis station and throughout the unit.

The service completed hand hygiene audits on a monthly basis. The audits showed an average compliance rate was similar to the service target of 95%. Monthly environment hygiene audits showed a 95% compliance rate over the same period. Hand hygiene and infection prevention and control audits were a standing agenda item at the monthly team meeting.

Nursing staff completed audits relating to cleanliness and infection control including dialysis connection processes, hand hygiene and maintenance of dialysis fluid pathway. Audits were completed weekly and the collected data was sent to Fresenius head office for analysis and recorded on the service dashboard. We were told that audit records from January 2018 to March 2019 showed 95% compliance with infection control audits. We saw the registered manager had included the results of audits and actions to be taken by staff to improve compliance with infection control in an action plan and in team meeting minutes. Fresenius monitored infection control practices through audit returns to head office which were measured against compliance with key performance indicators. We saw record of clinic assurance tool, which included the monitoring of waste bins on a monthly basis.

All dialysis lines were single use and pre-packed. Once dialysis treatment was completed, we saw that all used lines were disposed of in clinical waste bags and any needles placed in sharps bins.

We saw a clinic hygiene plan displayed which showed guidance on which area or equipment was to be cleaned and the frequency of cleaning.

Staff cleaned equipment after patient contact. We observed staff cleaning dialysis machines, ancillary medical devices, beds, trays and trolleys between patients to ensure good levels of hygiene and minimise the risk of cross contamination. Staff ensured the dialysis machines underwent a heat disinfection procedure after every use.

Patients used the same dialysis machine on each visit to the unit. The dialysis machines were numbered, and patients were allocated a specific dialysis machine and the number recorded in their records. This reduced any associated infection prevention and control risks if patients were to use different machines for their treatment.

Dialysis services

Water used for the preparation of dialysis fluid was monitored for contaminants and microbiology issues. Chlorine levels in water were tested daily and other contaminants such as nitrates tested monthly to ensure the quality of the water used. This was in-line with the Renal Association guideline 3.3 – HD: Chemical contaminants in water used for the preparation of dialysis fluid. We saw the daily water plant records, which were fully completed.

The service monitored if staff had considered infection where observations were outside of expected norm. We found well embedded escalation processes when infection was suspected, which worked well across the unit.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

There was one full sharps bin in the dirty utility room which had not been signed or dated. There was a domestic fridge/freezer in the clean utility room which staff told us was used to keep ice for water quality testing and blood/blood products for transfusion. Staff told us the fridge/freezer had been provided by Fresenius. We noted this was a domestic fridge/freezer, and therefore not suitable for the storage of bloods. Staff told us they did not monitor the temperature of the fridge as it was not in the policy to do so. There was a portable appliance testing sticker on the fridge/freezer which showed the next electrical safety testing was due in August 2020.

The unit had 18 dialysis stations, which included two isolation rooms for patients presenting an infection risk. Facilities in the unit included a designated waiting area within reception; a staff area with changing rooms; toilets and a staff room; a seminar room; a storage area; and three consultant rooms.

We saw that there was adequate equipment to enable regular servicing and maintain a full service. All dialysis machines were maintained according to the manufacturer's guidance. Technicians from an external provider visited the dialysis unit at regular intervals to complete routine servicing. All equipment was checked and logged, and a record held by the registered manager. Staff were aware of the escalation process for the reporting of faulty equipment.

Staff carried out daily safety checks of specialist equipment. Two spare dialysis machines were kept on site in case a fault developed on any of the machines on the main unit. The spare machines appeared clean and ready for use. All staff were trained on the equipment used in the unit. This training was provided by either Fresenius or external providers as necessary. The organisation used the same type of equipment in all clinical areas, so staff transferring between units would be familiar with equipment. We saw from viewing equipment training records that the centre's staff had achieved 100% compliance for equipment training.

The service had enough suitable equipment to help them to safely care for patients. A rolling annual maintenance and calibration programme for the dialysis machines, chairs and other clinical equipment was in place. This ensured that all equipment was checked and tested annually. Maintenance was undertaken by the provider's dedicated facilities management technicians. Staff told us the maintenance technicians were very responsive to request for repair of equipment.

Appropriate emergency equipment was available. There was a centrally located resuscitation trolley, a transfer trolley and bag. We found evidence of daily checks being completed and contents in line with Resuscitation Council (UK) guidelines.

Patients were protected from the risks associated with the unsafe use of equipment because staff maintained a reliable and documented programme of checks. Equipment was labelled and listed in the unit asset register. Maintenance and servicing were planned and carried out in accordance with manufacturer's guidance.

Storage areas on the ground floor were organised, with doors locked. We checked a sample equipment used at the unit and found evidence of up-to-date electrical safety testing. We inspected a wide selection of consumable items in resuscitation trolley's and store rooms in the unit and found all packets were intact and within expiry dates. We viewed the consumables trolley's in the medication room and in the clinic bays and noted these were tidy and well organised. We looked at 10 items of consumables (oxygen tubing and dialysis needles) and saw these were in date. We noted that there were wheelchairs been kept in the disable toilets.

Dialysis services

Each dialysis station had a reclining chair, dialysis machine, a working nurse call bell, table, a television with remote control, and Wi-Fi access. All equipment was numbered to ensure it remained in the same location. The centre had one spare dialysis chairs which could be used in the event of a dialysis chair malfunctioning.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and minimised or removed risks. Staff quickly identified and acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on arrival and updated them when necessary and used recognised tools. We reviewed five patient records, all of which indicated that the patient had been assessed for falls risk. Patients at risk of venous thromboembolism were assessed at the referring trust prior to transfer of care to the unit and were reassessed every three months by the local trust's renal team.

Patients had their vascular access sites assessed by staff prior to treatment. Fistulas or central venous catheters were assessed pre and post dialysis for infection, with any variances recorded.

Staff followed processes for patient identification, which met the NMC standards for medicine management. Staff routinely asked patients for their names and date of birth, prior to commencing dialysis and issuing medication.

Confirmation of identification was required by the dialysis machines. Patients used an electronic card, picked up on arrival in the waiting area, to record their weight; this card was then inserted into the machine which subsequently prompted staff to confirm the patient identity. This ensured patients received the correct treatment, as the machine would not progress until the patient's identity had been confirmed on the dialysis machine.

We saw that there was a sepsis training programme to ensure that staff were able to appropriately deal with signs of sepsis. Sepsis was included as part of the mandatory training programme and all staff we spoke with confirmed that they were trained in sepsis recognition and management.

Staff responded promptly to any sudden deterioration in a patient's health. Staff completed patient observations, such as; blood pressure readings, oxygen saturation

readings and patient temperatures to assess and monitor patient's health. Patients' blood pressure was recorded at regular intervals during their dialysis. Alarm settings were adapted to each patient, allowing any variance to the patients' normal readings to be highlighted to nursing staff. In the event of a patient deteriorating, the patient was transferred to a local NHS trust. The service had a service level agreement with a trust for this.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank staff a full induction.

The service had enough staff of all grades to keep patients safe. At the time of inspection, the unit employed twelve qualified nursing staff, four dialysis assistants, one healthcare assistant and one clinic secretary. The registered nursing staff included the unit manager and the deputy manager. Staffing levels were reviewed by the registered manager on a daily basis to assess staffing levels. Staffing levels were based on the actual number of patients attending for dialysis and to cover unexpected staff shortages caused by sickness. The unit manager reviewed daily staffing levels and adjusted them according to the actual number of patients attending for dialysis.

The number of nurses and dialysis assistants on all shifts matched the planned numbers from the three-month rota we reviewed. Where unexpected staff shortages were identified, action was taken to rearrange shifts with staff cooperation, or fill the shift with a bank or agency member of staff. The unit's e-rostering system was completed eight weeks in advance by the registered manager and forwarded to the Fresenius regional business manager for approval. This ensured shifts were covered in advance and any shortfalls in staffing were addressed.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The unit used the provider's in-house nurse bank, Renal Flexibank. Managers made sure all bank and agency staff had a full induction and understood the service.

Dialysis services

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The unit was supported by consultant medical staff from the local NHS trust. The unit was nurse led; however, consultants from the referring trust were responsible for, and managed the medical care and treatment of patients attending the unit. Each consultant was responsible for a group of patients. We were told the consultants organised a weekly clinic at the unit.

Staff and managers told us they could access the nephrologists through the trust if they needed advice and support, and they were contactable via phone or email. The service always had a consultant on call during evenings and weekends. A consultant nephrologist was available as 'nephrologist of the week' on an on-call 24-hour basis.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patients' records were held securely both electronically and in paper format. The Fresenius patient treatment database automatically transferred patient information into the NHS trust's clinical electronic records system; this enabled all patient information to be shared with the renal registry.

We saw that the electronic records detailed dialysis sessions by date and time. This meant that any changes in treatment, any problems occurring during the session and any treatment changes could be easily identified. Staff at the unit were able to access all records at the local NHS trust; reducing time spent chasing blood and test results.

Staff were competent in the electronic record system and all had received mandatory training in order to effectively use it. We reviewed 10 sets of patient records. These were of good quality and contained patient demographics including height, weight as well as the patient

prescription and blood results. All patients had a care plan and risk assessments in order to provide staff with the necessary information to provide safe care and treatment.

The unit kept paper records, which included the most recent dialysis prescriptions, next of kin and GP contact details, risk assessments, medication charts and patient consent forms. Paper records were stored in colour-coded files according to patient's dialysis day and time. The files were kept securely when not in use. All seen were completed legibly and accurately. Staff completed data protection training as part of their induction and annually. Training compliance was 100%.

Patients' records were audited monthly, with a review of the patients' records and dialysis prescriptions. We saw an action plan that was in place to address shortfalls in record keeping.

Access to the patient records was readily available and treatment plans were actioned quickly; particularly when people were referred or when they transitioned between services.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The service had a corporate medicines management policy and all staff we spoke with were aware of where to find it on the intranet. The unit had processes for the safe management of medicines. The medicines management policy provided staff with guidance on general medicines management, medicines administration, administration of Hepatitis B vaccination, oxygen therapy and reporting errors in medicines management. Staff followed the guidelines and protocols and were able to describe the anticoagulant process as part of the dialysis treatment. Anticoagulants are medicines that help prevent blood clots. They're given to people at a high risk of getting clots, to reduce their chances of developing serious conditions such as strokes and heart attacks.

Staff checked the temperature of the medicine fridge in the medication room on a daily basis. We viewed the records for all of January so far which showed the fridge temperature had been checked on all days and was within range. Staff had signed to show they had carried out the check.

Dialysis services

We looked at seven medication charts and found all had allergies documented, and six of seven had an up to date weight recorded for the patient. Staff had clearly recorded the date, time, dose given and signed on all medication charts we looked at.

We looked at 10 sets of patients records and found a dialysis prescription in place in all the records. Of those 10, nine were up to date and signed, and one was up to date but not signed. The service had arrangements with the consultants for confirmation of dialysis prescriptions.

Patients' prescriptions were reviewed monthly at multidisciplinary team (MDT) meetings and when patients saw the consultant. The outcome of the meetings and changes to prescriptions were discussed with the patient and the patient's GP was informed by letter of any changes to a patient's medicines. Haemodialysis treatment followed an individualised treatment prescription.

We reviewed a sample of medicines held by the unit. All medicines we reviewed were within the manufacturer's recommended expiry date. Staff followed current national practice to check patients had the correct medicines.

Staff stored and managed all medicines and prescribing documents in line with the Fresenius policy. Every patient had an individualised treatment prescription. The consultant nephrologists completed all medicines prescriptions. We saw that the prescriptions were kept on the unit's electronic patient record system and dialysis prescriptions were printed out and stored in the patient's paper patient records.

A renal pharmacist from the commissioning trust provided support to the clinic and advice relating to dialysis medicines. Additional advice could be sought by staff from the lead pharmacist based at the Fresenius head office.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support

Policies and procedures were in place to ensure there was a systematic approach to investigating safety issues. The service made sure that actions from patient safety alerts were implemented and monitored. Staff were aware of their responsibilities to report incidents and near misses. Staff reported incidents using an electronic system, which was monitored by senior staff and managers.

There were effective electronic systems in place to report incidents. Staff were able to explain the process they would follow in the event of an incident. Staff told us that at the end of every patient's dialysis session, they were required to input whether any incident occurred in to the patient's electronic record, and the record could not be closed until staff had answered this question. Staff also escalated any incidents to the nurse in charge, and reported the incident using an electronic system. Staff told us they took part in reflective sessions to share learning from incidents.

Managers debriefed and supported staff after any serious incident. Managers told us that those involved in a serious incident were involved in the investigation process and that all learning shared was anonymised.

Managers investigated incidents and involved patients and their families in their investigations. We requested the last three root cause analyses (RCA) investigations undertaken by the service. We saw that the incidents were appropriately investigated with contributing factors and learning from the incidents identified. We saw that the serious incident action plans assigned actions resulting from the serious incident report recommendations and provided a deadline for completion.

Staff understood the Duty of candour. 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. Staff were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff could give examples of incidents where the Duty of candour had been exercised including when the wrong piece of equipment had been used on a patient.

Dialysis services

Staff understood their roles and responsibilities for raising concerns, recording concerns, safety incidents, and near misses and where to report them both internally and externally.

Safety Thermometer (or equivalent)

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. The unit did not utilise the safety thermometer as it was a private provider, however they did monitor falls and infection prevention. We were told there were no falls recorded in the unit in the last year.

Are dialysis services effective? (for example, treatment is effective)

Good 

We rated it as **good**.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

The provider developed a NephroCare Standard Good Dialysis Care that took into account professional standards and guidance from the Renal Association, the National Institute for Health and Care Excellence (NICE), best practice and research literature from a range of sources. The standard addressed the processes to follow immediately before, at the beginning, during and at the end of haemodialysis treatment, and provided a guide for all staff to follow to ensure safe care and treatment for patients receiving treatment at the unit.

Patients were assessed using risk assessment tools based on national guidelines and standards. This included falls risk assessments, nutrition scores and skin integrity assessments.

Staff assessed patient's physical, mental health and social needs holistically, and their care and treatment were delivered in line with legislation, standards and evidence-based guidance, including NICE.

Patient records we reviewed showed treatment followed national guidelines. For example, National Institute for Health and Care Excellence: Intravenous fluid therapy in hospital. The service adapted and monitored compliance against NICE guidelines and took steps to improve compliance when further actions had been identified. The service undertook venous access screening as routine observation monitoring.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Patients were provided with regular hot and cold drinks at their bedside. Patients were offered biscuits and were able to bring in snacks and food from home if they required. Patients we spoke with were aware of the dietary restriction of their illness and appreciated the support of the team and dietitian.

We saw evidence of nutritional assessment in the care plans as the malnutrition universal screening tool (MUST) was completed in notes we reviewed. Patients were weighed pre and post dialysis treatment. This procedure contributed to assessment and the overall treatment prescription.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Individual pain control needs of patients were informally assessed by nursing staff and paracetamol was routinely prescribed by consultants for patients. Paracetamol was given when required for mild pain and recorded appropriately in the patient record. Patients we spoke with told us staff monitored their comfort and pain levels throughout treatment.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Dialysis services

The unit was nurse-led; however, overall responsibility for patient care lay with the consultant nephrologists from the commissioning trust. Patient treatment prescriptions and care plans were individualised to achieve effective patient outcomes in line with the UK Renal Association Standards.

Staff monitored patients' dialysis access (dialysis catheter, arteriovenous graft or fistula) monthly. The targets for optimising vascular access were set by Fresenius, following a review of the referring local NHS trust and the national standards. The unit monitored the length of patients' dialysis to ensure that patients were dialysed for 240 minutes. The percentage of patients dialysed for 240 minutes or more was in line with Fresenius standard.

The service audited its quality standards against the Renal Association Guidelines. Managers used information from the audits to improve care and treatment. Information about the outcomes of patients' care and treatment was collected and monitored by the service to ensure good quality care outcomes were achieved for each patient. The unit measured and reported to the commissioning trust on its effectiveness against the quality standards of the Renal Association Guidelines. Electronic treatment data collected by the dialysis machines was submitted to, and combined with data from, the commissioning trust for inclusion in its overall submission to the UK Renal Registry. The registry collects, analyses and reports on data from the UK adult and paediatric renal centres. The data submitted included patients under the direct care and supervision of staff at the dialysis unit.

Patient blood was tested for potassium, phosphate and calcium aluminium concentrations in-line with the Renal Association Guidelines. This demonstrated that patients received the treatment they were prescribed. Pre-dialysis serum potassium in patients' blood was monitored on a monthly basis. Renal Association Guidance suggests that pre-dialysis serum potassium should be between 4.0 and 6.0 mmol/l in haemodialysis patients.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The continuous development of staff's skills, competence and knowledge was recognised as being integral to ensuring high quality care within the service. Staff were supported and encouraged to develop new skills, use their transferrable skills and share best practice.

Staff were qualified, experienced and had the right skills and knowledge to meet the needs of patients. The service had an educational programme for nursing staff working in the unit.

Staff were required to complete competencies online or face to face, depending on the task. All staff we spoke with had completed relevant competencies for their role. This information was kept in individual staff folders. We reviewed staff files that covered staff competencies, and these competencies included shadowing nurses and completing online training. This included dialysis related competencies like cannulation, monitoring of venous access and recognition of fluid overload.

All bank staff undertook a corporate and short local induction programme with a training shift and competency assessment with the same standards and procedures as full-time staff. Job functions mirrored those of full time employed staff.

We were told that 98% of staff had an appraisal so far in the current appraisal year from April 2018 to March 2019 and 100% in the previous full year April 2018 to March 2019. All staff we spoke with told us they had completed their appraisals. Objectives were set and reviewed with their manager.

In addition to mandatory training, staff undertook renal course training, dialysis machine training and mentorship training. Rates of training were consistently high and an average of 95% of staff were up to date with training in the use of medical equipment. This meant staff were competent to use equipment specific to providing dialysis care. Staff spoke highly of their access to training and opportunities for professional development.

Each permanent member of staff performed a specialist link role, such as in diabetes or infection control. This meant each member of staff took the lead in their area of responsibility to attend training days and then deliver new information or practice guidance to colleagues. This

Dialysis services

system was reviewed on an annual basis and each member of staff had the opportunity to reflect on their progress and identify their training needs for the following year.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

The consultant from the referring trust had overall responsibility for the care and treatment of their patients on the unit and visited once a week to review their care. Electronic access to blood results and treatment data meant that consultants were able to review patient progress remotely.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary meetings were held monthly and included the consultants, the clinic manager, dietician, renal pharmacist, anaemia nurse, and specialist vascular access nurse. The multidisciplinary meeting reviewed each patient's treatment records and care plan, including any treatment variances (such as patients ending their treatment session early) since the last review. Any changes to a patient's care and prescription were recorded. Outcomes and changes were discussed and implemented with all patients by named nurses.

Seven-day services

The unit opened six days a week from Monday to Saturday with patients attending three times a week on alternative days. The unit operated three treatment sessions on a Monday, Wednesday and Friday with two treatment sessions on the other days.

Health promotion

Staff were consistent in supporting people to live healthier lives, including targeting those who needed extra support, through a proactive approach to health promotion and improving ill-health, they used every contact with people to do so.

The unit had relevant information on promoting healthy lifestyles and support for patients. Information leaflets and posters were displayed in the waiting area. These included information about sepsis, dietary advice,

dialysis while on holiday and information for patients awaiting transplants. A range of leaflets and contact details for support groups such as the renal social worker and the Kidney Care organisation were available.

Staff assessed each patient's health when they checked in on the day for their treatment and provided support for any individual needs to live a healthier lifestyle. Patients were encouraged to be involved in the planning and delivery of their care as much as was practicable given the nature of the service provided.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The service had a policy for consent to examination or treatment (UK-C-09-02). The policy provided guidance to staff on seeking consent to treatment and was available to staff on the intranet. The policy included seeking advice from or assessment by, the commissioning unit when a patient lacked capacity to consent to treatment.

The provider had a policy in place to guide staff in the correct use and interpretation of the Mental Capacity Act 2005. Staff completed this training as part of the mandatory training programme and understood issues in relation to capacity and the impact on patient consent. Staff were able to demonstrate their knowledge of consent and mental capacity. If there were concerns over a patient's capacity to consent, they would seek further advice and assistance from the unit manager and the renal social worker. Existing patients who developed capacity issues were discussed with the consultants at the commissioning trust so that a suitable plan for future care could be made.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Signed patient consent forms were required in order to start treatment at the dialysis unit. Consent forms were held within all the 10 paper records we reviewed. We observed staff obtaining verbal consent from patients before carrying out any interventions. All staff were fully aware of

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their roles and responsibilities in relation to the requirements of consent. We saw that patients were asked for verbal consent at the start of each dialysis session and for any treatments or care during their attendance at the centre. We saw that each patient completed consent forms for the completion of treatment and for dialysis at the beginning of their treatment. This consent form was filed in the patient's paper records. Staff told us completed consent forms were not reviewed or updated unless there was an identified need.

Are dialysis services caring?

Good 

We rated it as **good**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were compassionate and responsive when caring for patients. Staff spent time to interact with patients and those close to them in a respectful and considerate way. We observed staff on the unit, talking with patients or their family and ensuring that the patient was treated with dignity and respect.

Each dialysis station had a disposable privacy curtain. On the day of inspection, none of the curtains were drawn, which added to the open, airy feel to the unit. However, staff told us privacy curtains would be drawn in the event that intimate or emergency care was needed. Additional mobile privacy screens were available if needed.

All patients we spoke with were positive about the care they received, praising the staff as being like their family. We observed interactions between staff and patients prior to, during and following dialysis treatments to be good. Interactions throughout the dialysis set up process were seen to be positive, caring and patient led. Staff exhibited a caring, compassionate and sensitive manner to dealing with patients under their care.

One patient we spoke to told us they were happy with the care provided. Another patient told us staff were good and friendly. Patients described a positive relationship with the staff caring for them.

We observed all staff communicating in a compassionate way with patients including asking how they were feeling and informing them of the next steps in their care; for example, when they were about to disconnect them from the dialysis machine. We observed all staff frequently checking with patients that they were comfortable. Staff spoke to patients in a polite and reassuring manner. We noted staff chatting and laughing with patients and they took the time to get to know them.

Staff ensured the dignity of patients was protected through the use of curtains when providing personal care. We saw staff introducing themselves to these patients, explaining their role and what they were going to do and why the patient was in the unit.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Emotional support

Staff recognised and respected the entirety of people's needs. They understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.

Staff were always considerate of people's personal, cultural, social and religious requests and found ways to meet them through their daily interaction with the patients. People's emotional and cultural needs were known to be as important as their physical needs. Staff were aware of the importance of providing emotional support to both patients and their families. We observed sensitive and positive interactions between staff and patients. Patients told us service felt more like a family than anything else as some of them had been coming to the unit for the past 10 years. All patients we spoke to felt as though they were being fully supported throughout their care.

Dialysis services

The unit devised services that allowed people to express their views and be actively involved in decisions about their care, support and treatment wherever possible.

Staff provided patients and those close to them help, emotional support and advice when they needed it. Staff were able to refer patients for additional support, available to patients through the referring trust, including access to a renal social worker and psychological services. Patients we spoke with felt supported by the nursing staff and they could speak to them about concerns or worries if they felt they needed to.

Staff recognised the emotional impact dialysis treatment could have on patients. Staff told us they would often help patients to set up their dialysis station in the patient's preferred way; for example, having their drinks or possessions in a certain place, as they understood the positive impact this had on their wellbeing.

The nurse in charge saw all patients and relatives on the unit daily to assess if they had any concerns with their stay. All the patients and relatives we spoke with told us they felt supported throughout their treatment; they said the support provided by staff was very good.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We spoke with two relatives, who told us that staff had made them feel at ease.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients relatives told us they felt they had been included in the plan of care for their relative and that staff had made sure they understood what was happening to their relative.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We were told that importance was placed on being respectful and responsive to individual patient preferences and needs. We were also told the service

ensured that patients were involved in the planning and decisions about their care. One relative told us staff were accommodating, and they could visit or contact the unit anytime to receive an update about the patient.

The unit participated in the provider's 'Tell us what you think' leaflet system which allowed patients to comment anonymously on the service direct to the provider's head office. A high proportion of patients gave positive feedback about the unit in the patient satisfaction survey.

Patients who needed extra support were identified during initial assessment. Through the patient safety questionnaire, family members or carers were permitted to accompany patients and provide support during their treatment at the centre.

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

Good 

We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Dialysis services were available at the unit to meet the needs of the patient group. The unit planned and provided services that met the needs of the local patients.

The unit provided dialysis service for the individual who required dialysis treatment. Patients were given information and support regarding their care and treatment prior to receiving treatment at the unit.

We received mixed feedback about the transport provided including some delays, but most patients told us it was satisfactory. Patients could be reimbursed for mileage if they drove to their appointments. There were a small number of free parking spaces available outside the clinic, including disabled parking.

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The environment was patient-centred, with comfortable couches, refreshments and suitable toilets. There was a visitor's waiting area which was available for families and carers to rest and make refreshments whilst the patient was undergoing their dialysis treatment.

The unit had a waiting room and three consulting rooms for use by visiting consultants and other staff. The unit was wheelchair accessible and wheelchairs were available on the unit for patients who needed them. The service had wide corridors, large bays and wheel chair facilities to accommodate patients who were wheelchair bound. There was a large disabled access toilet on the first floor and one on the ground floor waiting area. A range of patient information leaflets were available in the waiting area. For example, literature on diet and lifestyle and the local kidney association.

Patients on dialysis require treatment for four hours, hence suitable entertainment to pass the time is essential. The unit offered patients free Wi-Fi access, and each dialysis station had a mounted television screen for patients own use.

Patient transport was provided by an independent patient transport service, contracted by the referring NHS trust. Transport and journey times were not routinely recorded, monitored or audited by the service; however, specific individual transport problems were recorded and discussed in contract meetings with the referring trust.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made reasonable adjustments to help patients access services; this included varying treatment times to suit their needs. Staff coordinated care with the local NHS trust. People were treated as individuals and their care was designed to take all their needs into account.

Staff told us that if a patient had a red circle on their paper records, this was a subtle indicator that they had some form of communication difficulties. For patients who did not speak English, staff arranged for a face to face interpreter to attend the unit with them during the

first few weeks of their dialysis treatment. Beyond that, staff had lists of frequently used words in the patient's language, so that they could meet their needs during treatment.

Staff used a risk assessment to record the actions of patients who presented with signs of delirium. This included an assessment by the medical team to identify causes of delirium to ensure the most appropriate treatment plan was initiated for the patient.

Staff were aware of cultural differences and differing needs of patients and did their best to accommodate these. Patients told us that they felt safe on the unit, and those who could not speak English could access interpreting services at any time either face to face or over the telephone.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

Allocation of dialysis sessions was organised according to availability with the patient's wishes in mind. If the patient requested a different time every effort was made to accommodate this. We saw evidence of the manager monitoring requests for alternative dialysis times.

Responsibility for the management, referral and prioritisation of new patients requiring dialysis was held by the referring NHS trust. However, the criteria for referral and acceptance of new patients were set out in the Patient Referral and Acceptance for Treatment policy. Patients were assessed for suitability prior to acceptance to the unit. The acceptance criteria included patients being stable with established and functioning vascular access, independently mobile, and no recent cardiac, cerebrovascular or psychiatric history, no ongoing medicines through infusion pumps, no wound dressings required, and copies of last blood results. Patient numbers were reviewed weekly in multi-disciplinary team meetings, held with the NHS trust's consultant nephrologist and renal team, where patient capacity at the unit was discussed. The service did not have a waiting list and there were no patients waiting to commence treatment at the unit.

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The referring NHS trust had responsibility for organising clinic appointments held at the unit. Staff told us they tried to support patients when attending these appointments; however, they could not always guarantee they were on duty during their dialysis days.

The unit manager liaised regularly with the referring NHS trust to ensure local people who met the criteria for dialysis at the unit were offered a place to receive their dialysis care at the unit.

The unit opened six days a week Monday to Saturday and had capacity to provide three dialysis treatment sessions (two daylight and one twilight session) for each treatment station per day. Where possible, staff took into account patients' lifestyle, social commitments, and preferences when allocating dialysis sessions.

In the previous 12 months, there had been no cancelled appointments due to non-clinical issues, and there was no waiting list for accessing the service.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

We saw that there was a clear process in place for the management of complaints. All staff were able to tell us what they would do in the event of a formal or informal complaint being made. The registered manager told us most patient issues were resolved informally and immediately at the unit. The unit treated concerns and complaints seriously, investigated them, learned lessons and used the learning to improve the service. The service used concerns and complaints as an opportunity to learn and drive improvement. This included looking at themes and trends. Senior staff told us they worked closely with the complainant to try and rectify a concern before it escalated to a formal complaint. They told us they regularly analysed complaints for trends and themes. Staff shared trends, themes and lessons from complaints during team meetings and daily handovers.

We saw a complaints policy which reflected best practice, and this was easily accessible to staff. The unit had systems to ensure patients comments and complaints were listened to and acted upon effectively. Patients could raise a concern, and have it investigated and

responded to within a time frame as set out in the complaints policy. Comments and complaints were used by the management team to improve the quality of the service provided.

We saw information leaflets were available in the reception providing patients and relatives with information on how to raise concerns and make a complaint. We were told that there was a freepost postcard available, to enable patients to make complaints to the Fresenius head office. On referral to the centre, patients and their relatives were given a copy of the patient guide, which contained details of the complaint's procedure, detailing how a complaint could be made, the process for investigation and the timescale.

The registered manager told us they had an open door policy where patients could escalate any concerns directly to them. This was in addition to the daily contact by the registered manager to ensure patient satisfaction. There were seven formal complaints between June 2018 and June 2019. Three of these were dealt with through the formal complaints' procedure; and two were upheld. The other complaints were dealt with informally and immediately on-site. Complaints were monitored by the Fresenius head office and themes identified. For example, there had been one complaint about transport, another complaint about cleanliness, and three complaints regarding quality of care and treatment.

Are dialysis services well-led?

Good 

We rated it as **good**.

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Leaders had the skills, knowledge, experience and integrity necessary for their roles, in line with the

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guidelines for the Provision of Dialysis Treatment. The nursing team was led by the registered manager/clinic manager, recognised as having overall responsibility for the nursing elements of the service.

Managers had the skills and knowledge to manage the service. Managers had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. They could clearly explain how the teams were working to improve the quality of care and treatment to patients. They had developed action plans to address areas for improvement identified at the previous inspection and regularly updated them to reflect the progress they had made.

Managers had the right skills, knowledge and experience required to run a service providing high-quality sustainable care. Many of the leaders had worked in the organisation for a significant length of time in other roles prior to been managers of the service, which therefore provided continuity for staff and an understanding of their experience. Managers understood the challenges to quality and sustainability, and actively sought to address them.

We saw positive relationships between staff and managers. All staff we spoke with had a clear understanding of the challenges to quality and sustainability of the service. They could identify actions to address these such as investing in staff pay, terms and conditions.

Patients we spoke with said that the unit was friendly, and they had seen improvements in the leadership and morale of staff since the last inspection.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a statement of purpose (SOP) which outlined to patients the standards of care and support

services the company would provide. They had a set of core values which were understood by staff and these were: Quality, honesty and integrity; innovation and improvement; respect and dignity.

The organisational aim was to 'deliver high-quality person-centred care' through effective leadership, governance and culture. Fresenius stated they were committed to honesty, integrity, respect and dignity. Staff knew and understood the vision, values and strategy, and their role in achieving them. Staff and key stakeholders were involved in the development of the strategy, vision and values.

The management team monitored and reviewed progress against delivery of the strategy and local plans. The service strategy aligned to local plans in the wider health economy, and how services were planned to meet the needs of local people. The leadership team worked collaboratively with staff in achieving their service plan. Teams had work plans, objectives and key performance indicators to allow systematic monitoring and managers regularly met staff to discuss outcomes.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we interacted with spoke highly of the organisation's culture. Staff said they were proud to be part of the team and showed dedication to their work.

The caseload of staff included working in complex patients who required a lifetime of dialysis treatment. Staff commented they received training and support to equip them with the necessary skills to undertake their role. Staff were positive in their role and spoke of high job satisfaction.

The service provided an environment which encouraged openness and honesty with the patient, their families and staff. Staff felt able to raise issues and concerns with their leaders and learning from incidents or complaints was shared in a supportive manner.

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Staff were aware of the whistleblowing policy and knew who their freedom to speak up guardian was. Staff were aware of their responsibilities to duty of candour. This is a duty placed on providers of healthcare to be open and honest with patients about when things went wrong in their care.

The provider's employee handbook detailed the provider's approach to equality and diversity, which focused any recruitment, promotion or dismissal decisions on the needs of the business, without discrimination on the grounds of any protected characteristic. This was reflected in the equality, diversity and human rights mandatory training at staff induction.

We saw positive interactions between patients and staff; all members of staff listened to and addressed patients' needs immediately. We saw that staff continuously reassured patients at several points during treatment.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a strong governance structure that supported the feeding of information from frontline staff to senior managers. The service held monthly team meetings and these meetings in turn fed into the service's monthly progress report. Board meetings were attended by senior managers in the organisation including the service leads.

Feedback from people who used the services and those close to them was regularly discussed at both care board meetings as part of the dashboard review. The service looked at compliments received, complaints and any concerns that had arisen through patients and their relatives. Concerns were discussed by the board and actions identified and assigned to senior staff members to lead on.

Staff at all levels in the unit were clear about their roles and what they were accountable for in providing care and treatment for patients, and in supporting the service. The

clinic manager was responsible for monitoring governance issues for the unit and had responsibility for submitting monthly governance reports and implementing governance improvements within the unit.

There were clear lines of accountability in the service. The service had nominated leads in areas such as safeguarding and infection prevention and control. These leads reported on these areas during clinical governance and board meetings.

The service had plans in place to ensure continuity of care in the event of an emergency through services emergency plan which could be located on the service's intranet. Staff were aware of the plan and had received training on example emergency situations.

Staff told us all incidents and any learning arising from them were shared across the team at team meetings and at staff handovers.

The area lead nurse had monthly meetings with the registered manager to discuss progress against targets, and any development plans or changes to practice. Regional meetings were held quarterly. These meetings included staff within the area and were used to review service provision and for service planning. The meetings had a standard agenda and included monitoring of clinical performance and corporate objectives, the risk register and audit schedules. The senior management team met with their national colleagues regularly and had the opportunity to travel to different dialysis units to share ideas for progressing the services offered by the company.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Senior staff understood its key risks and had oversight of them. The service kept a risk register, which was up to date and staff knew how to escalate any concerns. The unit and senior managers were able to describe the main risks affecting the unit, which included loss of facilities, contract risks, and staffing. The risks on the risk register reflected the risks staff had told us about throughout our inspection. Mitigation was in place for the risks, and

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specific staff were responsible for providing updates to the board on progress made towards managing or removing the risk. There was evidence that risks were being reviewed and updated regularly. Risks that were on the register had control measures in place and a review date.

The unit had developed an action plan to mitigate and track risks identified on the register and the requirement notice from our last inspection report. The requirement notice was centred around sepsis training and using effective aseptic technique. We were told that all actions related to the last inspection had been completed by December 2019.

The service had clinical work instructions to ensure that staff carried out their duties in line with corporate policy and legislation. Work instructions provided staff with flow diagrams to follow. Staff signed to confirm they had read and understood the work instructions; this was monitored by the unit manager, who highlighted information that had been recently updated and required staff to read.

Staff undertook mortality and morbidity meetings on a monthly basis. All members of the multi-disciplinary team were invited. Minutes for the meetings clearly recorded background information to the cases discussed, details of the discussions held and any learning that was identified as part of the meeting. This meant that the minutes could be shared with those not in attendance, to ensure that learning was shared with all relevant staff. Actions were identified in response to learning that had been identified as part of the discussions held in the meeting.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and

treatment. Patient's records were stored securely in line with personal data security standards and entries made in patient's records could be easily ascertained and attributed to the person creating them.

Patient records were easily accessible via the computer terminals. All staff had secure, personal log-in details and had access to e-mail and hospital systems. Patient treatment, observations, and monitoring data was recorded by the dialysis machines and automatically uploaded to the provider's electronic patient record system. Patient blood results were recorded electronically and fed in to the commissioning trust's database.

There were arrangements in place to ensure that data and notifications were submitted to stakeholders and regulatory agencies when required. Access to individual patient's records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role.

The intranet was available to all staff and contained links to current guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained therein. Staff we spoke with told us they could access the information they needed to provide safe and effective care. There were systems in place to manage and monitor care records. All staff had access to their work email and we were shown that they received organisational information on a regular basis, including clinical updates and changes to policy and procedures.

Engagement

Leaders and staff actively and openly engaged with patients and staff, to plan and manage services.

The provider operated a patient satisfaction survey. We reviewed the results of the 2018 survey which indicated overall improvement in scores compared with the 2016 survey. Results showed that 89% would recommend the service to family and friends, 89% felt the clinic was well run, 94% thought patients were treated with dignity, and 92% felt nurses kept them well informed about decisions taken about their treatment.

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The service was proactive in seeking feedback from staff, volunteers and patients and could provide multiple examples of where service improvements had been implemented as the result of this engagement.

The unit had completed a staff engagement survey at the end of 2019 and results have now been published and the clinical staff will be working collaboratively to create action plan for the unit.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The service was committed to improving services by learning from when things went well or not so well and promoted training and innovation.

Fresenius followed a “green nephrology” ethos with the aim of minimising waste produced by dialysis treatment. The company had targets for contaminated waste per treatment; electricity consumption per treatment and water consumption per treatment.

Leaders strived for continuous learning, improvement and innovation. The service ensured that continuous learning took place at the unit to help improve performance by accessing training at the organisation’s head office.

One member of staff told us they were proud of the aseptic non-touch technique carried out at the unit and felt this was an area in which they excelled.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that blood and blood products were not kept in the domestic fridge freezer.
- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to infection control and prevention, e.g. overfill of waste bin, unlabelled sharps bins robust process of identification of clean equipment.

Action the provider **SHOULD** take to improve

- The provider should consider whether equipment such as wheelchair was stored appropriately in the unit.
- The provider should consider whether the sink area in the sluice room is suitably cleaned and well-kept and to consider the appropriateness of the use of reusable gloves used in the sluice room.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Care and treatment were not always provided in a safe way because:

1. There were fully closed, and unlabelled sharps bin kept in the dirty utility room ready to be disposed of by the waste management company.
2. There was an unsecured and overfull waste bin in the dirty utility room.
3. There was no robust identification of clean equipment in the unit. During the inspection, we found there was no process for identifying whether equipment was clean or when it was last cleaned. There was no evidence of the use of "I am clean" green label used at the centre.

Regulation 12 (h).

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Some equipments were not properly maintained or suitable for the purpose for which they were being used because:

1. Bloods samples were kept in the domestic fridge/freezer.
2. There was no record of the fridge temperature being monitored.
3. Wheelchairs were stored in disabled toilets.

Regulation 15 (1)(c), (e)