Worcester 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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

Worcester Dialysis Unit is operated by Fresenius Medical Care Renal Services Limited. The service opened in 2009 and provides haemodialysis to patients from the local area of Worcestershire. This is a satellite dialysis service, which has a contract with University Hospitals Birmingham NHS Foundation Trust.

The service provided over 11,200 dialysis treatment sessions per year and had 72 patients at the time of the inspection.

All the patients were over 18 years old:

- 31% of patients were aged 18 to 65 years.
- 69% of patients were over the age of 65.

The service is located away from an acute hospital site. Facilities included 20 dialysis stations (four of which were in isolation rooms), three consulting rooms, and a meeting room.

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

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection 6 June 2017, along with an unannounced visit to the unit on 19 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 services 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:

- The unit and equipment were visibly clean, with evidence of effective cleaning regimes and schedules in place. Staff were observed using effective precautions to maintain patient safety and reduce the risks of infection.
- The facilities were purpose-built and met Department of Health guidance.
- There were systems in place for reporting, investigating and escalating incidents both internally and externally.
- Equipment was maintained according to the manufacturer's guidance, with an adequate supply to cover maintenance or breakages.
- Patients' records were held securely, and staff had access to relevant information.
- Nursing staffing levels were maintained in line with national guidance.
- There was a walk round handover process, which was inclusive of the patient.
- Systems and processes were generally in place to ensure that patients received safe care and treatment. Medical advice was available, with direct access to the consultant or renal team at the NHS trust.
- Staff completed a detailed competency assessment on commencement to post and were reassessed annually. At the time of our inspection, 100% of staff had received their annual appraisal.
- Patients received regular assessment and support regarding nutrition.
- There were effective processes in place for gaining patient consent for treatment.
- Patients who required dialysis were assessed by the NHS trust's staff for suitability to dialysis in a satellite unit and then referred to this unit.
- The unit provided two dialysis sessions per day.
- Patients were treated respectful, caring manner. This was reflected in the positive local annual patient satisfaction survey and patient feedback we received during the inspection.
- There was appropriate monitoring of patient outcomes and the service's performance.
- Patients were encouraged to take part in their care, with two patients fully competent to self-care.

However:

- Not all staff had completed safeguarding adults and children training in line with national guidance and corporate policy at the time of the inspection. However, we found that nursing staff were aware of their roles and responsibilities in the escalation of safeguarding concerns. The provider took action to address this lack of training after we had raised it as a concern.
- We found that there were gaps in compliance with training, including practical manual handling, preventing medicine errors and link nurse training.
- Not all senior staff had had Duty of Candour training in line with the provider's policy.
- Staff did not consistently follow best safe practice regarding timing of second checks prior to administration of medicines.
- We were not assured from records that appropriate actions were being taken when fridge temperatures, including the medicines' fridge, were out of recommended range. This was raised during the inspection and actions were taken.
- The service did not provide patients with easy to read information in line with the Accessible Information Standard.

Summary of findings

- While patients were observed closely during treatment, the service did not use the National Early Warning Score system for monitoring a patient's risk of deterioration. This was on the unit's risk register.
- We found that some items were stored inappropriately, for example, sodium chloride solutions in a general storeroom. Subsequent to the inspection, this issue was resolved.
- The services risk register was set corporately and did not describe risks found at a local clinic level.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals, Central Region

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. • Staffing levels were maintained in line with national guidance and all staff were compliant had received an annual appraisal. However, there were gaps in compliance with training including, safeguarding, practical manual handling, duty of candour and prevention of medicine errors. • Patients were positive about the service they received and staff aimed to include them in decisions about their care and treatment. • Systems were generally in place to keep patients safe including, incident reporting, infection prevention and control and quality assurance meetings. However, there was inconsistent practice regarding timing of second check of medicines and risk registers were set corporately and did not include risks we found at the clinic.

Summary of findings

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Services we looked at:
Dialysis Services

Summary of this inspection

Background to Worcester Dialysis Unit

Worcester Dialysis Unit is operated by Fresenius Medical Care Renal Services Limited. The service opened in 2009 and provides haemodialysis to patients from the local area of Worcestershire. This was in response to a request from the regional renal team (NHS trust) to provide a dialysis unit within a specified area.

The manager was registered with the CQC in April 2017.

The service is registered for the regulated activity of diagnosis and treatment of disease.

The service was previously inspected on 25 April 2012 with the report published in May 2012.

Our inspection team

The team that inspected the service comprised a CQC lead inspector a specialist advisor and another CQC inspector. The inspection team was overseen by Phil Terry, Inspection Manager.

Information about Worcester Dialysis Unit

Worcester Dialysis Unit is a 20-bedded unit that provides dialysis for patients with chronic renal failure. The unit was built in 2009 following the increased demand for dialysis in the Worcestershire area.

Fresenius Medical Care Renal Services Limited (Fresenius) is contracted to complete dialysis for local patients under the care of nephrologists at a contracting NHS trust. All patients attending Worcester Dialysis Unit receive care from a named consultant from the NHS trust, who remains responsible for the patient. Fresenius has 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, and regular contact with a dietitian. This team attend the unit regularly and assess patients in preparation for monthly quality assurance meetings.

The unit is open between 7am and 6.30pm from Monday to Saturday. It is currently providing treatment for 72 patients; all aged over 18 years of age.

During the inspection, we spoke 14 staff including registered nurses, health care assistants, reception staff, and senior managers. We spoke with six patients and one relative. We reviewed six sets of patient records and associated documents. We also received 29 completed comment cards.

Track record on safety from May 2016 to April 2017:

- No never events.
- No incidences of healthcare acquired MRSA.
- No incidences of healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- No incidences of healthcare acquired E-Coli.
- Five complaints.

Services provided via contract included:

- Domestic cleaning.
- Laundry and waste management services.
- Equipment maintenance.
- Water treatment plant maintenance.

Services accredited by a national body:

- ISO 9001 quality management system
- OHSAS18001 Health & Safety system

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 do not currently have a legal duty to rate dialysis services.

We found the following areas of good practice:

- Nursing staff were generally aware of their roles and responsibilities in the escalation of safeguarding concerns.
- The unit and equipment were visibly clean, with evidence of effective cleaning regimes and schedules in place. Staff were observed using effective precautions to maintain patient safety and reduce the risks of infection.
- The facilities were purpose built and met Department of Health guidance.
- There were systems in place for reporting, investigating and escalating incidents, both internally and externally.
- Equipment was maintained according to the manufacturer's guidance, with an adequate supply to cover maintenance or breakages.
- Patients' records were held securely, and staff had access to relevant information.
- Nursing staffing levels were maintained in line with national guidance.
- Systems and processes were generally in place to ensure that patient receive safe care and treatment. Medical advice was available, with direct access to the consultant or renal team at the NHS trust.

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

- Not all staff had completed safeguarding adults and children training in line with national guidance and corporate policy at the time of the inspection. The unit's safeguarding lead had not completed training in line with national guidance.
- We found that there were gaps in compliance with training including practical manual handling, preventing medicine errors and link representatives training. Not all staff had had duty of candour training in line with the provider's policy.
- Staff did not consistently follow best practice regarding timing of second checks prior to administration of medicines.

Summary of this inspection

- We were not assured from records that appropriate actions were being taken when fridge temperatures, including the medicines fridge, were out of range. This was raised during the inspection and actions were taken to address this.
- While patients were observed closely during treatment, the service did not use the National Early Warning Score system for monitoring a patient's risk of deterioration. This was on the unit's risk register.
- We found that some items were stored inappropriately, including, sodium chloride intravenous solution in the general storeroom. Subsequent to the inspection, this issue was resolved.

Are services effective?

Are services effective?

We do not currently have a legal duty to rate dialysis services.

We found the following areas of good practice:

- Policies and procedures were based on national guidance.
- There was appropriate monitoring of patient outcomes and the services performance.
- There were effective processes in place for gaining patient consent for treatment.
- Staff completed a detailed competency assessment on commencement to post and were reassessed annually. At the time of our inspection, 100% of staff had received their annual appraisal.
- Patients received regular assessment and support regarding nutrition.

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

- The service did provide with easy to read information in line with the Accessible Information Standard.

Are services caring?

Are services caring?

We do not currently have a legal duty to rate dialysis services.

We found the following areas of good practice:

- Patients were treated respectful, caring manner. This was reflected in the positive local annual patient satisfaction survey and patient feedback we received during the inspection.
- There was a walk round handover process, which was inclusive of the patient.

Summary of this inspection

- Patients could be referred by staff to access to support such as a social worker or psychologist if required.

Are services responsive?

Are services responsive?

We do not currently have a legal duty to rate dialysis services.

We found the following areas of good practice:

- Patients who required dialysis were assessed by the contracting NHS trust for suitability to dialysis in a satellite unit and then referred to this unit.
- The unit provided two dialysis sessions per day and did not have a waiting list for patients to commence dialysis.

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

- Some patients complained about delays encountered with patient transport. However, this service was not the responsibility of the unit and managers frequently liaised with the transport provider to resolve this issue.

Are services well-led?

Are services well-led?

We do not currently have a legal duty to rate dialysis services.

We found the following areas of good practice:

- Leaders had the appropriate skills and knowledge to manage the service.
- Staff had effective working relationships with staff from the contracting NHS trust, for example, the renal consultant.
- There were monthly quality assurance meetings to assess and monitor the effectiveness of treatment and tailor individual patient's dialysis plans.
- Governance tools such as risk registers were maintained to address risk and drive improvements to patient care.
- Performance of the unit was monitored, locally, corporately and during contract meetings with the NHS trust.

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

- The risk register for the service was set corporately and therefore did not describe the risks to providing care and treatment at a local level, specific to Worcester Dialysis Unit.

Detailed findings from this inspection

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- There was a clinical incident reporting policy that guided staff regarding reporting pathways. The unit had a system in place for recording, investigating and monitoring incidents. Staff were aware of their roles and responsibilities in the recording of incidents, both internally and externally.
- There were no serious incidents or never events reported from March 2016 to March 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There were four types of incident reports used by the service: treatment variance reports, non-clinical and clinical incidents and unit variance reports.
- Treatment variances were used to record when there had been a change from the expected dialysis treatment. We saw that any incidents or changes to the patient's normal dialysis session were recorded on treatment variance records (TVR). These treatment variances were documented electronically and formed part of the patient's dialysis record.
- Non-clinical incidents were those that related to health and safety. A health and safety incident form would be completed and sent to the provider's health and safety manager. We saw that this process was followed and the health and safety manager reviewed and signed off the incidents and considered any changes that may be required to risk assessments.
- All patient falls were reported. The provider categorised this as a non-clinical incident. There had been five patient falls reported in the twelve month ending May 2017, resulting in no or low harm. Action plans were developed to prevent reoccurrence.
- Clinical incidents included for example medicine errors. We saw that clinical incidents were reported investigated, action plans developed and staff were involved in debriefing to learn lessons. We also saw that staff involved in medication errors had their competencies regarding medicines reassessed.
- There had been two clinical incident reported regarding blood transfusions reported in the twelve months ending May 2017. These related to team communication and were classified as no harm events. They were investigated and action plans were developed to prevent reoccurrence.
- Clinical incident reports were completed and emailed to the regional area chief nurse and the provider's chief nurse. We were told that clinical incidents were monitored centrally with clinical updates, and we saw that learning bulletins were distributed by the chief nurse to support lessons learned across the organisation.
- Incidents and any learning arising from them were shared at team meetings and at staff handovers. We saw minutes from meetings, which evidenced feedback to staff regarding local incidents and actions to be taken.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The 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. There was policy relating to duty of candour, which outlined actions to be taken when something went wrong. Staff

we spoke with during the inspection told us that patients attended the unit frequently and they built close relationships with them. They said that they were open and honest with patients and would discuss anything that may affect care and treatment. We could see that when incidents were reported, patients and their relatives (when appropriate) were informed.

- The clinic manager had completed training in duty of candour. However, this was also mandatory for the deputy clinic manager and team leaders and they had not completed this training. This meant that we could not be assured that they could support staff and understand the steps to follow when something goes wrong.
- There had been one incident graded as moderate in 2017, reported by the service. There was evidence to suggest that they kept the patient and relatives informed. It was not clear whether the service complied with all the requirements of the duty, such as offering to share the outcome of the investigation.
- Patient safety alerts were distributed centrally from the provider's head office to the clinic manager for sharing with the team.

Mandatory training

- All the staff at the unit had to complete mandatory training. This included annual updates regarding infection prevention and control, anaphylaxis, basic life support, fire training, and manual handling. This was in addition to three yearly training in safeguarding adults and children, slips, trips and falls training, practical manual handling and fire marshal training. There were e-learning modules that were also completed including legionella, control of substances hazardous to health regulations (COSHH) and disability discrimination.
- Face-to-face training was provided at a local centre, and staff were rostered into attending sessions.
- Compliance with training was reviewed at annual staff appraisals and monitored by the deputy clinic manager and the clinic manager. We saw that there was a spreadsheet maintained to facilitate this. Some aspects of the training for example basic life support, had 100% compliance (excluding one new healthcare assistant). However, there were some gaps noted in compliance with mandatory training. Particularly practical manual handling, preventing medicine errors (see medicines management) and safeguarding training (see safeguarding). We requested a copy of the annual training plan issued by the training and education department; along with any mitigations or action plans to improve compliance. However, this was not provided.
- Mandatory manual handling practical training was not up to date. Only six out of 16 (38%) staff were up to date with practical manual handling training. We discussed this with the clinic manager and the area chief nurse. They explained that the training was delivered by an external company and there had been some delays. They felt that the risk relating to this was low as this was an update and 100% of staff were up to date with the theory manual handling mandatory training module. We saw that all the staff had dates allocated for training to take place in the next few months. However, this was documented on the units risk register.
- Mandatory training was completed annually or three yearly depending on the topic. The majority of courses were completed through e-learning, and could be accessed from staff home computers following a secure log in.
- After the inspection, the senior managers told us that due to the first come, first serve basis for booking classroom study days, some staff were not able to book in the earlier slots so practical manual handling training for some staff had expired before their booked dates. All staff were up to date with their e-learning manual handling interactive course.
- All unit staff had access to an electronic safety-learning platform. This held details of the mandatory training that was required to be undertaken.
- Staff were able to use the clinic rooms for training when the unit was quiet. We saw this during inspection, when one nurse was released from clinical duties to update their mandatory training.

Safeguarding

- Staff were aware of their roles and responsibilities for escalating safeguarding concerns. Nursing staff told us they had not had to report or escalate many safeguarding concerns but were able to talk through scenarios and were clear about their responsibilities. Staff were able to describe examples of what they would consider a safeguarding concern and how they would escalate it.

- There was a corporate policy that reflected national guidance to advise staff regarding their responsibilities regarding safeguarding. This contained flowcharts to advise what actions to be taken.
- The clinic manager was the unit's lead for safeguarding and had completed level two training. However, they had not completed adult safeguarding training to the required level (level three). This meant that we were not assured the clinic manager was trained to the appropriate level for their role in order to protect the adults they were caring for from abuse.
- At the time of our inspection, 13 out of 16 (81%) staff had completed safeguarding adults' level two training. We requested details of training targets, however this was not provided.
- The unit did not treat patients under the age of 18 years and children were generally not allowed on the premises. However, staff were required to complete level two safeguarding children training. Records showed that three out of sixteen (19%) staff had completed this. We requested details of any mitigations or action plans to improve compliance. This was not provided. This meant that we were not assured that staff were trained to the appropriate level for their role in order to protect children associated with the adults they were caring for from the risk of abuse.
- The provider took action to address this lack of training after we had raised it as a concern.

Cleanliness, infection control and hygiene

- The unit was visibly clean. Domestic cleaning was subcontracted to an external provider. This general cleaning was completed outside normal business hours. Staff were able to escalate any concerns to a supervisor by telephone but did not have regular meetings to discuss performance. Senior staff told us that the domestic supervisor audited the unit monthly and discussed the result with the clinic manager and feedback was provided to staff.
- We saw that dialysis stations were cleaned thoroughly at the end of each dialysis session.
- Daily checks were allocated to staff and recorded in a file kept at the nurse's station. We saw that a timetable detailed checks to be completed on a daily basis. This included tasks such as cleaning the utility room, weighing scales and wheelchairs, disinfecting spare dialysis machines and flushing non-regular use water points. Records viewed showed that all checks had been completed since the beginning of May 2017.
- The unit had four side rooms, which were observable from the workstation. Each side room had a clean room or anti chamber where staff prepared to enter the room. These chambers included a handwashing sink, personal protective equipment storage and clinical waste facilities. We were told that patients using the rooms were mainly isolated due to blood borne viruses.
- Clinical waste was segregated from domestic waste and stored in a locked waste room. We saw that waste bags were sealed appropriately and not over filled. Full sharps boxes were stored in the clinical waste room and collected by an external provider monthly.
- Water used for dialysis needs to be specially treated to prevent risks to patients. There was a large water treatment room, which was monitored remotely by the manufacturer. This enabled them to identify any issues with supply, effectiveness of treatment or leaks. In addition to the remote monitoring, staff had telephone access for emergencies.
- On a daily basis, nursing staff monitored the water supply. In the event that a result showed an anomaly, staff would contact the engineers for an urgent review. Water testing was completed daily to ensure that water used during dialysis was free from contaminants. This was in line with guidance on the monitoring the quality of treated water and dialysis fluid. 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.
- Equipment was cleaned between patients. Dialysis machines completed a disinfectant wash. A specific disinfectant was used to clean the dialysis machines.
- Staff used appropriate aseptic non touch techniques to attach patients to their dialysis machines. This was completed through either the insertion of large bore needles into an arteriovenous fistula/ graft or central line. Arteriovenous fistulas (AVFs) are an abnormal connection or passageway between an artery and a vein created through vascular surgery specifically for dialysis. Grafts (AVGs) are artificial veins inserted for dialysis, and central lines are larger cannulas that are inserted for long periods for dialysis.

- We observed that staff wore appropriate personal protective equipment for interactions with the patients. Patients and staff wore facemasks when connecting or disconnecting patients to dialysis catheters.
- We saw staff washing their hands appropriately, using correct techniques, to maintain patient safety. This included before and after any patient contact
- Patients were screened for MRSA monthly and this was coordinated with the monthly virology blood screening.
- There was guidance for staff regarding patients who return from holiday at high risk destinations. This included details of screening and isolation precautions.
- The infection prevention and control link nurse was responsible for completing monthly local audits. Results of the audits showed 100% compliance including general cleaning standards and handwashing practice.
- Unit staff were required to undergo an infection prevention and control annual competency assessment. Records indicated that staff were up to date with this at the time of inspection.
- The provider informed us that a corporate sepsis policy was under development. Sepsis is a life-threatening condition, when the body's response to infection causes injury to its own tissues and organs. Staff at the clinic followed the NHS trust's sepsis guidelines, with any patients thought to be unwell being referred directly to the renal team for an urgent medical review.
- From April 2016 to May 2017, the centre reported no cases of healthcare acquired infections such as MRSA or Methicillin-sensitive staphylococcus aureus (MSSA).

Environment and equipment

- The Department of Health provides best practice guidance for the design and planning of new healthcare buildings and the adaptation or extension of existing facilities, via health building notes. Worcester Dialysis Unit facilities were in line with 'Health Building Note 07 01: Satellite dialysis units' (2013).
- There were systems in place to monitor and manage the maintenance of equipment for the service. This included the dialysis machines and other clinical equipment. There was also a helpdesk provided for staff to raise any issues. All equipment we checked during the inspection had been electrical safety tested. The nursing staff received training on the equipment in use.
- The unit had three spare dialysis machines that could be used in an emergency or as a replacement while maintenance was taking place. These were stored in the technician's room, ready for use.
- We saw the maintenance log for dialysis machines. This detailed dates of machines being reported and all were serviced.
- There were patient wheelchair weighing scales at the unit. There was also spare weighing scales available.
- Staff were allocated their own visors, for personal protection. Staff cleaned these before each use and the spare visors were cleaned on a weekly basis.
- We saw that equipment was electronically tested and serviced annually. This included a patient hoist.
- The unit had equipment to be used in case of a clinical emergency. The resuscitation trolley was located in the main unit. The trolley had been checked every weekday and the equipment was fit for use. We saw that single use items were clearly identified.
- The resuscitation trolley was not locked but was observable from the workstation. There was minimal risk that it could be tampered with. Emergency medicines were stored in tamper evident packaging.
- The unit had a water treatment facility, which was monitored daily by nursing staff. We were told that this was checked by the first member of staff attending the unit in the morning. This made sure that the water supply was appropriate before the dialysis machines were switched on for treatment. Technicians were available through a 24 hour on call service. Any incident was reported and logged to the head office, and then technicians were contacted by the head office. This meant that the head office had an oversight of the maintenance issues in each unit.
- Waste was managed appropriately with the segregation of clinical and non-clinical waste. Bins were not overfilled and were emptied regularly. We were told that filled bin bags were stored in secure units awaiting collection.
- We were not assured that the fridge temperatures, throughout the unit were being escalated and actions taken when they were not within range. This included the blood sample storage fridge, patient's food and separate staff food fridges. We informed the clinic manager who would address this. We were also told that the staff fridge had been recently replaced.

- During the inspection, we found that some items were not stored appropriately. These included sodium chloride solutions in a general storeroom and corrosive liquids in the linen room. At the unannounced inspection, we saw that these issues had been rectified.
- The corrosive liquids were found stored in unlocked cupboards in the dirty utility room and the technician's room. These rooms were not locked but they were in an area of restricted access in the service corridor.
- All staff at the unit (except a new member of the team) had completed mandatory training regarding COSHH at the time of our inspection.

Medicine Management

- The unit had processes in place for the safe management of medicines. Patients attending would receive prescribed medicines as necessary for their dialysis treatment.
- Controlled drugs (those requiring extra security of storage and administration) were not used or available on site.
- Medicines were stored in the treatment room, which was located off the main unit. We found that the treatment room was locked at all times during the inspection, with the nurse in charge holding the keys. All cupboards and the medicine storage fridge were locked.
- The ambient room and refrigerator temperatures were checked and recorded daily. However, there were three readings since the beginning of May 2017, which detailed elevated temperatures. Staff had followed recorded instructions and reset the thermometers. However, there was no evidence that these had been escalated to the clinic manager.
- We checked medicine fridge records during the unannounced and found that there were three more occasions when readings were not within range. This meant that the fridge had been recorded outside recommended parameters on five out of 14 days. Temperature was above 19 degrees Celsius on four of these occasions. Therefore, we were not assured that temperature sensitive medicines were being stored appropriately. We raised this during the inspection and the clinic manager subsequently informed us that they took action including assessment of the risk, training of staff and increasing manager's spot checks of fridges from monthly to weekly.
- Boxes of sodium chloride solution for intravenous administration were found in the general storeroom. We brought this inappropriate storage to the clinic manager's attention at the time of the inspection. At the unannounced inspection, we found that these intravenous solutions were now stored appropriately in the clean utility room.
- During the inspection, we looked at six medicine charts and found that the medicines were all clearly prescribed. We saw that the charts included the patients' details, their weight, allergy status and were dated with review or renewal dates. The prescriptions were validated with a signature, although the name was not printed for ease of reading.
- We saw that when medicines were administered, two nurses completed a verbal patient identity and medicine check and we saw that medicine charts detailed two signatures next to each medicine when administered. This was in line with the Nursing and Midwifery Council standards for medicines management. However, nursing staff told us that for sodium chloride solution flushes, one nurse checked the medicine when distributing it to each dialysis station and then the nurse attaching the patient to the dialysis machine checked the medicine before administering it (at the start and the end dialysis sessions). We escalated this to the clinic manager at the time of inspection and they stated they would review medicines procedures. At the unannounced inspection, we found the practice of second checking in advance rather than at the time of administration continued in some cases. However, this was not best practice and increased the risk for medicine errors.
- There was mandatory training for all registered nurses at the unit to complete regarding preventing medicine errors. None of the staff had completed this at the time of our inspection. However, we saw that dates were arranged for the clinical manager and their deputy to complete this.

Records

- Patients' records were held both electronically and in paper format. We saw that the electronic records detailed dialysis sessions by date and time. This meant that any changes in treatment or any problems occurring during the session could be easily identified.
- Patients' details and dialysis information was recorded electronically and automatically uploaded to the national database at the parent NHS trust hospital.

- Patients' weights were recorded on cards, which were inserted into the weighing scales and then the dialysis machine. The card recorded details of the patients last four dialysis sessions.
- Patient cards were stored in boxes according to the dialysis day and session, for example, Monday morning cards were held separately to Monday afternoon cards.
- Patients collected their card from a box in reception and inserted it into the weighing scales for that days recording, prior to the card being inserted into the dialysis machine. Patient cards were labelled with the patients initial and surname.
- We reviewed six patient records. Each file contained a dialysis prescription, consent for treatment, medicine chart, any completed early termination of treatment forms, dialysis pathway, copy of blood results and an admission assessment document. We found that paper records were completed appropriately and signed and dated as required.
- We saw that the consent forms and admission assessment documents were completed upon referral to the service and not usually updated or renewed. This was in line with corporate policy. We noted one exception to this when a patient's clinical condition had changed, their admission assessment was updated to detail changes in mobility.
- We saw blood results in each patient' file. These were ticked to confirm that they had been reviewed but had not been signed or dated to confirm the review. This meant that it was not clear when the review had taken place or by whom. All of the patients' blood results were formally reviewed during quality assurance meetings each month.
- Staff completed information governance training as part of their induction and annually thereafter. Training compliance at the time of the inspection was ten out of sixteen (63%) staff were up-to-date with this training.
- Standard of record completion was audited each month. We saw the audit results for March to May 2017 and there was one error noted regarding lack of post dialysis temperature recorded on one occasion.

Assessing and responding to patient risk

- There were systems and processes in place to provide safe care and treatment.
- Patient's details were held on an electronic system and each patient had their own electronic card. We saw that these cards were labelled with the patients details and kept in boxes according to the sessions they attend. We observed staff checking patient identity against the prescription charts, dialysis machine and patient weighing card. We also observed patients being asked to confirm identity prior to commencement of treatment.
- Patients had clinical observations recorded prior to commencing treatment. This included blood pressure, pulse rate and temperature. We saw that nursing staff discussed the frequency of blood pressure recordings with patients when commencing dialysis.
- The nurse reviewed any variances prior to commencing dialysis, to ensure the patient was fit for the session. Treatment variance reports were used by staff to electronically record any issues that occurred during dialysis, such as low blood pressure. This record could remain open, which would then alert the staff at the start of future dialysis sessions that this had been a problem. This would ensure that staff were up to date with previous episodes and could take any necessary precautions.
- The service had access to the provider's policy to guide staff regarding patient complications, reactions and other clinical events including, seizures, chest pain and technical complications during dialysis. It outlined staff responsibility related to training, escalation, and if required emergency transfer of patients. The unit did not use an early warning system, such as the National Early Warning Score. Patients were monitored closely before, during and immediately post dialysistreatments. The lack of formal early warning score was documented on the unit's risk register.
- Patients who were unwell on arrival to the unit or during dialysis were referred to the nurse in charge for a review and the satellite haemodialysis unit coordinator (from the NHS hospital) for advice. The consultant or the on call renal team at the parent trust would be contacted for an urgent review if required.
- In clinical emergencies, nursing staff called 999 ambulance services to support and transfer patients to hospital. There was resuscitation trolley available at the unit and a policy in place to guide staff regarding these incidents including their reporting requirements. We saw that there had been seven transfers via 999 from January 2017 to May 2017.
- Staff assessed patient's central lines access for signs of infection. For example, a patient with redness to their line site attended the unit; staff contacted the medical

staff who advised that the patient be to be transferred to the renal unit at the NHS trust. Blood cultures that were taken showed a bacteraemia (presence of bacteria in the blood).

- The unit had a document called a patient concerns' register. Staff would document any concerns that may affect the patients care such as low blood pressure following dialysis. The concerns or issues were detailed followed by progress updates, including escalation details if required. The clinic manager was responsible for maintaining the register.
- We were told that patients with any renal related illnesses could bypass the emergency department and be admitted directly to the renal unit at the NHS hospital.
- We saw that one patient became unwell while on dialysis. Nursing staff were attentive to the patient's needs, completing clinical observations and reducing the dialysis pump speed to ensure patient safety. The patient was referred to the satellite haemodialysis unit coordinator (who was onsite visiting the unit) and the on-call team at the parent hospital for advice on treatment. We saw that the patient was kept informed of actions and outcomes of discussions. The staff called the patient's family to inform them and gave advice about monitoring the patient when at home. We saw that this information was recorded in the patients' notes.
- 100% of staff were up to date with training in basic life support and use of the automated defibrillator (available at the unit).
- During our inspection, we saw that dialysis machine alarms were responded to within a few seconds. Alarms would sound for a variety of reasons, including sensitivity to patient's movement, blood flow changes and any leaks in the filters.
- Each patient had a mobility risk assessment completed on referral to the service. We saw that this was updated if mobility changed.
- Patients' nutrition was assessed using the malnutrition universal screening tool (MUST). These were completed a minimum of monthly and updated weekly if identified at risk.
- There were systems and processes in place for patients to receive blood transfusions at the unit.
- Any patients, who participated in their own treatment, were assessed for competence before being allowed to manage their treatment independently. Patient folders contained a booklet to document patient's self-care training. At the time of the inspection, two patients were fully competent to self-care including needling their fistulas.
- If patients had dialysis via lines rather than a fistula there had to be an explanation documented on a risk register. This was part of the contract with the NHS trust.

Staffing

- Staffing planning took place via an electronic roster system to ensure compliance with staffing ratios. This was completed eight weeks in advance by the clinic manager and approved by the regional business manager.
- At the time of our inspection, the staffing consisted of 10.6 full time equivalent (FTE) registered nurses and 3.6 WTE health care assistants (HCA). There was a new HCA due to start and then there would not be any vacancies. There was a member of the team on maternity leave and cover had been arranged.
- Staff predominantly worked long days, which were 7am to 6.30 pm. We reviewed the duty roster and saw that staff worked a combination of short and long day shifts. We saw on the May/ June 2017 duty roster that some staff worked three consecutive long days and up to four days together. However, staff told us that routinely, they did not work more than two days consecutively.
- Staffing ratio consisted on one qualified nurse to four patients. We saw that patient and nurse allocation was clearly displayed on the unit white board, with staff allocated to a number of dialysis stations, for example, one nurse to stations one to four.
- We checked rotas during the inspection, and found that planned staffing levels were maintained to meet patients' needs. Sometimes the clinic manager covered short-term absence of staff. Temporary staff such as bank and agency were also used.
- We were told that bank staff were employed from the provider's own renal-trained team. We saw that often the same three members of bank staff had covered recent gaps in staffing. These staff members were trained by the provider and familiar with policies, procedures and equipment. The head office were responsible for monitoring the bank staff training and competencies. Agency staff were accessed as a last resort.

- Information provided showed that five clinical shifts had been covered by the provider's trained bank staff in the three months ending April 2017. Agency staff had covered four shifts in the same period.
- We checked local induction sheets for temporary staff that had recently worked on the unit. One had an induction sheet completed on the day of their shift; another had been completed the week before when they had worked their first shift. However, we found that one nurse had not had an induction sheet completed since 2015. We checked the corporate policy regarding the induction checklist and found that it did not specify when the form needed to be completed. Subsequent to our inspection, the clinic manager had raised this with the team and requested that local induction forms were always completed. At our unannounced inspection, we found that staff had completed an induction form on the day the temporary worker attended their shift.
- Sickness rates were low with rates of 1.2% for qualified staff and 2.7% for healthcare assistants (February to April 2017).
- There were systems in place to support staff regarding return to work following absence. This included a corporate employee assistance programme accessed via human resources.
- Due to working in an isolated unit, that was not located at the NHS trust, staff were responsible for the management of any untoward incident or emergency. The duty roster was created to ensure that there was always a senior member of staff on duty to ensure that staff had access to a more experienced member of staff.
- The clinic manager worked 8am to 4pm, Monday to Friday and completed a clinical to managerial work ratio of 30% to 70%. This was flexible according to unit activity and the manager completed clinical shifts where necessary, to maintain safe nurse to patient ratios.
- Medical care was provided by the renal team at the contracting NHS trust. The unit had a dedicated consultant who attended weekly. Outside the normal weekly visit, the consultant was available for telephone advice, and contactable by email. We saw this in practice during inspection.

Major Incident awareness and training

- Patients attending the unit who rapidly deteriorated were referred to the emergency services and transported to the most appropriate location. For example, if the deterioration related to the patients dialysis, the patient was transferred to the parent acute trust. If the patient as unwell for another reason, they were transferred to the nearest acute trust.
- The unit had a tailored 'Emergency Preparedness Plan' (EPP) in place, which detailed the plans for the prevention and management of potential emergencies. The plan included roles, responsibilities, and contact details for emergency services.
- The unit's EPP also included prevention of fire, loss of electricity, loss of computer systems and site evacuation due to possible emergencies. These included; gas and water leaks, storm damage and building collapse.
- The unit was registered as requiring essential utilities, which meant that in the event of a local electrical failure or loss of water the centre would be reconnected as a priority.
- Staff told us that there were adequate supplies of dialysis equipment for a two-day delay in delivery. In the winter months, the excess stores increased to five days to allow for bad weather.
- We saw that generic risk assessments were displayed across the unit at locations of escalated risk. For example, we saw that there was an assessment detailing the risks associated with bicarbonate powder, detailing correct storage and actions to be taken in the event of a spillage.
- There was a poster displayed in the unit reception, detailing the emergency evacuation plan. This was dated February 2015.
- The unit completed weekly fire checks, which involved the checking of firefighting equipment, fire exits and hazardous areas. We saw that there was a checklist, which had been completed weekly was kept at the workstation.
- Staff completed fire training each year via e-learning. At the time of the inspection, two staff needed to complete this (one of which was a new member of the team). The clinic manager and their deputy had also completed training in fire risk assessment and fire marshal training.

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

Evidence-based care and treatment

- The unit had an International Organization for Standardization (ISO) accredited integrated

management system to ensure that policies and procedures supported best practice evidence. The policies and procedures were required to be reviewed annually to ensure that they were still based on current evidence.

- The policies and procedures were developed in line with national guidance, standards and legislation. This included guidance from the Renal Association, National Service Framework for Renal Services and the National Institute for Health and Care Excellence (NICE).
- We saw that the IT systems used enhanced the collection of data and ease of monitoring. This was largely due to the system uploading data collected during dialysis to the NHS trust database. Similarly, staff at the unit were able to access records at the trust; reducing time spent requesting blood and test results.
- Staff monitored and recorded patients' vascular access each time the patient attended for treatment. Patients were predominantly dialysed through arteriovenous fistulas. We saw that some patients had less established fistulas and were told that more experienced staff were responsible for cannulating these patients. This was in line with the NICE Quality Statement (QS72) statement 4 (2015): 'Dialysis access and preparation'.
- The centre met the national recommendations outlined in the Renal Association 'Haemodialysis Guidelines' (2011). For example, Guideline 5.7: 'The monthly measurement of dose or adequacy of haemodialysis' and Guideline 6.2: 'Monthly monitoring of biochemical and haematological parameter (blood tests)'.
- The unit was not responsible for any patients who completed their dialysis at home. These patients were managed by the NHS trust.
- The centre 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 audit programme to assess their effectiveness. This included healthcare documentation and infection prevention and control, and hand hygiene audits. For example, we saw audit results for infection prevention and control showed 100% compliance from January 2017 to May 2017.
- The area chief nurse supported the clinical manager with completion of audits of clinical practice such as hand hygiene, especially in response to identified poor compliance.
- Records were audited each month at the clinic for compliance with policy. We saw the audit results for March to May 2017, and there was one error noted regarding lack of post dialysis temperature recorded on one occasion.

Pain relief

- Patients' pain relief needs were assessed and managed appropriately. Patients did not routinely receive oral analgesia during their dialysis sessions: however, local analgesia was available for cannulating the patients' arteriovenous fistula or graft (AVF/G).
- We saw that patients were prescribed paracetamol for pain control. Of the six charts we reviewed, paracetamol was not required often.
- We were told that most patients preferred not to use local anaesthetic for the needle insertion as this meant they had two needles inserted instead of one. For example, one needle containing local anaesthetic and the second needle for dialysis. Needling is the process of inserting wide bore dialysis needles into the AVF/G, which some patients find painful.
- Any issues identified with pain were discussed initially with the nursing staff who escalated concerns to the NHS trust renal consultant.

Nutrition and hydration

- Patients in renal failure require a strict diet and fluid restriction to maintain healthy lifestyle. We were told that patients were reviewed by the dietitian monthly who assessed their past medical history and their treatment plans to advise patients on the best diet for them.
- The dietitian was employed by the NHS trust and part of their role was to support satellite dialysis units.
- The dietitian attended the monthly quality assurance meeting to advise and support the patient's individual plan. At this meeting, the patients' nutritional, fluids and blood results would be assessed.
- Some patients were observed weighing themselves prior to dialysis, and inputting this into the dialysis machine. Nursing staff told us that patients were encouraged to participate in their treatment to different levels.

- Patients' nutrition and hydration was assessed at each visit, through weighing and a review of the Malnutrition Universal Screening Tool (MUST) score.

Patient outcomes

- Their renal consultant from the NHS trust defined the patient's treatment plan. The renal consultant provided clinical oversight at the unit and was also the responsible consultant for all the patients attending the unit. Individualised treatment prescriptions were developed to aim for positive patient care outcomes.
- We saw that the patients' blood results, progress and general condition was considered at monthly quality assurance meetings. Any changes to treatment parameters or referrals to other services were coordinated by the clinic manager or deputy and reported to the clinical staff for further action.
- Patients were weighed on arrival to the centre 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 and formed part of their dialysis treatment plan, which was adjusted as required.
- The patients' blood was tested each month as per the schedule set by the NHS trust consultant. The blood results and treatment data were captured by the electronic database. This data system provided customised reports and trend analysis to monitor and audit patient outcomes and treatment parameters.
- Electronic patient outcome data was available to the clinic manager and consultant, in order to monitor and audit individual patient performance and identify where improvements could be made. The clinic manager explained that when they started at the unit (February 2017), some of the indicators for effective dialysis were not being met. The corporate data application specialist came to the unit to support the clinic manager and identify improvements. These included, for example checking the type of access lines that were being used to improve the effectiveness of dialysis.
- Dialysis information was collected centrally at the parent hospital, and automatically uploaded from the dialysis machines.
- The unit did not directly contribute data to the UK Renal Registry. However, the unit's data was uploaded to the national database from the NHS trust. Data specific to the unit was available via the provider's own database and was used to benchmark patient outcomes and to drive improvements in the service. For example, for May 2017, the unit met or exceeded the target of 70% for effective dialysis indicators including weekly treatment time, infusion blood volume and Kt/V. Kt/V is used to measure how effective a haemodialysis treatment is. It is based on tests of blood urea, by measuring the levels before and after treatment, to show how much has been removed.
- A clinic review report was completed monthly by the clinic manager for review with the area chief nurse. This included, number of patients who had required hospitalisation, fistula access versus lines, efficiency of dialysis indicators and number of patients that did not attend for sessions.

Competent staff

- We saw that there were systems and processes in place to ensure that staff were competent to deliver safe care and treatment.
- The pre-employment of staff was managed by a central human resources' team and progress with pre-employment checks was monitored by the business manager. This included disclosure and barring service (DBS) checks. A start date would not be provided for a new member of staff until all checks were fully completed.
- Staff completed a six to eight week supernumerary induction programme on commencement of post. This included specialist training in theoretical and practical skills. We were told that new staff started with a smaller number of patients to gain confidence in techniques before building up to four patients. One staff member told us the induction period could be extended if necessary although staff were usually confident to start to have their own clinical workload at the end of the induction period.
- Classroom training was provided to new staff included subjects such as:
  - Introduction to chronic kidney disease, and care and management of the dialysis patient.
  - Vascular access.
  - Infection prevention & control in the dialysis unit.
  - Patient assessment and documentation.
- New staff (with no renal experience) were allocated patients with established fistulas or dialysis catheters, to develop their clinical skills before being made responsible for patients with recently established or difficult vascular access.

- Each staff member had a training folder, which was held in the clinic manager's office. These detailed records of training attended and competencies. Staff told us that the clinic manager informed them when training was due for renewal.
- When necessary, additional staff were sought from the organisations bank or through an agency. Staff were required to be experienced with dialysis and where possible, familiar with the unit. Staff reported that they often used the same nurses who were familiar with the local policies, procedures and patients.
- Annual appraisals identified any areas for development and an agreed timescale for completion. All staff completed competencies, and these were reviewed annually as part of the staff member's appraisal. 100% of staff had completed their annual appraisal at the time of our inspection. The clinic manager and the deputy clinic manager completed the appraisals for the team.
- All staff were required to undertake an annual reassessment of competence. For example, general trained nurses assessments included the use of the dialysis machine, to demonstrate skills in assessment and management of patient's vascular access and to demonstrate clinical competence related to 'nephrocare standard good dialysis' guide. During the inspection, we checked five registered nurse folders and found evidence of an annual assessment of competence in all applicable cases.
- The area chief nurse supported the unit with training monitoring and delivery. There were face-to-face training sessions available for certain subjects at regional training centres.
- Some registered nurses at the unit had completed external renal courses. The number was not clear from the training matrix provided. Information subsequently provided, showed that three staff had completed this training. The matrix indicated that completion of this course was mandatory for deputy clinic managers. However, they had not completed this.
- The clinic manager had a monthly system in place, to check that training nursing staff were registered with the Nursing and Midwifery Council.
- The unit had link nurse representatives for areas including, infection prevention and control, health and safety, information management systems, venous access and patients holidays. However, we saw from the training matrix that staff had not attended training for link representatives in health and safety, information management systems or the electronic renal patient management system. In the meantime, the registered manager was supporting staff with these roles.
- Staff were required to undergo the NHS training for blood transfusions. However, the training matrix provided to us on inspection was blank for blood transfusion training. We requested this information from the clinic manager who informed us that there were six staff trained out of 11. At the time of our first site visit, there were three staff with this training. This meant that not all staff had been provided with the training to give patients' blood transfusions.
- The area chief nurse provided unannounced resuscitation scenario simulation skill sessions at the unit. The latest was in April 2017. Following the session there would be a feedback for areas to improve.

Multidisciplinary working

- The multidisciplinary team, worked effectively to provide dialysis treatment at Worcester Dialysis Unit.
- The NHS trust provided specialist support for patients with the exception of nursing staff who were employed by the provider.
- The trust consultant and the renal dietitian attended monthly multidisciplinary team (quality assurance) meetings at the unit. The clinic manager or a designated deputy and the satellite haemodialysis unit coordinator also attended these meetings.
- The nursing team were supported by the satellite haemodialysis unit coordinator. Their role was to provide a link between the satellite units and the parent NHS trust. The satellite haemodialysis unit coordinator was often the first point of contact for staff with problems associated with patient care or processes. We saw that they had an open relationship with the unit staff and attended the clinic regularly.

Access to information

- Staff had access to information they needed to deliver effective care and treatment.
- There were electronic and paper based healthcare records. Paper records consisted of patient risk assessments, consent forms and dialysis and medicine prescriptions. This enabled patients' dialysis treatments to continue in the event of a computer issue preventing the data to be uploaded from the database.

- Electronic records, including those from the NHS trust and blood test results, were accessible to staff attending the unit. For example, the renal consultant could access records held regarding patients at the NHS trust while attending the unit.
- Staff had access to the parent hospital database and blood reporting systems. This enabled patients' clinical condition to be tracked and staff to have access to the most up to date information and investigation results.
- Dialysis away from base (holiday) patient requests were made via head office to the unit. There were systems in place to ensure that the clinic received the relevant information required to ensure that holiday stays could be managed safely.
- We saw that policies and procedures were available and accessed electronically.
- GPs received notification in the post of any changes to treatment following the monthly quality assurance meetings.

Equality and human rights

- From 1st August 2016 onwards, all organisations that provide NHS care were legally required to follow the Accessible Information Standard. The standard aims ensure that people who have a disability, impairment, or sensory loss are provided with easy to read information and support to communicate effectively with health and social care providers.
- The unit provided care for a patient with a learning disability at the time of the inspection. Staff were able to assist patients who required additional support by allocating staff accordingly and working with the patient's usual carers. However, the service did not have any easy to read versions of information leaflets. After the inspection, senior managers told us that at the time of the inspection, no current patients needed an easy to read leaflet. There was a poster in the waiting area in different languages informing patients and visitors to talk to the clinic manager if they needed any documents translated. An interpreter was also available if needed which was included in the patient agreement to treatment and data protection consent leaflet.
- The Workforce Race Equality Standard (WRES) is a requirement for organisations that provide care to NHS patients. This is to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The centre was located in a culturally diverse area and staff employed by the service reflected this. However, there was not a formal report for the location and we were informed that this had been added to the risk register at a corporate level for the provider.

Consent, Mental Capacity Act and Deprivation of Liberty

- Staff were aware of 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.
- The unit staff had completed training regarding consent, mental capacity and Deprivation of Liberty Safeguards. Four out of sixteen staff were required to attend this training (three of which, were new staff). Nursing staff told us that currently they did not have any patients who lacked mental capacity.
- Staff told us and we saw evidence that consent to receive dialysis treatment was obtained and documented on referral to the service. However, there was not a review of this consent. This was raised with nurses during the inspection, Staff discussed that patients attended their dialysis sessions and accepted treatment and therefore consent was assumed. This practice was in-line with the corporate consent policy.
- If staff suspected any changes to patient's mental capacity, this would be escalated to the nurse in charge and the consultant, to review the patient. Mental capacity assessments would be completed by the consultant and nurse in charge. Alternatively, patients could be referred to their GP for an urgent review. Staff reported that this had not yet been required, but they were aware of their responsibilities related to the Mental Capacity Act 2005.

Are dialysis services caring?

Compassionate care

- We saw that all staff interactions with patients were respectful and considerate. Staff spoke politely to patients and were supportive. We saw that staff were responsive to the patients' needs, including calls for assistance, alarms on dialysis machines and any non-verbal signs of distress.

- We saw that staff assisted patients to mobilise as necessary. They were not rushed, were spoken to respectfully and treated with dignity. Staff made sure that patients were well following treatment prior to leaving patients in the reception to wait for transport.
- We observed that the patients and staff had developed appropriate friendly relationships. There was general chat and appropriate use of humour. We saw that staff spent time talking to patients throughout their treatments and their waiting time before and after.
- Patients we spoke with were very complimentary about the unit, the staff and the treatment received. One patient told us they felt that they received exceptional care. This was also reflected in the 29 comment cards completed by patients and carers during the inspection period.
- We saw that the latest annual patient survey results were displayed in the reception area. The survey from 2016 stated that 83% patients would recommend the service, 86% of patient had confidence in the nurses, 88% found the unit well maintained and clean, 90% thought the service was managed well, and 98% found the service friendly. The survey also showed that 59% thought the introductory dialysis process could be improved, 69% found that clearer instructions should be given on caring for dialysis access, and 58% found the stations comfortable. Actions had been detailed to improve these figures including the purchasing of new chairs and mattresses, an education programme for patients and introduction to dialysis meetings.

Understanding and involvement of patients and those close to them

- It was the provider's corporate policy for staff to allocate a named nurse to all patients. The named nurse's role included keeping the patient informed regarding blood results and treatment plans. This encouraged patients to be involved in decisions about their care and treatment.
- Patients we spoke with during the inspection, knew who their named nurse was.
- Staff had recently started to do a walk-round handover (rather than at a workstation), which was inclusive of the patients. Staff told us that patients had reported preferring this, as it gave them the opportunity to speak to the nursing team and discuss any concerns. During the inspection, we joined a walk round handover and found that the patients appeared to welcome the opportunity to talk with the team.
- We saw that staff were inclusive of patients when completing tasks or procedures, involving them in their dialysis planning and treatment. We saw a patient being assessed by the nurse immediately prior to attachment to the dialysis machine and a discussion about taking additional fluid off to prevent leg swelling. The patient's dialysis history was checked prior to ensure that the patient could cope with the process.
- Patients could participate in their own treatment and we saw that the majority weighed themselves at the start and end of each dialysis session.

Emotional support

- Staff were aware of the impact that dialysis had on a patient's wellbeing, and supported patients to maintain as normal life as possible.
- Staff encouraged patients to continue to go on holiday, and participate in the management of their treatment.
- Patients were helped by the nursing staff to access support and additional services as necessary, such as social workers or psychologist.

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

Service planning and delivery to meet the needs of local people

- The unit was opened in 2009 and had been converted from an industrial unit, in line with specifications outlined in the health building notes. The Department of Health provides best practice guidance for the design and planning of new healthcare buildings and the adaptation or extension of existing facilities, via health building notes. Worcester Dialysis Unit facilities were in line with Health Building Note 07 01: 'Satellite dialysis units' (2013) guidance.
- There were four main areas that included a reception, staff area (rest room and changing rooms), treatment area and service corridor.
- The reception area was large and held approximately 20 chairs. The reception area was accessed through a ramp

and through secured doors. The front door call bell was opened remotely by either the unit receptionist or nursing staff. The receptionist worked 10am to 4pm daily and their role included general administration support for the unit. Outside these times, a shutter could be closed to prevent unauthorised persons accessing the receptionist's working area.

- The manager's office and four clinic rooms and the receptionist desk, were accessed off the reception area. This meant that patients were observed during their wait for dialysis.
- Patients who required dialysis were assessed by the NHS trust renal team for suitability to dialysis in a satellite unit and then referred to the centre.
- Patients with acute kidney disease were treated at the NHS trust and chronic, long-term dialysis patients were referred to the unit for treatment.
- Patient transport was not the responsibility of the provider. The system for accessing patient transport had changed at the beginning of May 2017. We were told that patients were responsible for arranging their own transport through an external provider, sourced by the clinical commissioning group (CCG). We were told that this had caused some delays in patients arriving, which had affected patient dialysis sessions, as it reduced the time available for treatment. One patient had to reduce their dialysis by one hour due to their late arrival. In response to this, the CCG had set up monthly operational meetings with the transport service, and the parent hospital were completing daily conference calls.
- Patients included transport issues as an issue in around half of the 29 CQC comment cards completed by patients and carers, during our inspection.
- Patients travelled for varying amounts of time up to one hour to attend dialysis sessions. This was outside the renal recommendations of travel for less than 30 minutes. However, this was not being formally monitored.
- Some patients attended the unit using either private transport or volunteer drivers. We saw that there was a small car park for use by patients and/ or family.

Access and flow

- The service reported to provide on average 872 treatments sessions each month.
- The utilisation rate for the service from December 2016 to February 2017 was 90% and there were no patients currently on a waiting list.
- There were no patients' dialysis treatments cancelled or delayed in the twelve-month period ending April 2017.
- The current dialysis sessions were being run daily, with one morning and one afternoon session from Monday to Saturday. There were no plans to include a twilight session currently due to lack of demand.
- Each area was accessed through keypad secured doors. Patients would remain in the reception area until the dialysis machines were ready for use, and then staff would call them through.
- If patients did not arrive for their dialysis session, staff would record this in their notes and contact the transport service. If they reported no answer at the home address, staff would attempt to call the patient at home, contact their next of kin, and speak with the parent hospital to identify if they have been admitted.
- Patients who no longer wished to continue with dialysis were referred to the NHS trust's renal consultant for review.

Meet the needs of individual people

- Patients were able to attend other dialysis units, while they were on holiday. There was a corporate process in place to arrange this. Medical acceptance was sought and information would be provided to the receiving unit, to ensure that they are prepared for to the patient's arrival for treatment. Worcester Dialysis Unit also accepted holiday dialysis patients.
- Services were planned so that patients could participate in their own care. At the time of the inspection, two patients were fully competent to self-care including needling their fistulas. Patients, who participated in their own treatment, were assessed for competence before being allowed to manage their treatment independently. Patient folders contained a booklet to document patient's self-care training.
- The unit provided disabled access and wheelchair accessible toilets. We saw that hoists were available for patients who could not transfer and wheelchairs were used to assist patients to and from their transport.
- There were two disabled toilets adjacent to the main reception area and one within the treatment area.

- Each side room had a disabled access toilet attached to enable patients to remain isolated for infection prevention and control.
- The patient wheelchair weighing scales were situated in reception away from patient chairs, which enabled some privacy when weighing patients. There was also stand on weighing scales available.
- Patients were allocated to the same dialysis station and machines at each visit.
- We saw that patients with mobility difficulties were assisted to their stations by staff.
- Staff had access to a hoist for transferring patients with mobility difficulties or assisting with a patient if they had fallen. All staff were trained on the use of the hoist as part of their mandatory manual handling training.
- We saw that information leaflets were available in non-English languages. There was also a poster in reception stating that if translation was required for any language not present, the staff would be able to arrange suitable translation services.
- The reception area had a small book and film library for patients to use during their dialysis sessions.
- Wi-Fi was available for patients to use. The password was displayed in reception.
- Patients attending the unit were offered oral refreshments, which included a drink and a snack (biscuits). Patients brought their own foods and were able to use a patient fridge to keep products cool.
- Staff provided patient vaccinations rather than them attending their GP for seasonal or treatment vaccinations.
- Patients' carers were encouraged to join them during dialysis sessions if required. Staff told us they worked in partnership with carers. Patients on the unit could have visitors during treatment sessions.
- There were privacy curtains available at each dialysis station.

Learning from complaints and concerns

- There was a policy and a process in place for the management of complaints. The centre manager was the lead for complaints at the unit. The target was to respond within 20 working days. It was not clear from the information provided whether the service was meeting this target.
- Data showed that there were five formal complaints received by the unit from May 2016 to April 2017. Two of which were upheld were regarding uncomfortable mattresses used on the dialysis stations. We were told and saw that many of the stations had new mattresses in place during the inspection.
- Details for the patient advice and liaison service were displayed in the reception area.
- The ward manager was very visible on the unit and available to discuss any arising concerns. Staff were aware of the complaints procedure for the unit.
- Patient satisfaction audits were completed annually using an external company to complete a survey. Patients, their friends and families, were able to complete an anonymous questionnaire to identify any areas for improvement. Following completion, the unit compiled an action plan to address any areas where improvement was required.

Are dialysis services well-led?

Leadership and culture of service

- Leaders had the appropriate skills and knowledge to manage the service. Locally, the clinic manager was supported by a deputy manager, nursing staff, health care assistants and an administrator.
- There was an area chief nurse, who covered a number of dialysis units who provided line management and senior support for the clinic manager. The area chief nurse, clinic services director and training and education manager were present during the inspection, and it was clear from their interactions and knowledge of staff that they had regular contact with the team. They formed part of the management structure that linked from a local and regional level to a national level for the provider.
- The clinic manager had an open door policy and was accessible to patients, relatives and unit staff. We saw during the inspection, that staff and patients asked for advice, assistance or information when necessary.
- The clinic manager worked mainly supernumerary, this meant they were free to support the running of the unit.
- The unit used a named nurse approach to patient care. The named nurse was responsible for maintaining the patient's records, and ensuring they had a detailed understanding of the patient's condition and treatment.

- We saw that staff had effective working relationships with staff from the NHS trust, for example the renal consultant. Medical staff and specialists confirmed that the working relationships were positive.
- Staff told us that there was good teamwork within the unit.
- We saw evidence that staff worked with stakeholders. There was understanding of each role and professional interaction to meet patients' needs. We saw open discussions between centre staff and staff employed by the NHS trust.

Vision and strategy for services

- The corporate vision and priority was to ensure the delivery of safe, high quality care for patients. This linked with their four key areas of focus, which were, the patients, shareholders, the community and employees.
- There was a corporate strategy for the delivering of quality care, with policies, guidance and procedures based on national guidelines. Staff understood this strategy.

Governance, risk management and quality measurement

- The clinic manager was responsible for monitoring and leading on delivering effective governance and quality monitoring in the dialysis unit, supported by the wider provider management team.
- The clinic manager attended provider's managers' meetings twice a year. This was a two-day conference to be attended by all managers and area chief nurses.
- The unit was required to be audited on a routine basis usually every one or two years by the provider. This included health and safety inspections and the provider's chief nurse conducting unannounced audits of the clinic. Performance with this would be discussed at the provider's clinical governance committee meetings. The provider's system was designed to indicate those units, which were not meeting the standards expected of the provider, and to strive for continuous improvement in audit results. We saw performance results for the service. However, we requested information regarding performance against other clinics, but this was not provided.
- A unit review report was completed monthly by the clinic manager for review with the area chief nurse. This included the number of patients who had required hospitalisation, fistula access versus lines, efficiency of dialysis indicators and number of patients that did not attend for sessions.
- Staff discussed incidents and shared learning regularly during team meetings.
- The unit had a risk register, which described risks to the service providing safe care and treatment. We saw that this document contained risks, mitigations and was updated regularly. However, this was set at a corporate level with and did not capture risks identified at a local level. This also meant that risks that we identified during the inspection had not formally been recognised, such as inappropriate storage and inconsistent medicines checking practises.
- Issues that may affect individual clinical care and outcomes were logged by the clinic manager onto a patient concerns' risk register. For example, a patient's poor compliance with dialysis session times.
- There was a risk assessment document developed by the provider's Health and Safety Manager to address the treatment of patients and general patient handling. It included, fall slips and trips of patient and staff, fire, needle stick injury, electric shock, infection control and untoward clinical events. It contained details of existing controls that should be in place for all dialysis units.
- Each month there were joint contact meetings with the NHS trust's renal team and representatives from the provider's units. We saw standing agenda items included a review of the units' performance against quality indicators, audits results, staffing, transport, water testing and finance.
- Data collected by the unit was inputted into the renal registry by the NHS trust. This information was validated.
- All staff followed a robust induction programme, which consisted of online training and competencies. We saw that roles and responsibilities were clearly defined. A matrix detailed what training was required by staff in particular roles. Lines of staff accountability and responsibility in the unit were well defined.

Public and staff engagement

- The unit sought patient feedback in order to improve the service they provided. This was formally captured through the annual patient satisfaction survey and the unit had action plans for these areas where improvement was required.

- Each year the unit invited their staff to provide feedback through an employee satisfaction survey. The latest survey (November 2016) had a response rate 100%. The results included areas to improve on including 57% of staff agreed that they were involved in deciding changes that affects their team and 43% agreed that the corporate body blames or punishes people who are involved in errors, near misses or incidents. The action plans for these improvement areas were in progress and the clinic manager was looking forward to seeing the results improve when repeated later in 2017.
- Staff told us that there was a supportive team on the unit, and reported they enjoyed working there.
- There were regular monthly staff meetings. The clinic manager or their deputy led these. They were well attended and structured in to the four key areas of focus, the patient, the shareholder, the employee and the community. General status updates were given including clinical incidents, and positive feedback for example the staff were congratulated for achieving 100% in hand wash audits.

Innovation, improvement and sustainability

- The clinic manager had introduced some improvements in the short time that they had been in post (February 2017). This included changing the way the handover took place. This used to be at the workstation. Now this was a walk-round handover, inclusive of the patients. We observed it gave patients the opportunity to raise any issues and seek advice. The clinic manager stated that a patient came to the office to report how this had been a welcome improvement to the way the unit was run and they no longer felt like 'just a number'.

Outstanding practice and areas for improvement

Outstanding practice

- The service achieved 100% response rate, with all members of staff taking part in the employee satisfaction survey in November 2016.

Areas for improvement

Action the provider MUST take to improve

- To ensure all staff's safeguarding training is in line with national guidance, which specifies that designated safeguarding leads should be trained to level three in safeguarding adults to support staff in recognising and reporting potential safeguarding concerns, and staff should receive training to safeguard children associated with the adults they care for.
- To ensure that all staff receive the appropriate mandatory training for their role in order to provide effective care and treatment.

Action the provider SHOULD take to improve

- To achieve a consistent approach to medicine management including the storage and timing of second checks to meet best practice.
- To review how all fridges are monitored and that actions taken are clearly documented to ensure appropriate storage conditions, particularly for temperature sensitive medicines.
- To follow the Accessible Information Standard to ensure that people who have a disability, impairment, or sensory loss are provided with easy to read information and support to communicate effectively.
- To ensure senior staff had duty of candour training in line with the provider's policy.
- To ensure that specific risks to providing treatment at the unit were formally documented on a risk register.

This section is primarily information for the provider

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	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: • The safeguarding lead was trained to level two in safeguarding adults. This was not in line with national guidance, which recommends that designated safeguarding leads should be trained to level three in safeguarding adults. • Not all staff had completed appropriate safeguarding training in order to protect children associated with the adults they were caring for from abuse.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • Not all staff had completed the mandatory training required for their role in order to provide safe care and treatment. This included (but was not limited to), training in order to safely administer blood transfusions, practical manual handling and prevention of medicine errors training.