Assure Dialysis Services, Smethwick

Quality Report

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Date of inspection visit: 05 June and 15 June 2017
Date of publication: 08/09/2017

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Assure Dialysis Services, Smethwick is operated by Assure Dialysis Services Ltd and has been open since June 2015. The service has 32 active dialysis stations; including eight within individual isolation rooms. However the service has the physical capacity for 40 stations. Facilities include clinic rooms for appointments with staff from the referring trust, meeting rooms and a training area.

The service provides outpatient dialysis treatment for patients over the age of 18 years.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 5 June 2017 along with an unannounced visit to the service on 15 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 when they are provided as a single specialty service. 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:

- Staff knew how to report incidents; and were aware of learning following on from incidents. We saw evidence of investigations carried out following the reporting of an incident; and where appropriate concerns were added to the unit's risk register.
- Staffing was in line with safer staffing requirements. Staff had completed mandatory training, were had been assessed as competent to perform dialysis related procedures and had regular appraisals.
- Data from the unit demonstrated they were producing positive health outcomes for patients following their treatment. The unit monitored adherence to quality standards on a monthly basis in a collaborative way with the referring trust.
- We saw the unit was purpose built and facilities and the building layout were designed to be inclusive of all individuals, including people with additional or different needs.
- Staff were caring, respectful and interested in the lives of the patients whom they treated. We observed staff work in a collaborative way with patients; listening to individual preferences regarding treatment and care.
- Multidisciplinary working was embedded within the unit; we saw a variety of specialist staff, such as a renal psychologist, renal social workers, dietitians and renal consultants offered appointments to patients at the clinic from consulting rooms; therefore making it easier for patients to attend.
- We saw the unit management was supportive and open. Both staff and patients highlighted that the unit manager was approachable and worked actively to manage concerns and problems.

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

- Patients were exposed to risks due to some staff using a technique called 'dry needling' in a non-competent way: (dry needling is using a needle that is not filled with sodium chloride to cannulate the fistula prior to commencing

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dialysis treatment). We saw that two staff were pushing air into the venous and arterial needle tubing which carried a rare but significant risk of an air embolus entering the blood stream. We raised this at the time of inspection. By the time of the unannounced inspection visit, a competency framework had been developed for staff and we saw staff using this technique were doing so competently.

- We found that 23 out of 40 viable dialysis machines had not been serviced within their due date; despite the maintenance of machinery and equipment being highlighted on the risk register for the unit. This was rectified by the time of the unannounced inspection.
- Infection prevention and control was variable. At times this was very good, with personal protective equipment (PPE) being used, and cleaning done to a high standard. At other times we saw that staff contaminated sterile areas when connecting patients to dialysis machines.
- We saw that staff were not checking patients identification when connecting patients to dialysis machines, or when administering medicine. This was despite warnings on the front of some patients' files to indicate they had the same name as another patient. We saw that previous medicine errors had been made as a result of this practice, in addition to a patient using a different patient's dialysis card which was not identified immediately by staff. This was resolved immediately when the wrong card was identified.
- We saw that not all patients were starting their dialysis treatment within 30 minutes of their arrival time; the unit was under their target of 90% within a three month period.
- We saw not all risks on the risk register for the service were monitored to ensure compliance from all parties identified on the action plan; resulting in safety risks to the service.

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 one requirement notice(s). Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals

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.

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Background to Assure Dialysis Services, Smethwick

Assure Dialysis Services, Smethwick is operated by Assure Dialysis Services Ltd. The service opened in 2016. It is a private dialysis service in Smethwick, West Midlands The service provides treatment to patients who live the local area. Patients are referred by a nearby NHS trust.

The hospital has had a registered manager in post since June 2015.

This is the first time this unit has been inspected since it's registration in 2015. We inspected this service on the 5th June 2017, and conducted an follow up unannounced inspection visit on the 15th June.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Anna Carrick-Leaver, one other CQC inspector, and a specialist advisor with expertise in renal nursing. The inspection team was overseen by Tim Cooper, Head of Hospital Inspection.

Information about Assure Dialysis Services, Smethwick

Assure Dialysis Service, Smethwick is based within one unit and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury

During the inspection, we visited the premises of Assure Dialysis Service, Smethwick, which are based within one building in Smethwick, West Midlands. Facilities included 32 dialysis stations in total. However the service has the physical capacity for 40 stations. Eight dialysis stations were within individual isolation rooms. The remaining 24 stations were split into three bays of eight stations each. The unit also contained outpatient clinic rooms, a separate staff area and a large training/ meeting room. A staff showering facility was also available for patient use if required.

A fourth bay was used for a separate purpose; that of a clinical follow up of a dialysis machine made a specific company. Two patients per day attended to use these machines; who were volunteers from the referring trust. The company who were conducting the follow up provided staff to supervise these patients. These staff were issued an honorary contact with Assure, and as such were security and competency checked prior to working within the unit. The lead nurse for Assure managed the monitoring process.

At the time of our inspection, the unit was running at 100% capacity. In February 2017, the service reported nine patients were awaiting treatment at this unit. These patients were being treated elsewhere until a space became available.

Sessions were run during the morning, afternoon and evening on Mondays, Wednesdays and Fridays. Morning and afternoon sessions were held on Tuesdays, Thursdays and Saturdays. The unit was shut on Sundays.

As of February 2017, the unit had 79 patients between the age of 18-65 and 59 patients over 65. This made a total of 138 patients. The unit did not treat patients under the age of 18.

In the previous 12 months to February 2017; the service delivered a total of 18,800 dialysis sessions. 10,716 of these were delivered to patients aged 18 to 65, and 8084 were delivered to patients over 65.

We spoke with 13 staff including; registered nurses, health care assistants, unit managers, and senior managers.

Summary of this inspection

Included within this number is a representative from the Kidney Patient Association. We spoke with 12 patients. We also received 28 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed six sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

Activity (April 2017 to March 2017)

- In the reporting period April 2017 to March 2017 there were 18,800 dialysis sessions recorded at Assure Dialysis Services, Smethwick; of these 100% were NHS-funded.

Assure Dialysis Services, Smethwick employed 23 registered dialysis nurses one of whom was employed on a zero hours basis, and ten health care assistants. At the time of receiving information prior to the inspection, the service reported having 2.07 full time equivalent vacancies for dialysis nurses. The service used bank staff to cover any staffing shortfalls. Bank staff came from substantive staff already employed by the unit, or bank staff from the referring trust.

Track record on safety

- Zero Never events
- Zero Serious Incidents
- Zero serious injuries
- One duty of candour notification
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- One incidence of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile
- Zero incidences of hospital acquired E-Coli
- Three incidences of other bacteraemia
- Two complaints; neither upheld

Services provided by other providers within the unit:

- Renal outpatient appointments
- Dietitian appointments

Services provided at the hospital under service level agreement:

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

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate dialysis services where these services are provided as an independent healthcare single speciality service.

We found the following issues that the service provider needs to improve:

- We saw staff use a technique called 'dry needling': using a dry (not filled with sodium chloride) needle to cannulate the fistula prior to commencing dialysis treatment. We saw that staff were not using this technique competently; pushing air into the venous and arterial needle tubing which carried a rare but significant risk of an air embolus entering the blood stream. By the time of the unannounced inspection visit, a competency framework had been developed for staff.
- We found that 23 out of 40 viable dialysis machines had not been serviced within their due date. This was rectified by the time of the unannounced inspection.
- Infection prevention and control was variable. At times this was very good, with personal protective equipment (PPE) being used, and cleaning done to a high standard. At other times we saw that staff contaminated sterile areas when connecting patients to dialysis machines.
- We saw that staff were not checking patients identification when connecting patients to dialysis machines, or when administering medicine. We saw that previous medicine errors had been made as a result of this practice.
- One bed did not have a call bell to alert staff to any patient concerns or queries.

However, we also found the following areas of good practice:

- We saw good incident reporting; staff were aware of how to report incidents and demonstrated learning from these.
- We saw the unit had spare equipment in the event of a breakdown. For example, there were five spare dialysis machines, and two spare sets of scales.
- We saw good record keeping which was accessible to staff at the referring trust.
- We saw staffing levels met the required ratio of nurses and healthcare assistants to patients. Staff were located in a way which meant they were visible to patients under their care.

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Are services effective?

We do not currently have a legal duty to rate dialysis services where these services are provided as an independent healthcare single speciality service.

We found the following areas of good practice:

- We saw good compliance against national standards. The unit measured their performance against 21 standards such as using the correct access point when connecting patients to dialysis machines. Of these 21 standards, the trust achieved 100% compliance against 19 for the months of January to April 2017.
- We saw the treatment provided by the unit achieved some good patient outcomes. For example, the for the measure urea reduction ration; the unit consistency scored higher than the England average for the months of April 2016 to March 2017.
- We saw staff competency was appropriately monitored; and competency booklets were signed off. The appraisal rate of completion for the unit was 100%.
- We were told about daily morning meetings during which the unit manager would update staff of any learning from incidents, clinical incidents, patient concerns and other topics.
- We saw that information was accessible to all staff which required this, through the use of an electronic patient record that the referring trust staff could also access.

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

- The percentage of patients starting their dialysis treatment within 30 minutes of their arrival time was consistently below the target of 90%. This was between January to April 2017.
- Staff training was reduced for a period of time. This was highlighted through the unit risk register, and actions were put in place to mitigate this risk.

Are services caring?

We do not currently have a legal duty to rate dialysis services where these services are provided as an independent healthcare single speciality service.

We found the following areas of good practice:

- We saw that staff presented as caring, personable and respectful to patients. We saw that dignity was maintained and patients were referred to by their chosen name or title. Patients also reported that they found the unit manager very approachable and caring.

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- Patients told us, and we saw, that staff updated patients on changes to their test results and any treatment changes.
- We saw patients were included and involved within their own care; we saw patients and staff interact with each other positively in order to best deliver care in the manner which the patient preferred.
- We saw staff welcomed carers, and family members onto the unit; and these people were able to stay with the patient during treatment.
- Emotional support was available to patients through various channels. A renal psychologist, renal social workers and a member of the Kidney Patient Association attended the unit regularly to conduct outpatient appoints and to engage with patients.
- We saw worked well to support patients who had non-dialysis related problems outside of treatment.

Are services responsive?

We do not currently have a legal duty to rate dialysis services where these services are provided as an independent healthcare single speciality service.

We found the following areas of good practice:

- We saw the building was built fit for purpose and had facilities suitable for individuals with additional requirements. For example, the toilets were dementia friendly, suitable for bariatric patients and suitable for patients using a wheelchair. Patient toilets contained call bells therefore patients could alert staff should the patient need assistance.
- Patients were able to attend the unit for outpatient appointments; such as with the referring trust's renal consultants, the renal psychologist, renal social worker and dietitians.
- Patients were allocated a named nurse based upon individual needs; for example for patients who did not speak English as a first language, where possible they were matched with a nurse that spoke the same language.
- We saw the unit was flexible about changing treatment times to accommodate patient's requirements. For example, patients told us if they had work or a social occasion to attend it was easy to swap sessions round. Patients could also request to use the isolation rooms for treatment if other patients for clinical reasons did not require them.
- Patients knew how to make a complaint. We saw the service proactively engaged patients and responded to patient requests or concerns.

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- We saw the unit had unisex toilet facilities demonstrating gender equality.

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

- We saw that during one treatment session in October, 28 patients were delayed by two hours in receiving treatment due to an external lighting failure.
- We saw that complaints and incidents had been reported about patient transport services (which were provided by an external provider); however we saw the unit were taking proactive steps to manage this.

Are services well-led?

We do not currently have a legal duty to rate dialysis services where these services are provided as an independent healthcare single speciality service.

We found the following areas of good practice:

- Staff were aware of the service's vision and values and demonstrated they were working to achieve these through continued professional development.
- Local management presented as visible and supportive. Staff and patients reported they could approach the unit manager in order to gain advice or support.
- We saw a comprehensive risk register specifically for the unit; which followed the referring trust's risk management and identification policy. Risks which were identified generally matched areas of concern we identified and action were generated in order to mitigate risks.
- We saw that patient and public engagement was positive, with open days being held, and different methods of patient engagement being used.
- We some proactive practice being taken to improve or develop the service. For example, staff going into residential homes where patients lived to encourage care home staff to use 'communication books' to better share information and improve care.

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

- We saw the risk register, although well-developed, was not monitored to ensure all third parties were compliant with action plans; for example the risk of machine maintenance. As

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previously reported, 23 out of 40 dialysis machines had not been serviced by required dates. When we raised it on the day of inspection; the management team were not aware. However, this was rectified by the time of the unannounced inspection.

- We found evidence of a period of low staff morale; through the staff survey results. The management team at the unit were in the process of creating an action plan regarding this.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- Staff told us they reported both clinical and non-clinical incidents via the referring trust's electronic reporting system. Staff told us they received an email to confirm receipt of the incident submission. Staff told us the unit manager received more detailed feedback following incident reporting; and fed this back to all staff during morning meetings and team meetings.
- Data from the unit showed 79 incidents had been reported between December 2015 and May 2017. Of these, we saw that one was assessed as 'moderate' and 78 assessed as 'minor'. Minor incidents included near misses. The 'moderate' incident was a needle dislodgment and is discussed below. The unit reported no serious incidents since opening.
- We were provided with an example of learning following an incident of needle dislodgement with a patient who moved around during treatment. We were told that following this incident, staff began to use an alternative taping technique to secure the needle. We were told that all staff now use this technique on all patients; and they have noted a reduced risk of needle dislodgement as a result. We saw this incident had been reported via the trust's electronic reporting system.
- Staff gave appropriate examples of what they would report as an incident. We were told that common themes were patient transport services and needle dislodgements. We also saw 16 incidents relating to 'medicine issues'. Staff told us when they received feedback about incidents during meetings, they would explore suggestions and advice to reduce the risk of recurrence.
- Staff demonstrated an understanding of the duty of candour. 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.
- Staff reported they are open and honest with all patients; we received an example of patients that are transferred to hospital during their treatment session due to a complication of some kind. Staff reported that by being transparent with patient; this alleviated patient worries.
- As part of an information request, we were given an example of an incident which triggered the duty of candour to be followed; this is the one 'moderate' incident as discussed above. The incident occurred in October 2016. This incident related to a needle dislodgement whereby the needle was found in the patient's bed. As a result to patient was transferred to hospital as an emergency. We were told about the root cause analysis which identified that poor practice had been followed to tape the needle into place when connecting the patient to a dialysis machine. In addition it was identified that staffing had temporarily been reduced to one nurse for eight patients due to staff break times. As a result of the investigation, the duty of candour process was followed which included contacting the patient to apologise and explain what had happened. Following this, a safety charter and peer checks were introduced to ensure nurses' work was monitored by peers. In addition, 15 minute patient checks were initiated to ensure patients were

monitored more frequently and guidance for managing patients during breaks was communicated. We observed 15 minute checks taking place at times during our inspection, although this was not always consistent. We were told that this incident was used as a learning experience for all staff to ensure practice was improved.

- The service reported no never events since opening in June 2015. 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.
- Data provided by the unit showed 18 patient deaths had been reported between June 2015 and February 2017. Four were referred to the coroner. Data from the unit reported that all deaths occurred outside of the unit and none required a statuary notification to CQC. We were told all such deaths were discussed at the referring trust's mortality and morbidity meetings which trust consultants linked to the unit attended.

Mandatory training

- Staff told us the initial training and induction package provided to new staff members was thorough and provided sufficient information for staff to undertake their role. Staff received their mandatory training through the referring trust's training programme.
- Data from the unit showed that in the main, staff were up to date with mandatory training. For example, a training record showed, out of 32 staff members, all but one member of staff had completed fire safety training in 2016, with one staff member who completed this in 2015. This training should be refreshed annually. Three staff were awaiting their manual handling training, and eight staff were awaiting conflict resolution.

Safeguarding

- Staff told us they were trained to level two in safeguarding vulnerable adults. We were told this training included PREVENT training which is to raise awareness of safeguarding people and communities from the threat of terrorism. This was confirmed within training records provided by the unit.
- Staff had a good understanding of the service's safeguarding policy and the procedure to follow if they had concerns regarding a vulnerable adult. We were told that the general procedure was to inform a senior member of staff such as the unit manager, or deputy managers who would liaise with the safeguarding team and safeguarding lead at the referring trust. In addition, staff told us that consultants from the referring trust were regularly in attendance at the unit; therefore they had ready access to support with any safeguarding concerns.
- We saw leaflets and cards with information about safeguarding, abuse and neglect within the patient waiting room.
- Information received from the unit's management team reported that staff also received level two training in safeguarding children. The unit did not treat patients under the age of 18 years of age. However, the intercollegiate document (2014), safeguarding children and young people: roles and competencies for healthcare staff, recommends clinical staff should have participated in level 2 training.

Cleanliness, infection control and hygiene

- We saw within patient records, that all patients who had returned recently from a country with a high risk of blood borne viruses (BBV) were screened every two weeks for three months. The outcome of the screenings were clearly recorded against each screening date.We also spoke to patients who had recently returned from high risk areas who confirmed this process was followed.
- Data from the unit indicated that they had dialysed five holiday patients from other areas since the unit opened. These patients were required to be infection free; and have relevant patient records including infection screening results, sent to the unit prior to arrival.
- We saw that the chairs in the waiting area and the chairs used at dialysis stations were made from a material that could be cleaned to a clinically sound standard.
- We observed a good standard of decontamination of the equipment between each patient use. For

example, health care assistants (HCAs) used clinical cleaning wipes to clean dialysis chairs, pillows and equipment. We saw all staff wore appropriate personal protective equipment (PPE) when cleaning.

- We saw clinical staff wore PPE when connecting and disconnecting patients from dialysis machines. This included aprons, gloves and splash proof visors. Some staff who wore glasses chose not to use visors.
- We observed part of the deep clean process within an isolation room which was conducted following the treatment session of a patient at risk of BBV. We were told this process including mopping the floors, walls and ceiling with antibacterial cleanser.
- Non-touch sinks were located at regular intervals between and around dialysis stations; enabling staff and patients to regularly decontaminate hands. We saw staff adhered to the World Health Organisation (WHO) five moments for hand hygiene guidance for effective hand washing.
- On the isolation room doors, we noted 'Stop' signs with instructions as to ensure good infection prevention and control techniques prior to entry.
- We saw hand hygiene audit results were below the unit's target. In March 2017; the unit scored 69%, in April this was 79% and May was 82%. We saw these results displayed in both staff and patient areas, along with action plans to improve. The improvement in the audit score between April to May 2017, as reported above, would indicate the action plans were having some effectiveness in improving hand hygiene.
- We saw that staff generally demonstrated good hand hygiene and adherence to infection prevention and control measures; however when observing direct patient care during the announced inspection we noted that some staff did contaminate sterile areas when connecting or disconnecting patients from dialysis machines. During the unannounced inspection we found staff use of aseptic non-touch technique in this area was improved; with less contamination of sterile areas.
- Staff adhered to 'bare below the elbow' requirements and wore uniforms that were clean and tidy.
- We saw daily and monthly water testing was completed correctly by trained individuals for the months of March, April and May 2017. This was to test for the presence of bacteria. An abnormal reading was noted in May 2017; this was re-tested and found to be an anomaly of the test rather than a problem with the water. Therefore no hemodiafiltration (HDF) dialysis was stopped.
- Data from the unit reported one incident of Methicillin-sensitive Staphylococcus aureus (MSSA) and three of 'other bacteraemia' between March 2016 and February 2017. The MSSA was linked to post surgical wound infection from the referring trust. Two of the other bacteraemia were linked to patients with dialysis lines and were resolved with antibiotics. One was linked to pneumonia.

Environment and equipment

- Staff used sharps bins (bins that are designated for used or contaminated needles) appropriately. These bins were labelled correctly. Staff had clinical waste bags close to them when connecting and disconnecting patients from dialysis machines; enabling staff to dispose of clinical waste quickly and efficiently to reduce the risk of infection. We saw posters on the walls which informed staff which bin to use for specific types of waste product.
- Clinical waste was stored in a locked room and collected by an external company three times per week.
- We saw that the fridge containing milk for patient beverages was temperature checked daily. We checked the log for this fridge and found all temperatures were within the required range.
- We saw the resuscitation trolley was well equipped; with all consumables in date with the exception of a packet of sanitary hand wipes which had expired in September 2016. We saw equipment such as the defibrillator was in working order and was regularly maintained.
- We saw oxygen cylinders were safely stored and labelled to indicate whether they were full or empty.
- During the announced inspection we found that 23 out of 40 dialysis machines were out of date with their service requirements. We raised this as a serious concern with unit management. By the time we

undertook the unannounced inspection; all but two machines had been serviced. Of the outstanding machines; one was broken and awaiting repair, and one was due for service that day.

- We observed that dialysis machines were disinfected between patient use; internally using a clean disinfection cycle; and externally using disinfectant wipes.
- There were five spare dialysis machines available for use; and two spare sets of patient weighing scales.
- We saw almost all patients had access to a call bell beside their bed whilst undertaking treatment. We saw staff ensured these were within patients' reach. Patients told us staff responded quickly to these alarms. One chair did not have a 'buzzer'; however the patient seated here reported that staff came if they shouted for them; and demonstrated that this strategy worked effectively. We saw there was an electronic monitoring system which recorded staff response times to patient buzzers. However, this data was not collected or audited. We were told that if response times became a problem; then this information would be monitored. The patient toilets also had emergency call bells within so patients could gain assistance if required.
- We observed staff responding to call bells and dialysis machine alarms within a timely manner.
- We saw there was sufficient space in between each dialysis station. The unit was generally very spacious with room for staff and patients to move freely when required; and sufficient space for wheelchair access to all areas.
- Cleanable privacy screens were available for use should a patient wish for privacy.

Medicine Management

- We were told, and we saw, that the unit manager held overall control of medicines management within the unit.
- We saw patient records contained prescriptions for, and overall lists of, patient's 'when required' (PRN) medicines; which were up to date and signed by the prescriber.
- We saw prescriptions for dialysis related medicines such as Tinzaparin (used to prevent blood clots), were updated regularly; and up to date within patient files. We saw an incident was reported regarding staff using prescriptions from a previous satellite dialysis provider.We saw immediate action was taken to update the prescription and to remind staff about the importance of medical record keeping.
- Staff told us they were aware of the risk of medicine errors due to some patients having the same name. They told us as a result they ensured they complied with appropriate patient ID checks. We observed that nurses were not conducting patient ID checks prior to administration during the announced inspection. We escalated this on the first day of inspection. During the unannounced inspection visit we saw nurses were identifying patients in line with Nursing and Midwifery Council (NMC) standards.
- During the announced inspection we observed not all staff were administering medicine as per the Nursing and Midwifery Council (NMC) standards. This requires two nurses to check both the prescription for intravenous medicines, and the actual medicine itself including the expiry date prior to administration. We saw that some nurses completing the second check were not checking the medicine against the prescription prior to signing to say they had. However during the unannounced inspection, we observed staff were following NMC guidance around medicine administration. This included two nurses checking the medicine.
- We were told about a medicine error that had occurred prior to the announced inspection, where a patient had received medicine due for a different patient, because both patients had similar names. The patient's blood results were checked, and no harm had occurred to the patient. Staff told us the patient was told about the error at the time, and a letter was sent to their home. However, when looking at the unit's incident log we saw 16 medicine related incidents had been reported between December 2015 and May 2017. Five of these related to staff not following medicine administration policy including patient identification checks.

- The unit manager had a patient group direction (PGD) for adrenalin; for use in emergencies such as anaphylactic shock. A Patient Group Direction (PGD) is a written instruction for a named individual to supply and/or administer specific medicines to patients.
- We saw medicine storage was completed as per required guidelines. Both fridge and room temperature was monitored to ensure correct ranges were adhered to. We saw on one date, the medicine fridge was not temperature checked. An incident report was logged following this occasion. All medicine stored, including any patients' personal medicine, was in date and neatly stored.

Records

- We saw that the unit used paper records to record contemporaneous information about patient's treatment; which was then inputted onto electronic systems. The referring trust consultants could access this system at the trust.
- We saw that record keeping allowed for information to be shared between the trust and unit staff. For example, consultants and unit staff had access to patient blood results. Unit staff were sent copies of letters and referrals to other professionals.
- A second electronic record used, a specific dialysis system, recorded information about the treatment which was uploaded automatically every 15 minutes whist a patient was receiving treatment. This data then transferred to the patient electronic record used by the trust. We were told that on occasions, this system did not upload full information that it should to the trust electronic system; which meant some information was not immediately accessible to consultants. This issue was on the unit's risk register with plans to manage this in place.
- Patient record audits were conducted. We saw that 70 records were reviewed between January and April 2017 with the vast majority showing 100% compliance against 17 standards such as 'are care assessments reviewed and completed'. Compliance with this particular standard ranged between 60% and 100%. For the standard of 'have all monthly care assessments been completed', compliance again dropped to 60% within March 2017. Compliance for the standard 'have patients at home medicines been checked each month' achieved between 90% to 100% within this timeframe.
- Paper patient records were securely locked away when not in use.

Assessing and responding to patient risk

- During the announced inspection we noted some staff were using techniques in such a way that could compromise patient safety. For example, one staff did not clamp an arterial line prior to disconnecting a patient from a machine. This could lead to air entry or blood spillage.
- Another technique being used in a non-competent manner was that of dry needling; using a dry (not filled with sodium chloride) needle to check the needle was placed properly prior to commencing treatment. Although 'wet needling' (purging the needle of air and using sodium choride to flush the needle prior to treatment) is considered safer and therefore best practice as opposed to 'dry needling' as per the National Kidney Foundation Disease Outcomes Quality Initiative (DOQI) 2006, it is acceptable to use 'dry needling' should staff be competent and the unit have policies to support this use.
- During our observations of direct patient care, we saw that staff members chose which method of 'needling' to use when connecting patients to dialysis machines; that of either 'wet needling' or 'dry needing'.
- We observed 'dry needling' on two occasions by two separate members of staff. On both of these occasions we observed that air was present in the syringe and line; staff did not purge the air prior to commencing treatment. This creates a risk of air embolism causing a blood vessel blockage which is rare but can be fatal. This was observed for both venous and arterial needles. We raised this concern with the clinic manager; who took steps to address this including the temporary ceasing of the 'dry needling' technique until staff competencies were assessed.
- Following the inspection; the unit management team provided us with a competency framework they had devised to assess staff competence when using the technique of dry needling. By the time we returned for

our unannounced inspection; one member of staff had been assessed as competent with plans in place to assess all clinical staff. During our unannounced inspection, we used this framework when observing staff. We observed two staff using the dry needling technique. Both used the technique competently to connect patients to dialysis machines.

- Staff told us that if a patient requested to end a treatment session early; they discussed this with the patient. If the patient made the decision to end their session; staff asked the patient to sign an early termination form with reasons as to their choice; and staff alerted the relevant consultant at the referring trust. Where patients were unable to sign the form; we saw their decision was documented within electronic patient records.
- Staff told us they conducted Waterlow assessments and liaised with other medical professions to manage the risk of pressure ulcers. If a patient was assessed as high risk, staff told us they would conduct a Waterlow assessment weekly and ensure they were adjusting the patient's position at regular intervals to reduce the risk of a patient developing or worsening pressure ulcers.
- We were told about patient transfers to hospital during a treatment session. Staff were aware of why a patient may require a hospital transfer, and what constituted a higher risk. For example, septic access points, lack of access therefore staff were unable to dialyse patients, a fistula bleed, or fistula clot, an elevated heart rate that doesn't decrease on monitoring. Staff told us they would dial 999 for patient transfers whereby they have identified a risk such as those above; usually following a consultation with the patient's doctor. Staff told us they were mindful of responding to raised risk factors; and preferred to send the patients to hospital due to a wider range of facilities even if staff at the unit may be able to address the concern.
- Within the reporting period April 2016 to March 2017, 28 patients were transferred to hospital whilst in attendance at the unit. We discussed this with the unit manager who reported that transfers had occurred for a variety of reasons including a clotted fistula and post-operative infections. We were told the majority of transfers were related to patient access points which prevented or limited safe connection to dialysis machines.
- We were told of an incident whereby a patient had a cardiac arrest on the unit. Staff from the unit who were trained in hospital life support attended to the patient and undertook CPR and administration of oxygen whilst an ambulance was called; the patient made a good recovery. Staff told us they received a debrief following this incident.
- We saw medical records were labelled with stickers to indicate if there were two patients with the same name, or a very similar name, so staff would be aware to conduct appropriate identity (ID) checks. Staff told us they completed ID checks on all patients prior to administering medicine. Staff told us this included asking for the patients' date of birth, full name and address. However, this differed to what we saw during the announced inspection. On this day we found that staff did not check ID despite patient photographs being available in all patient files. During our unannounced inspection we found that all staff we observed checked patient identification including a photograph visual check; and verbal checks of identifying information (date of birth/ home address/ full name).
- Staff told us that any patient having a blood transfusion was required to wear a wristband.
- We saw staff conducted risk assessments, such as falls assessments. These were retained within patient records and updated more regularly if a patient was assessed as at risk from falling. There were eight beds available on the unit for those patients assessed as frail or requiring additional support.
- We saw within patient records, and from observing direct care of patients, that staff conducted observations in order to identify deteriorating patients. Staff undertook these observations before, during and after dialysis treatment. These observations included temperature checks, pulse checks and blood pressure checks. Staff also conducted blood sugar checks prior to treatment.
- Staff were aware of the risk of sepsis, and there was a structured approach to follow if sepsis was suspected.

We saw the service had access to the referring trusts clinical guidelines regarding sepsis, and we were shown a training package for staff on the recognition and management of sepsis.

- We saw the unit had a system of 'peer checks'. These checks involved a nurse double checking another nurses' practice such as connection to, or disconnection from a dialysis machine. We saw posters on the wall explaining to staff how to conduct these checks. However, during the announced inspection whilst observing direct care we did not see any peer checks take place. We saw staff ask other staff to check their connections during the unannounced inspection.
- We were told of an incident where a peer check and been done but neither members of staff noticed that blood lines had been put on the wrong way for one patient; this was only noted by the staff member who disconnected the patient. We saw that this incident had been reported; however this type of incident was reported as an incident several times between December 2015 and May 2017; despite it being highlighted after each occasion that dialysis machines specify that staff need to check they are undertaking this aspect of connecting correctly.
- We saw that patients were not monitored whilst collecting their dialysis card (a card which records data such as the patients' weight and uploads this to dialysis machines). However when a patient did need assistance, such as patients using wheelchairs or patients with cognitive impairments we saw that staff accompanied these patients; helped to weight them, and escorted the patient to their dialysis station. We saw one incident where a patient had picked up the wrong card, and the staff member did not notice due to other incidents occurring in the unit at that time. Learning was demonstrated after this incident.
- Staff told us how they managed patients that did not attend their treatment sessions (DNA). Individualised plans were created to manage non-compliance; and patients were educated upon the importance of attending for treatment. The referring trust were involved with this and supported the unit to manage frequent DNA patients. The unit took a flexible approach to manage patients in order to suit the patients' lifestyle rather than risk the patient not turning up.

Staffing

- We saw that during both days we inspected the unit; staffing met required levels ensuring the unit was safely staffed.
- Data from the trust showed that staffing was based on the British Renal Guidelines (2002) which require a minimum staffing ratio of one staff member to four patients with a split of 70% qualified nurses and 30% nonqualified such as health care assistants (HCA).At the unit; rotas were scheduled to incorporate one nurse to four patients and one extra HCA to eight patients. The clinic manager worked in a supernumerary position. There was a vacancy for a professional development nurse at the time of our inspection; this position is also supernumerary.
- We were told about assessments conducted by management to assess staffing needs. These were based upon the acuity of the patients seen regularly within the unit; the Safer Nursing Care Tool (SNCT). Following this extra staffing was built into the rota in addition to the unit manager and deputy managers working supernumerary.
- We saw within minutes of a board of directors meeting held in May 2016, that due to low staffing, twilight shifts on a Monday, Wednesday and Friday had temporarily reduced from 12 stations to eight stations in order to maintain patient safety.
- We saw that staff were assigned to a bay, with a desk and a computer at the end of each bay. This meant staff could see the patients under their care at all times.
- Data from the unit for the time period March 2016 to February 2017 showed that 23 dialysis nurses were employed (one on a zero hours contract) to cover 19.48 full time equivalent positions. We saw there was one part time specialist nurse employed, and 10 health care assistants (HCA), one of which was part time. There were 3 vacancies for dialysis nurses at the time this data was submitted to us.

- We saw on the day of our announced inspection the unit was fully staffed with the exception of one health care assistant on the twilight shift.
- Bank staff were sourced from the unit's existing staff, the referring trust and if necessary, an agency. Bank staff therefore received mandatory training in the same way as the unit staff. Bank and agency staff, if not already employed by the unit, were required to read Assure policies and procedures during a local induction. This included unit orientation, use of the dialysis machines used at the unit and any specific competency assessments which was monitored by either the professional development nurse, or the manager.
- We saw as of February 2017, within the previous three months, 74 shifts had been covered by bank dialysis nurses, and 15 shifts had been covered by bank HCAs.
- Student nurses were invited to complete placements at the unit from Birmingham City University.
- Technical staff were not employed by the unit, but were based on site to provide ongoing support.

Major incident awareness and training

- We saw there was an in date major incident policy, however this was from the referring trust and was very specific to the hospital setting. Therefore it did not cover major incidents which may occur within the unit.
- Data from the unit reported that all dialysis machines had a 20 minute battery backup to allow safe disconnection in the event of a power failure.
- Staff told us they completed fire drills to familiarise themselves with the process to undertake in the event of a real fire.
- In the event of a loss of power or water, the unit had access to a help desk which operated 24 hours a day, every day of the year.
- The unit held an emergency drug box including treatment for anaphylaxis, and a defibrillator in the case of a medical emergency whilst awaiting an ambulance.
- The unit had an alarm system which notified the police if activated.

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

Evidence-based care and treatment

- Treatment protocols were based on national guidance, for example the Renal Association Guidance, National Kidney Foundation's Kidney Disease Outcomes Quality Initiative, European Dialysis Transplant Nurses Association and National Institute for Health and Care Excellence (NICE) Guidelines.
- All patients received hemodiafiltration (HDF). This is viewed as a more effective treatment than hemodialysis (HD).
- We saw that needle taping using a chevron method, known for being more effective at minimising the risk of needle dislodgement, was audited. For the months of January to April 2017, compliance with this method was 100%.
- Fistula prevalence rate was 88% for the months of January, February and March 2017, and 87% for April 2017. The percentage shown here is a positive outcome, demonstrating the unit was complying with national standards and good practice.
- We saw an audit of prescription delivery was conducted on 80 patients between January 2017 and April 2017. This assessed compliance against 21 areas, including national standards, such as blood pressure checked pre and post treatment, the correct access point was used, and the correct HDF rate was used. For 19 standards, compliance was 100% throughout this time frame. The two standards which fell below this are discussed below.
- We saw that the standard of 'weight recorded post dialysis'; compliance ranged between 85% and 95%. For example, in January 2017, three out of 20 patients were not weighed post dialysis which resulted in an 85% compliance rate. Information provided by the unit confirmed the reasons for this was in part due to the scales not consistently uploading information to electronic patient records, and in part to patients forgetting to weight themselves post dialysis. In order to manage this, staff spoke to patients who had not weighed themselves on the following dialysis session

and reinforced the importance of doing so. The unit provided data reporting that the average rate of compliance for this measure for the year ending April 17 was 93%.

- For the standard of 'temperature recorded post dialysis'; this achieved 100% compliance, with the exception of February 2017. During this month, one out of 20 patients audited did not have their post dialysis temperature recorded which resulted in 95% compliance.
- Data from the unit reported a vascular access specialist attended the unit to conduct outpatient appointments with patients.

Pain relief

- Patients told us they could obtain pain relief, such as numbing cream, from their GP to minimise discomfort. Staff supported patients to ask for pain relief from their GPs if required. We saw that patients used this type of analgesia to relieve pain during connection the dialysis machines.
- Patients had prescriptions for painkillers such as paracetamol contained within their records. These were on an 'as required' basis.

Nutrition and hydration

- Patients told us they had access to hot drinks and biscuits during their treatment session. Patients could bring food in from home, and there was a food trolley within the unit from which patients' could purchase food and snacks.
- Patients told us they had access to a trust based dietitian and could attend appointments within outpatient clinics at the same location as their dialysis treatment. There were two trust dietitians that attended the unit regularly.
- We saw staff discuss diet with patients; and supported patients' adherence to specific diet programmes as prescribed by dietitians.

Patient outcomes

- We saw audit results that recorded waiting times for treatments. Treatment sessions should commence within 30 minutes of patient arrival to the unit. We saw the unit were expected to meet a target of 90% for this standard. Between January and April 2017; the unit achieved 83-86% compliance. This meant that within this timescale, 14-17% of patients were not commencing their dialysis treatment within 30 minutes of arrival. We saw various reasons for this including late patient transport, lateness of patients, temporary water failure, and patients turning up for the wrong session.
- Data from the unit between April 2016 and March 2017 showed that the percentage of patients who received over 240 minutes (4 hours) of dialysis treatment per session was 90% or over, with the exception of October 2016, and January to March 2017 when this number dipped to just below 90%. This means approximately 90% of patients were receiving the recommended length of treatment. However, it should be noted of this 10% of patients receiving less than four hours treatment; a proportion of these were prescribed a lower length of dialysis for clinical reasons.
- We saw that the percentage of patients who received dialysis via an arteriovenous (AV) fistula or graft was consistently above the UK average between April 2016 to March 2017. This ranged between 77% and 88% for this unit. Dialysis received via an AV fistula or graft is associated with fewer infections than using a dialysis line (central venous catheter usually inserted in the neck or groin area).
- The unit demonstrated they were better than the UK average with the percentage of patients with a urea reduction ration of more than 65%. Between April 2016 and March 2017, the unit consistently achieved 90% and above against this measure of effectiveness. Urea reduction ration is a measure of removal of toxins in the blood by dialysis.
- We saw that the UK average for percentage of patients with haemoglobin (Hb) levels between 100-120g/l was approximately 58-59% for the months of April 2016 to March 2017. This measures anaemia and how this is being managed in patients on dialysis. We saw that the unit achieved above the UK average for all months in this timeline except those of May to August 2016. During these months, the percentage of patients at this unit who met this measure was between 45% and 58%.

- Data given to us by the unit showed that the unit was performing well against outcomes relating to phosphate management. Phosphate levels reflect the effectiveness of dialysis, the patients' adherence to an appropriate diet, and patients' compliance with taking medicine relating to chronic kidney disease (CKD). We saw that the UK average of patients who had phosphate levels below 1.78mmol/l was just above 70%. However at this unit, the percentage ranged between just over 70% to 90% between April 2016 to March 2017.
- The unit submitted data to the Renal Registry; however this was through the referring trust who collated the data.

Competent staff

- Staff told us the new starter induction programme was comprehensive and enabled staff to achieve the required level of competency prior to working independently. The programme was described as including a week of training at the referring trust; completion of a dialysis specific competency folder which was supervised by a suitable nurse educator, and a six to twelve week period of working supernumerary on the unit. For nursing staff who were new to working within renal medicine; they received a week of training to use the dialysis machines used at the clinic, and also completed a month of training on the dialysis unit of the referring trust to develop competencies in connecting patients to dialysis machines. We saw documents which confirmed this was the case.
- New nurses were allocated a mentor during their supernumerary period which was between six to twelve weeks depending on previous experience.
- We looked at four staff files; all of which contained competency booklets relating to dialysis specific and general nursing skills. We saw that required competencies were signed off by the completing member of staff and a supervising member of staff. We saw that competencies that required subsequent verification, such as yearly renal catheter assessments were signed off within correct timescales.
- Some competencies were self-verified which is standard practice for nurses; therefore the member of staff signed independently to record they felt they were competent with a particular skill or area of work; for example certain haemodialysis clinical competencies.
- We saw that staff with previous renal experience were required to prove their competencies prior to working independently on the unit. For example, we were told that upon starting work at the unit, several staff were unable to prove their competency with regards to intravenous medicine despite being competent. Therefore the unit undertook additional assessments with these staff to evidence they were competent prior to starting practice. We saw evidence of this within staff files.
- The unit manager told us they completed one to two clinical shifts a week to maintain their skills and competency.
- Staff reported that they were able to update their skills and knowledge as required; and were supported by the unit manager to complete required training. Management reported a recent period of time whereby support for staff training was reduced due to unexpected changes to nurse trainer staffing; however this had been addressed and management of staff training was underway. This had been recorded as a risk on the unit's risk register.
- Staff told us they received updates to practice through a morning meeting, 'real time governance' (RTG) which occurred each day the unit was open. We saw the agenda for a team meeting in February 2017 which had items relating to training and updating knowledge listed.
- We saw adverts for short training courses on the walls within the staff room.
- During our announced inspection staff told us they were not formally trained to use the blood sugar testing machines; rather they learnt how to use these 'on the job'.
- We saw within four staff files that yearly appraisals were conducted; these highlighted action points to progress within roles. Data from the unit reported that as of February 2017, all staff were up to date with yearly appraisals.

- We saw up to date basic life support (BLS) training certificates in staff files.
- Link-nurse roles were under development at the time of inspection; whereby a designated nurse undertakes additional training and learning in specialist areas in order to provide support and guidance to the whole team when required. The areas of specialism identified were transplants, infection prevention and control, shared care and Hepatitis B. The unit manager currently undertook these roles and was a designated link nurse for access.
- Bank and agency staff were required to undertake a short local induction; and were required to be competent to undertake the role they were to be doing. Bank staff were mostly used from the current staff at the unit, or from the referring trust's renal department. Staff from the referring trust were also rotated into the unit to ensure they were familiar if used as bank staff.

Multidisciplinary working

- Nursing staff told us about their role as a named nurse for allocated patients. They told us this role included acting as a communication link between the patient and the referring trust; in particular if a patient was experiencing problems with their access. In addition, the named nurse aided with referrals to renal social workers if this was required. We saw evidence in staff files that the named nurse role was a formalised process. In addition; almost all patients knew the name of their named nurse and could describe how they worked together.
- The service worked with independent renal social workers who attended twice a week to provide appointments to patients. We were told staff at the unit were able to refer patients easily, and the social worker was very flexible with regards to attending to support patients.
- Staff told us they liaised with patients' GPs, and where applicable district nurses, in order to support patients; for example with the management of pressure ulcers. Consultants forwarded copies of patient letters to GPs.
- We saw renal consultants working in the unit on the days we inspected. These consultants interacted with patients and staff in a collaborative way and were clearly known on the unit.
- We saw referrals to other specialists were contained within patient records. Dietitians and a renal psychologist attended the unit weekly to provide multi-disciplinary care and support; and were able to see patients in consulting rooms. In addition, vascular access specialists provided support was provided from within the unit on an outpatient basis.
- We were told of excellent relationships with community health and social care providers, such as district nurses and care home staff, in order to provide individualised continuous care for patients. We saw examples of communication between the unit and a care home demonstrating that this occurred.
- Monthly quality monitoring meetings were held. Attendees included trust consultants, trust dietitians, the unit manager and the trust lead nurse linked to the unit. At these meetings, attendees discussed on going patient care including medicine changes which were immediately actioned. Any information to be filtered to the wider unit staff was recorded within a communications diary.

Access to information

- We saw staff rotas allowed for a 30 minute handover at the start of each shift in order to share any current information regarding patients. In addition the unit had a communications diary which staff could contribute to and read as an ongoing record.
- Staff told us they had access to the referring trust's electronic systems; including emails. Staff told us of regular communication between them and the trust staff to share information regarding patient treatment. We saw updates, for example from dietitians, were recorded within the patients' records.
- We saw within patient records that information was shared between the referring trust consultants and the staff at the unit; such as concerns regarding patient fluid levels. Consultants communicated any treatment changes with patients' GPs in a timely manner; we saw these letters within patient files.Patients confirmed that letters were sent from the trust to their GPs.

- We were told that information from a dialysis unit management system, a specific dialysis electronic patient record did not always transfer patient data to the trust electronic system as it should do. This issue was on the unit risk register.
- Patients told us they were provided with an information leaflet when they commenced treatment at the unit. We observed staff updating patients about changes in treatment and the reason for this. Some patients told us they felt they had learnt a lot about their condition from the staff at the unit.

Equality and human rights

- We saw in the patient waiting room many information leaflets covering various topics. For example, there were an abundance of leaflets relating to different aspects of dialysis and health management available. Other information included infection prevention, safeguarding information, guides to organ donation, shared care information, dietary advice and support and information about the unit. Following the inspection, the provider informed us they had leaflets available in languages other than English to meet patient needs.
- We were told, and we saw, that some members of staff at the unit were bi-lingual and could communicate with those patients that used the same language. For those patients where this was not possible, interpreters could be brought in via services at the referring trust.
- We saw there was adequate space and facilities for patients who require this, such as patients and carers using wheelchairs. We saw the scales used to weigh patients' pre and post dialysis were able to be used by individuals in a wheelchair.
- We saw toilet facilities were unisex; therefore supporting transgender equality.

Consent, Mental Capacity Act and Deprivation of Liberty

- We saw that consent was sought from patients prior to starting dialysis treatment at the unit. We saw that patients gave non-verbal consent during sessions, such as holding out arms to be connected and disconnected to machines. We saw some patients had an open dialogue with nurses and requested the staff deliver treatment in specific ways, such as the amount of fluid to be taken off during treatment, or how blood flow should be stemmed following disconnection from machines. This indicated that the patients were consenting to the treatment and accompanying procedures.
- During the inspection, we were made aware of a patient who had a lesser ability to consent to treatment due to other health conditions. We discussed this with the manager who explained that they used a communication loop to engage with the patient to gain consent. The patient often chose to end their treatment sessions early. We saw that staff discussed this with the patient and documented in notes as the patient was unable to sign the relevant documents. The unit had worked with carers at the patient's residential home to request a carer accompany the patient for the full treatment session in order to provide support. Staff had referred the patient back to the trust for dialysis as staff were concerned the patient had lost capacity to consent and was unwilling to be connected to dialysis machines. We saw the trust consultant had made appropriate referrals to geriatric psychiatric services for a full assessment of capacity and best interest decisions; and decisions were made at each individual treatment session regarding the patient's ability to consent. When the patient chose not to, staff respected this decision.

Are dialysis services caring?

Compassionate care

- We saw, and patients told us, that staff treated patients with kindness and respect. Patients told us they found the staff caring and compassionate; and consistently professional. Patients described staff as 'amazing' and some reported the unit as having a 'family feel'.
- Staff engaged with patients; and held friendly conversations which showed the staff were familiar with each patient they cared for. We observed staff to show a genuine interest in the patients' lives; asking questions about patients' holidays and lives outside of dialysis.

- A patient told us how staff enabled them to bring their own personal mug for hot drinks, and kept the mug stored at the unit for them.
- Patients told us that if another patient had an emergency whilst at the unit, staff always put up privacy screens to maintain the dignity of that patient.
- We saw staff were respectful of patients' cultural preferences during interactions and direct care.
- The unit provided us with the results from their patient satisfaction survey from November 2016. We saw 44 patients responded, of which 89% reported they would be 'extremely likely' or 'likely' to recommend the service to friends and family. 11% stated they 'don't know' in answer to this question. 91% of patients who responded said they were either 'very satisfied' or 'quite satisfied' with the nursing care at the unit.
- We saw examples of letters from staff to agencies outside of the remit of healthcare, in order to ensure patients were cared for in a holistic manner. For example, we saw letters staff had written to housing agencies to support a more comfortable living environment for a particular patient.

Understanding and involvement of patients and those close to them

- Patients told us staff kept them informed of their blood results and any other relevant information about their treatment. We observed staff having conversations about blood test results with patients to ensure patients were involved with and informed of their condition.
- We saw a consultant from the referring trust walk round and speak with individual patients. Patients we spoke with confirmed this, reporting that the consultants came to talk patients through any treatment changes.
- We saw patients were involved in their own care; for example one patient requested that, upon disconnection, their exit area was dealt with in a specific way. Nurses respected patient's wishes and worked with the patient to accommodate this.
- We spoke with a self-care patient who was supported by a family member to undertake treatment. We were told by the patient and facility member that they had received adequate training and information to make an informed choice about treatment, and to undertake self-care.
- The majority of patients we spoke to were aware of who their named nurse was and told us their named nurse kept them informed and updated. Patients told us that they felt staff made an effort to get to know patients and had an open and empathetic approach.
- Patients told us they felt listened to by staff, including the clinic manager, and reported that staff presented as treating patients as individuals when it came to patient care and treatment.
- Staff encouraged 'self-care' with all patients in the unit, and took opportunities to discuss this with patients and their families. However, most patients chose not to self-care.

Emotional support

- Staff reported that they felt they had the time to build relationships with patients. Particularly through the 'named nurse' arrangement.
- We observed staff approached patients whose body language indicated they may be unhappy in order to provide support.
- Patients told us they were able to bring a carer or supportive person with them, who could sit beside them for the duration of their treatment if the patient wanted this.
- Patients told us they had been offered psychological support through the referring trust. A renal psychologist attended weekly to provide emotional support to patients who requested this service. A representative from the Kidney Patient Association regularly attended the unit to provide support to patients.

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

Service planning and delivery to meet the needs of local people

- Patients we spoke to told us they did not experience significantly poor patient transport journeys; however they were collected late at times, particularly following treatment. This was also reflected within the patient satisfaction survey conducted within November 2016. Please note that the patient transport was provided by an external provider.
- We were told that previously, patients raised concerns about patient transport services; such as waiting too long to be collected or being transported for a very long time as many patients were being taken home on the same ambulance. However, since a change in the delivery of the patient transport services contract, we were told improvements had been made.
- Staff told us they raised incidents via the trust's incident reporting system, if concerns were raised regarding patient transport services. Management confirmed this happened. Data from the unit highlighted staff had reported five occasions relating to delays in collecting patients after treatment in May 2017.
- Patients told us they lived close by to the dialysis unit, and that travel times were less than 30 minutes.
- Staff told us if afternoon or evening treatment sessions ran late; for example due to delayed transport, they remained with the patient to ensure they were collected safely. We were told that the unit had funded private taxis home occasionally to ensure patients were returned home in a reasonable time.
- The unit supported eligible patients to claim refunds for travel to and from the unit. This involved completing paperwork and submitting this to the referring hospital who provided the funds.
- Data from the unit suggested there was a transport user group for patients. However, this group was led by staff at the referring trust and we were not assured that unit patients were directly involved in discussions about patient transport. A member of the Kidney Patients' Association attended meetings as an advocate for all renal patients who attended satellite units from the referring trust.
- The unit had ample parking space designated for staff, patients and visitors.
- The unit had been purposely designed and fitted for the purpose of delivering a satellite dialysis service and therefore was fit for purpose. The local area in which the unit was based was identified as having a population with a high prevalence of chronic kidney disease (CKD).

Access and flow

- Data from the service between April 2016 to March 2017 showed the unit was at 100% capacity. At the time of the inspection were informed this was still the case. We were told that the patient numbers were based upon the initial contract agreement and subsequent staffing. At the time of submitting data, the unit had nine patients on the waiting list. These were being seen by alternative units until a space became available.
- We were told that occasionally, the unit treated additional patients. In these cases supernumerary staff, such as the manager, would work clinically to support patient access to treatment.
- We were told that the unit was able to manage additional patients due to some patients being on holiday, or an inpatient at hospital for a period of time. In addition, a small number of patients only required two sessions a week. Since the unit opened in June 2015, five holiday patients from other areas and countries had used the service.
- Patients told us they felt treatment sessions generally started on time and as scheduled. Staff informed patients or any delays to treatment start times.
- Data from the unit reported that in October 2016, planned dialysis sessions were delayed for a non-clinical reason; that of equipment failure. This was due to an external lighting failure which delayed treatment for two hours.
- Patients were able to attend the unit for outpatient appointments with various specialist staff; both from the referring trust and external. These included renal consultants, renal psychologist, dietitians, renal social workers and a member of the Kidney Patients' Association.

- Staff told us they cared for several younger patients, and several patients that were employed. Staff told us of a flexible approach to treatment which enabled patients to attend sessions at a time which suited them; including holding twilight shifts.
- Patients told us about the unit's flexible approach to arranging sessions to enable the patient to attend work or social events. Some patients requested not to be dialysed on certain days of the week due to religious requirements; these requests were fulfilled.

Meeting people's individual needs

- Renal social workers, employed by an external company, saw patients within the unit for appointments about all aspects of individual social requirements such as housing and benefits. In addition a young person's social worker was available for younger patients attending the unit.The renal social workers were available to aid patients apply for financial support for holidays where appropriate.
- Staff told us they, as a named nurse for a patient, would aid patients to attend holidays through contacting alternative units in the patient's location of choice to confirm holiday details, and to manage the required medical paperwork transfer that was required.
- Staff told us, and we saw, they were 'matched' with patients as a named nurse to take into account individual patient needs; such as if, staff spoke the same second language as a patient. Staff told us this aided better communication and understanding whilst patients were in the clinic, and staff could help with interpretation at social worker appointments. We saw that staff spoke to patients in their first language appropriately. Patients also told us staff members had acted as interpreters on occasions. We saw patients had access to a wide variety of information via leaflets.Following the inspection, the provider informed us they had leaflets available in languages other than English to meet patient needs.
- Staff told us they could access interpreters through the referring trust; however this was generally for structured appointments such as when patients attended the hospital for a review. We were told if a patient spoke a language which staff did not speak, staff liaised with family members to communicate. Staff told us some patients had a 'communication book' which family could fill in and travelled with the patient.
- Staff told us they sometimes used picture cards to communicate with patients who had a lesser understanding of English verbal communication either due to language barriers, or cognitive impairment.
- We saw there was a communication box which contained equipment to aid patients who were Deaf or hard of hearing to communicate. Staff told us about a patient that they had used this equipment with; and as a result were able to respond to the patient's needs.
- We were told about a patient who attended with a carer; staff ensured the carer was able to remain with the patient throughout treatment. We were also told about another patient who lived in a residential home, but attended appointments alone. Staff told us how they identified this patient found it difficult to stay still and seated during treatment due to health conditions; therefore staff liaised with the residential home who arranged for a carer to stay with the patient. Staff told us this eased the patient and enabled treatment to be delivered more effectively.
- Staff told us, and we saw, that they aided patients who attended in a wheelchair, or who had reduced mobility, to weigh in and be seated in the relevant dialysis chair or bed. We saw staff assist patients at the end of dialysis also.
- We saw that patients were able to request the use of isolation rooms or beds on the bay rather than the chairs, for non-clinical reasons, such as privacy or extra comfort. We spoke with patients who confirmed this was possible and reported that when they moved into one of these beds, staff clearly explained that if a patient had a clinical requirement for the location, then the current patient would be relocated.
- Patients told us that the televisions provided for entertainment during sessions were sufficient to meet their needs. We noted a folder of photocopied puzzles was available for patient use. We also saw books and magazines within the patient waiting area for patients, carers or family and friends to read whilst waiting

before or after treatment. Carers and family were able to stay with the patient during treatment sessions. We saw there was adequate room to enable this, including space for wheelchairs.

- Patients told us staff were responsive towards managing other medical conditions which may affect the patient during treatment sessions; for example being able to help patients take their own medicine quickly.
- We saw within patient records, that staff noted patients' preferred name, or what they would like to be called for example 'Auntie'.
- We saw equipment suitable for bariatric patients, for example seating and beds, were available for patient use both within the waiting area and within the clinical area.
- We noted toilets allocated for patient use were dementia friendly in terms of colour scheme and layout; and were spacious enough to accommodate patients with additional needs, such as patients using a wheelchair, bariatric patients and those patients who required a carer to accompany them to the toilet.
- Toilets were unisex to provide a non-discriminatory approach to gender identity.
- Staff showers were available for patient use should any patients require or choose to have a shower during their attendance at the unit.
- We saw privacy screens were available for use for any patients that requested these.
- We saw leaflets available for patients regarding organ donation and specific religious beliefs to enable patients to gather further information.
- We were told that where space permitted, staff encouraged 'weller' patients to attend during twilight shifts due to the late leaving time, and less medical renal staff availability at the referring trust during the evening to provide support.
- We received varied feedback regarding the temperature of the unit and the comfort of dialysis chairs. However, the majority of comments were positive about the quality of the facilities and environment. We saw the unit provided patients with pillows and blankets to patients in order to aid comfort and warmth.
- We spoke with a Kidney Patient Association representative who told us the unit management respond positively to requests for outings and trips for dialysis patients. These trips were funded by the Kidney Association.

Learning from complaints and concerns

- Patients told us they were aware of the complaints procedure. We saw leaflets within the patient waiting aware with information for how patients could make a formal complaint.
- Patients told us they were involved in patient surveys in order to improve the service. We saw a 'you said, we did' board displayed which outlined concerns raised by patients, and how the service had improved. For example, one concern raised was that of delays getting through the front door due to a lack of receptionist during maternity leave. The unit response was to employ a receptionist to cover this period of absence; and to create better signs to indicate to patients how to access the building.
- Between March 2016 and February 2017, the service received five complaints. Three of these were about patient transport services so were referred to the patient transport service provider. We saw on the day of inspection, the patient transport provider had to come in to actively engage with patients about this service, and to offer alternative solutions and to reassure patients.
- Of the other two complaints which related directly to the service, one was upheld. This was regarding patient refreshments arriving later than usual. The other, which was not upheld, related to a technique used to insert dialysis needles for treatment.
- We saw within minutes of a board of directors meeting held within February 2017, a verbal complaint had been regarding the privacy and dignity of a patient. Within these minutes, it was reported that the complaint had been resolved with the patient's family at the time.

Dialysis Services

Are dialysis services well-led?

Leadership and culture of service

- The local management structure of the unit comprised a unit manager, who was an experienced renal nurse. Two deputy managers supported the unit manager in the day to day running of the service. A lead nurse, a clinical director, a business manager, and the managing director of Assure (also the registered manager with CQC) supported the unit manager. Further support was offered through the referring trust via trust consultants, and other linked staff.
- Staff told us they enjoyed working within the unit and felt supported by the wider team. We were told staff felt they needed advice or guidance; the environment was such that staff could ask each other for help at any point in the working day.
- Staff told us they felt supported by managers to deliver care to the best of their potential by ensuring mandatory training was up to date; being offered refresher courses, hand hygiene training and having yearly competencies signed off.
- Staff told us they were willing to assist one another, for example if a colleague was running late for work, staff would be willing to cover until that person arrived.
- We observed positive working relationships and effective teamwork between staff during the inspection.
- We saw the unit manager and deputy managers were visible on the unit; their office opened directly onto the unit and was based in the middle area therefore accessible to all staff. Patients reported they also found the manager approachable, flexible and friendly.
- Staff told us there was opportunity for progression within the unit, for example Assure Dialysis Service were planning to recruit for the role of dialysis assistants (DAs). Health care assistants (HCAs) would be able to apply for these positions as a career development move.
- We were told about a period of low morale during a period of being short staffed, which had negatively affected working relationships. Staff told us they felt this issue was being resolved through the use of bank staff. We saw this concern was reflected within the most recent staff survey, April 2017, and was raised as a reported incident in March 2017. Management were in the process of creating an action plan around this to support staff at the time of inspection.

Vision and strategy for this core service

- We saw the service had a clear vision and set of values. The vision was “to deliver the best in dialysis care”. The values incorporated having a transparent approach to patient care, treating patients, families and carers with respect, being innovative to improve clinical practice and working in a collaborative way to ensure patients receive the best care. The business model of the service highlighted that expansion of the service to enable more patients to dialyse there was a short to medium term objective.
- The managers told us their vision for the service was to be the best for delivering dialysis care. The unit manager reported they would achieve this through sharing good practice and felt it was an exciting time within the company.
- Staff told us about the vision and values for the service. They described how they tried to consistently meet this vision. For example, staff told us if they gained further knowledge or information about an area of dialysis, they strove to update their colleagues and patients. Staff presented as proud to work for the service. Staff were aware of ideas to progress the service, such as the aim to recruit dialysis assistants as standalone roles.

Governance, risk management and quality measurement

- We saw the unit used the referring trust’s procedures for assessing risks and managing a risk register. The service provided us with a copy of their risk register as of February 2017. At this point, 12 risks were identified. Included within these risks were concerns about staffing levels, patient transport services, and IT systems. We saw that risks were appropriately scored according to impact to the service and the likelihood of these occurring; and structured plans were in place to manage such risks. However, we noted that equipment servicing was identified as a risk as ‘Failure to supply or maintain equipment’. Despite plans

including regular review meetings, during our first inspection visit, we found the facilities team had not serviced 23 out of 40 dialysis machines by the required date. This indicated accurate information about this particular risk had not been effectively communicated during meetings; as when we highlighted this during our inspection; the unit's management team were not aware. On our return to the unit for our second, unannounced, inspection visit, we found all but two machines had been serviced.

- During the inspection we identified risks which had not been specifically and individually identified and added to the risk register such as the use of 'dry needling' in a non-competent manner, concerns regarding medicines management, and the lack of positive identification of patients prior to treatment. However, we did see a risk recorded regarding patient safety due to nursing staff not being trained to expected levels thus delivering unsafe and poor clinical care. We saw action points had been identified to manage this. However; staff were still working in ways which compromised patient safety at times.
- Management of the unit told us more about risks to the service relating to staffing levels due to sickness and maternity absences. We were told about the use of bank staff to manage this who were sourced from the referring trust. In order to ensure bank staff were competent and familiar with the service, they were rotated from the renal department at the trust into this unit.
- Management of the unit held monthly contract monitoring meetings; attendance included the unit manager, the registered manager, and a renal consultant from the referring trust. We saw patient outcomes were discussed so the quality of dialysis being delivered at the unit was regularly monitored. Also discussed were incidents and learning from incidents, patient transfers to hospital and patient deaths.
- We were told that patient deaths were also discussed in the referring trust's mortality and morbidity meetings. If attendance at coroners court was required; consultants undertook this role and were supportive to the unit in following any necessary processes.
- We saw minutes from quarterly board of directors meetings which discussed incidents, complaints, staffing and risks including financial risks. In addition, capacity of the unit was discussed; and the location of any patients waiting for a space at this unit was checked. We saw attendees included the registered manager, the clinical director for the service and the overseeing renal consultant from the trust.
- We were told about regular staff team meetings whereby a variety of subjects were discussed. These topics included staff concerns, timekeeping, improvements to the service and any changes to practice. Staff told us minutes of the meetings were circulated via email; therefore staff unable to attend were able to view the points. In addition minutes were kept in folders in the staff rest room.
- We noted that within the staff room, a pile of unopened pay slips for staff were left out. These pay slips contained staff members' full name and home address. Whilst this area was secure and only staff members had access; this may still pose a threat to data protection.
- Management of the unit told us of good working relationships with the referring trust; regular meetings were held with trust consultants. We saw consultants working in the unit; they presented as working cohesively with unit staff to provide care.
- The unit manager held 'real time governance' (RTG) meetings every morning with staff. Within these meetings incidents and feedback were discussed; including areas to improve practice.
- The unit did not routinely collect Workforce Race Equality Standard (WRES) data. WRES is a mandatory requirement for NHS commissioners and NHS provider organisations since 2015, to ensure employees from black and minority ethnic (BME) backgroundshave equal access to career opportunities and receive fair treatment in the workplace. However, we did observe that the unit employed staff from a range of BME backgrounds which was reflective of the local community.

Public and staff engagement

- We saw preliminary results of the April 2017 staff survey. The qualitative aspects of this survey

highlighted concerns about staff morale, especially within the healthcare assistant (HCA) grade. We discussed this with management who said they were in the process of developing an action plan to improve staff engagement. We were told that management were making an effort to keep staff better informed of any changes and updates. We were told that continued professional development (CPD) had been highlighted as a concern by staff previously; as a result staff had been invited to observe at coroners court to experience the full process following a patient death. This was also identified as a risk on the unit's risk register; and actions identified to mitigate this risk.

- We were told that management, including senior management, had an 'open door policy' whereby staff were encouraged to discuss any issues or concerns they had. If the unit manager was away; senior manager such as the clinical director would visit the unit to chat to staff. Staff were invited to attend monthly staff meetings and briefings.
- The unit ran a 'chat and dash' service for patients which was a drop in session for patients to air any views or concerns with the manager of the service. We saw the results of the 'chat and dash' service. In addition to 'you said, we did' feedback following patient surveys was displayed openly within the patient waiting area. We saw other up to date information; such as the staff hand hygiene results and accompanying action plan were displayed.
- Further information for patients was displayed transparently in the waiting room such as the number of staff on duty for each shift that day; the names of the staff on duty; names and photographs of the unit managers and senior management team.
- We were told about patient engagement which included participation in a patient survey; the last one was held in November 2016.
- We were told about an open day with the Kidney Patient Association held at the unit whereby staff, patients and members of the general public were invited to attend. The purpose of this open day was to raise awareness of kidney conditions and to aid engagement.
- The unit was purpose built for the current contract. We were told that during the design of the unit, patients were invited to provide input and ideas as to the structure and layout, and equipment such as chairs.

Innovation, improvement and sustainability

- We were told about plans to sustain appropriate staffing levels through recruitment and retention. One such plan was to create additional roles such as dialysis assistants (DAs) which the existing healthcare assistants (HCAs) would be able to apply for as a career progression role. We were also told about plans to create support roles such as housekeepers; therefore enabling HCAs and nurses to have more time to provide direct patient care.
- We saw that student nurses from Birmingham City University were able to complete placements within the unit. We were told that feedback received from the students was very positive; and we saw a thank you card from a student nurse who had completed their placement.
- We saw within monthly contract monitoring meeting minutes, that the unit's staff had started visiting care homes in which some patients resided, in order to promote the idea of the 'communication book'. This is a book which both the unit staff and the care home staff could contribute to in order to aid effective information sharing.

Outstanding practice and areas for improvement

Outstanding practice

- Staff at the service worked with patients and other professionals to help manage problems external to dialysis. For example, we saw letters from the unit manager to housing associations to aid a patient to gain suitable housing; letters of support were also sent to grant providers to support patient applications.

Areas for improvement

Action the provider MUST take to improve

- The provider should take steps to ensure that risks included on the risk register are thoroughly discussed and shared with all relevant individuals, and robustly checked, to ensure actions are taken as outlined.
- The provider must ensure that any staff undertaking the 'dry needling' technique are competent to do so. In addition the provider should refer to the National Kidney Foundation DOQI guidelines regarding priming needles prior to cannulation.
- The provider must make sure that any medicine management must be done in line with requirements of the Nursing and Midwifery Council.
- The provider must ensure they have a robust method of monitoring machine and equipment maintenance and repair.

Action the provider SHOULD take to improve

- The provider should ensure that staff are consistently compliant with infection prevention and control measures.
- The provider should consider how to improve the time taken for patients to commence treatment in line with their appointment time.
- The provider should ensure every dialysis station has access to a nurse call bell.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (b) doing all that is reasonably practicable to mitigate any such risks; (g) the proper and safe management of medicines. We saw that staff were using a technique 'dry needling' in such a way air could be transported into patients' blood stream potentially causing an air embolus. We also saw that identification checks were not being completed when collecting and administering medicine, and connecting patients to dialysis machines.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

This section is primarily information for the provider

Requirement notices

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Although the provider had a well-developed risk assessment document (risk register) in place; they had not recognized the risk of non-compliance with action plans from other parties; for example the facilities team.