

Clifton Dialysis Unit

Quality Report

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Date of inspection visit: 26 June 2017

Date of publication: 16/11/2017

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

Clifton Dialysis Unit is operated by Fresenius Medical Care Renal Service Limited. It has been operating since September 2005. Patients attending the unit are referred to the local specialist renal and dialysis commissioning trust. The unit, located in the grounds of Blackpool Teaching Hospitals NHS Foundation Trust, functions as a satellite unit and treats patients in the Blackpool, Fylde and Wyre areas.

The unit is a nurse led unit, comprising of a manager, deputy manager, two team leaders (all registered nurses), five other registered nurses, and eight dialysis assistants. The unit has 20 haemodialysis stations, two of which are located in side rooms, and provides three treatment sessions per station per day. It is located in a purpose built unit in the grounds of the local NHS hospital (the host trust). Facilities include a patient waiting area with a disabled access toilet, a patient treatment and weighing area, a range of offices, clean utility, waste utility, staff changing rooms and kitchen, storeroom, technician's rooms and a water treatment plant.

The unit provides haemodialysis treatment to adults aged 18 years and over, who have non-complex needs. Currently the unit provides treatment to 38 patients between the ages of 18 and 65 (6292 sessions between March 2016 and February 2017) and to 55 patients aged over 65 years (8328 sessions in the same period). The unit did not have any patients who were receiving home treatment.

We inspected this unit using our comprehensive inspection methodology. We carried out the announced part of the inspection on 26 June 2017, along with an unannounced visit to the unit on 5 July 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we do not rate

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

- There were reliable systems and processes in place to keep patients safe, including staff training, incident reporting, hygiene and infection prevention and control measures.
- The unit's layout and staff use of equipment, including prompt response to machine alarms, kept people safe. Medicines were stored, prescribed and reviewed in line with provider's medicines management policy.
- Patients were assessed for suitability for treatment to ensure the unit was able to accommodate their care needs. The multidisciplinary team reviewed individual treatment prescriptions monthly, and patients' vascular access sites were regularly monitored.
- Dietitians provided advice monthly to each patient, and there was access to psychological and social work support if needed.
- Staff rarely cared for patients living with dementia or learning disabilities. Staff were trained in and aware of the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards.
- Appointment slots were allocated to patients taking into account their individual needs. Staff supported patients to go on holiday through co-ordinating care at other clinics in the UK, Europe and other countries.

Summary of findings

- Care and treatment was evidence based in line with appropriate guidance. Staff were competent to provide the right care and treatment, and competencies were regularly reviewed. New staff were supported through an induction and mentoring programme.
- There were no written complaints in the reporting period; but there was evidence of shared learning from complaints and incidents that occurred in the provider's other clinics.
- A named nurse for each patient helped to ensure continuity of care. The annual patient survey reflected improvements in the key areas such as staff treating patients with dignity and providing opportunities to discuss their care, and in patients' views that the unit had a happy friendly atmosphere.
- Staff supported families who were bereaved and ensured attendance at patient funerals.
- A clear management and reporting structure was in place. The clinic manager and deputy manager had the appropriate skills, knowledge, and experience to lead and engage effectively with their staff and patients.
- The unit's clinical governance strategy supported the provider's strategic aims; effectiveness against this was monitored through a full range of clinical and governance benchmarking audits.

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

- Staff did not always check patients' identification prior to connecting patients to the dialysis machines or prior to administering additional medicines.
- Mandatory training completion rates were low for some topics including data security awareness and duty of candour training
- Records of what cleaning had been undertaken were not made, which meant staff could not provide assurance that daily cleaning took place in all of the necessary areas.
- There was no policy or procedure on the identification and management of potential sepsis in a deteriorating patient and staff did not use a nationally recognised early warning score tool.
- We found repeated issues identified following audits over several months. We were concerned that actions following these results were not bringing about the required improvements.
- The resuscitation trolley was not sealed, which meant there was a risk that staff would not be aware of any unauthorised access to the equipment stored in the trolley, including anaphylaxis medicines.
- Documentation to record checks of resuscitation equipment did not include the automatic defibrillator battery.
- Discussions between staff and patients were not always held in private, which meant there was a risk other patients would overhear confidential information.
- Patients' records did not always contain the necessary information including evidence of consent, evacuation plans, prescriber signatures and patients' details on each page. Additionally, patients' records were stored in unlocked cabinets in the main patient treatment area which, although inaccessible to the general public, still posed a risk of unauthorised access.
- Managers had no formal process for monitoring or recording compliments received. In addition to this, staff recorded informal complaints in individual patients' records rather than somewhere central, which made it more difficult to monitor trends over time.
- The unit did not monitor compliance with the requirements of the NHS workforce race equality standards.
- The unit's risk register was not yet fully embedded and information such as who is responsible for managing each individual risk was missing.

Summary of findings

Following this inspection, we told the provider that it should make improvements to help the service improve. We also issued three requirement notices. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals North

Summary of findings

Our judgements about each of the main services

Service

Dialysis Services

Rating

Summary of each main service

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

Summary of findings

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Clifton Dialysis Unit

Services we looked at:

Dialysis Services

Summary of this inspection

Background to Clifton Dialysis Unit

The Clifton Dialysis Unit has been operated by Fresenius Medical Care Renal Service Limited since September 2005. It is a privately operated satellite unit to provide haemodialysis (dialysis) services commissioned by a renal specialist trust, Lancashire Teaching Hospitals NHS Foundation Trust. The unit primarily serves the communities of the Fylde, and it will accept holidaying patients when capacity permits. The unit is located in the grounds of the host trust.

The unit's current clinic manager has been in post since November 2016 and was in the latter stages of applying with the CQC for registered manager status.

We last inspected this unit in October 2013. The unit met all the essential standards of quality and safety inspected and did not identify any areas of concern or areas that required improvement.

Our inspection team

The team that inspected the unit comprised a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Omar Khan, Inspection Manager.

Information about Clifton Dialysis Unit

The Clifton Dialysis Unit is operated by Fresenius Medical Care Renal Service Limited. It is a 20 'station' mixed gender dialysis treatment unit and is registered to provide the following regulated activity to patients over the age of 18 years:

- Treatment of disease, disorder, or injury.

The commissioning NHS trust provides the multidisciplinary team who support the unit in providing the dialysis service. It primarily serves communities in and around the Fylde.

The unit is situated in a standalone building on the grounds of the host trust. Dialysis is provided for patients six days a week from Monday to Saturday. There are no overnight facilities. Three dialysis sessions run each day starting at 6.45am, 12.15pm and 6pm. The unit has 20 treatment stations (two of which are in side rooms) offering haemodialysis and haemodiafiltration but not peritoneal dialysis. Home dialysis services are not supported by staff at this unit.

The single level unit is accessed from the main hospital car park; however, there are 15 separate designated car parking spaces available for patients to use. Entry to the unit's reception and waiting area is via a secure doorbell.

The main referring unit is the specialist renal centre based at the commissioning trust, which provides two consultant nephrologists (doctor) who visit each week.

There are ten registered nurses (9.24 whole time equivalent including managers and team leaders) and nine (7.7 whole time equivalent) dialysis assistants employed by the unit. No healthcare assistants are directly employed.

Between March 2016 and February 2017, staff provided 14620 treatment sessions to adult patients with an average of 1200 sessions provided each month. All of these treatments were NHS funded. Services are not provided to children or young people under the age of 18 years. The unit has capacity to treat 104 patients per week with 93 patients currently receiving treatment.

During the inspection, we spoke with six staff including the chief nurse, the area head nurse, the clinic manager, and three registered nurses. We spoke with seven patients and one carer. During our inspection, we reviewed six sets of patient paper 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. The most recent

Summary of this inspection

inspection of the unit was a follow-up inspection which took place in December 2013. We had previously found, during an announced inspection in February 2013, that the provider was meeting all but one of the standards it was inspected against. The follow-up inspection was to make sure improvements required to support staff had been made; we found the unit was meeting this standard.

In the twelve months prior to the inspection:

- There were no never events or serious incidents which occurred at the unit.
- One patient death was recorded by staff, and this was notified appropriately to the CQC.
- No incidents occurred which triggered the Duty of Candour process. However, at the time of the inspection, staff experienced one incident which triggered the process.
- The unit reported two patient falls.
- There were no reports of pressure ulcers, urinary tract infections or hospital-acquired venous thrombo-embolism (VTE).

- There were no cases of methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA), blood borne virus, clostridium difficile (C.Diff) or other bacteraemia reported as having occurred in the unit.

- No complaints were received by the unit.

Services accredited by a national body:

- ISO 9001 accreditation for the integrated management systems.
- OHSAS 18001 accreditation for the health and safety management system.

Services provided at the unit under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Pathology
- Fire safety
- Water Supply
- Building maintenance

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

- The unit had an incident reporting procedure in place, which staff were aware of and used. The unit reported no serious incidents but had appropriately notified CQC of one patient death in the reporting period.
- The unit had reliable systems and processes in place for infection prevention and control, water quality monitoring and treatment, disinfection and maintenance of equipment, and screening procedures for blood borne viruses.
- The unit's layout and staff use of equipment, including prompt response to machine alarms, kept people safe.
- The unit held minimal medicines. These were stored, labelled, and administered appropriately. Staff followed the provider's medicines management policy, and a process was in place for review of patient medicines by the medical team when required.
- Patients' electronic and paper records were, on the whole, stored and managed appropriately, although we found examples of missing information in all six patient records we reviewed.
- Patients were assessed for risk before, during and after treatment and processes were in place for requesting urgent medical assessment of patients, or resuscitation if needed. The unit had two isolation rooms and staff were aware of processes to follow for screening patients with infection and blood borne viruses.
- Staff were aware of the major incident plan, and understood their responsibilities during an evacuation. Each patient had a personal emergency evacuation plan in place.

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

- Mandatory training completion rates in some areas were low. For example out of 17 staff only six were up to date with data security awareness, ten were up to date with safeguarding and no staff were up to date with Duty of Candour training.
- Staff who had contact with parents and carers in the unit had not received safeguarding vulnerable children level two training.
- Cleaning records were not kept which lessened assurances that required cleaning in all areas was undertaken regularly.

Summary of this inspection

- Staff did not always check patients' identification prior to connecting patients to the dialysis machines or prior to administering additional medicines.
- There was no process in place for the identification and management of patients with suspected development of sepsis.
- The resuscitation trolley was not secured with tamper tags, which meant unauthorised access could not be easily identified. Defibrillator battery checks were not included in the records.
- Patients' records did not always contain the necessary information including evidence of patient consent, evacuation plans, prescriber signatures and patient details on each page. Additionally, patients' records were stored in unlocked cabinets in the main patient treatment area which, although made them inaccessible to the general public, still posed a risk of unauthorised access.
- Regular record audits were undertaken with action plans developed. However, as the same issues were recurrent through the audits we reviewed, we were not assured ongoing issues were being addressed.
- Only 24 patients out of 37 surveyed, felt their privacy was respected when discussing their treatment with nurses. This was because discussion took place in an open treatment area.

Are services effective?

We do not currently have a legal duty to rate dialysis services. However, we found the following areas of good practice:

- Care and treatment at the unit was evidence based and provided in line with the provider's Nephrocare Standard Good Dialysis Care. The unit's policies and procedures took into account professional guidelines, including the National Institute of Health and Care Excellence, the Renal Association Guidelines and research information.
- Data relating to the unit's treatment performance was submitted to the commissioning trust for inclusion in the renal registry, and the unit was benchmarked against the provider's other units across the country.
- Patients' had individualised treatment prescriptions that were reviewed monthly by the multidisciplinary team, which included the renal consultant, dietitian, the clinic manager, nurse and dialysis assistant representation. The unit had access to psychological and social work support if needed.

Summary of this inspection

- Patients' vascular access sites were regularly monitored, and patients were appropriately assessed before, during, and after dialysis.
- Patients' nutrition and hydration needs were monitored and two on site dietitians were available to provide face-to-face advice to every patient at least once a month.
- The unit's staff were competent to provide the care and treatment patients required. A competency programme was in place and regularly reviewed. New staff were supported through an induction and mentoring programme.
- All staff were trained in basic life support and life support exercises were carried out.
- Staff had access to the information they needed to provide good care to patient.
- The unit rarely cared for patients with dementia or learning disabilities; however, staff received training in and were aware of the principles of the Mental Capacity Act.

However:

- Consent forms were not always fully completed or completed as regularly as they should be.

Are services caring?

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

However, we found the following areas of good practice:

- The unit had a named nurse for each patient, which helped to ensure continuity of care. All patients in the unit knew who their named nurse was.
- We observed staff interacting with patients in a compassionate and caring manner. This was reflected in comments made to us by patients during the inspection.
- The annual patient survey indicated an improvement in the overall number of patients who felt staff were caring, treated them with dignity, and explained things in a way they could understand. A patient guide was given to each patient, which included a range of helpful information about dialysis care and external sources of information.
- Staff understood the importance of building a strong and friendly rapport with patients.
- Staff supported families who were bereaved and ensured attendance at patient funerals.

Summary of this inspection

- Staff supported patients to go on holiday through co-ordinating care at clinics abroad.

However:

- Only 24 patients out of 37 surveyed, felt their privacy was respected when discussing their treatment with nurses. This was because discussion took place in an open treatment area.

Are services responsive?

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

However, we found the following areas of good practice:

- The unit's service specification was defined and agreed with the commissioning trust to meet the need of local people, and took into account the trust's policies.
- The unit met the Department of Health's Health Building Note 07-01: Satellite Dialysis Unit guideline.
- The unit was accessible with designated patient parking, access ramps, and secure but automatic doors. Arrangements were in place for patient transport with a local taxi firm contracted by the patient transport service provider.
- Interpreter services were available through the commissioning trust, and information could be made available in a range of languages and media.
- Patients were assessed for suitability for treatment at the unit to ensure it was able to accommodate their care needs in a safe and effective way.
- The unit opened six days a week and was able to provide a maximum of 330 individual treatment sessions per week, and accommodated requests for holidaying patients where slots were available.
- Appointment slots were allocated to patients taking into account their individual needs and staff worked to accommodate requests to change appointments as required.
- The unit received no written complaints in the reporting period; however, learning from complaints received was shared within the unit. The unit had received numerous compliments and thank you cards.

However:

- Managers had no formal process for monitoring or recording compliments received. In addition to this, staff recorded informal complaints in individual patient records rather than somewhere central, which made it more difficult to monitor trends over time.

Summary of this inspection

Are services well-led?

We do not currently have a legal duty to rate dialysis services. However, we found the following areas of good practice:

- The unit had a clearly defined management and reporting structure. The clinic manager and deputy manager had the appropriate skills, knowledge, and experience to lead effectively.
- The provider had a clear strategy and vision, which was supported by a set of core values. Staff were aware of these although they were unable to discuss them in detail.
- The unit had a clinical governance strategy document, which supports the provider's strategic aims. Effectiveness against the strategy was monitored through monthly benchmarking audits.
- The unit held a risk register, which identified clinical, operational, and technical risks, scoring each appropriately to determine the impact and likelihood with mitigation actions identified.
- Staff appeared to be engaged in their roles, and this reflected an improving picture on the unit following a previous challenging period. Patients' engagement and satisfaction with their care and treatment showed a similar improvement from previous patient survey results and this was reflected in a number of comments we received direct from patients.

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

- The risk register was very new and some details were missing. For example, the register named the person who had identified each risk but not all risks had been assigned an owner to take responsibility for managing them.
- The unit did not monitor compliance with the requirements of the NHS workforce race equality standards.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- The provider had a clinical incident reporting policy, which set out staff responsibilities, definitions of clinical and serious incidents including near misses, and the provider's clinical incident reporting requirements and timescales. The policy detailed the provider's external reporting requirements, including to the CQC, coroner, police, local safeguarding boards, and Public Health England. It also set out specific reporting requirements for a range of incident types such as, but not limited to cardiac arrest, medical device incidents, medicines errors, safeguarding, and seroconversion. Staff we spoke with were aware of the policy requirements, how to report incidents, and the escalation process.
- Incidents were graded according to the level of harm sustained. Grades ranged from severe harm to no harm. Between June 2016 and May 2017 staff reported six incidents. Two of these were categorised as severe harm (involving bleeding and a cross infection risk), and the rest were categorised as low or no harm.
- The unit reported no serious incidents or never events between March 2016 and February 2017. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined. However, at the time of the inspection, the unit had very recently experienced one incident relating to the suspected unintended exposure of a number of patients to a blood borne virus. This was investigated using root cause analysis and appropriate actions taken to minimise further risks to patients such as temporarily removing the machine from service.
- The unit reported one patient death in 2016, which was notified to the CQC. Deaths which did not occur on the unit were reviewed by the commissioning trust.
- The unit reported no incidents of patient falls, pressure ulcers, urinary tract infections, or hospital-acquired venous thromboembolism (blood clots) for the same period.
- All staff had access to the incident reporting system. Staff were aware of the type of incidents that should be reported, including near miss incidents. The 2016 staff survey showed that all staff who had last witnessed an incident or near miss that could have caused harm to staff or patients either reported it, or witnessed a colleague report it.
- Incidents were discussed with the clinic manager before the incident report was forwarded to the provider's central clinical incident reporting team; the regional area manager was also informed. The reporting team graded and investigated each incident, and developed appropriate action plans to address any issues. Any incidents involving the death of a patient were referred to the executive board for review and sign-off.
- Both the area head nurse and the chief nurse contributed to investigations and as a result had been trained to conduct root cause analysis. The clinic manager did not undertake root cause analyses but was still being provided with root cause analysis training for personal development purposes. This was scheduled to take place in September 2017.
- All staff we spoke to told us that learning from incidents within the unit were discussed with any individuals involved and in monthly staff meetings. Lessons learnt from clinical incidents, serious incidents and safety alerts from all the provider's clinics were shared through colleague update bulletins, and within staff meetings.
- The clinic manager was responsible for reviewing alerts and clinical updates to check if they applied to the unit. For example the use of antiviral medicines alert issues

Dialysis Services

on 12 June 2017, and the 'floan powder and solvent for solution for infusion' alert issued on 23 January 2017. Staff were required to sign to confirm they had received and read the relevant update bulletins. We viewed copies of the sign-off sheets for a range of updates, which confirmed compliance with this process.

- Learning was also shared with the provider's clinics through quarterly regional clinic managers' meetings.
- 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.
- The duty of candour was referred to in the unit's clinical incident reporting policy and in the being open and duty of candour policy.
- Staff reported no incidents between March 2016 and February 2017 that triggered the duty of candour. However, the duty of candour had been triggered at the time of the inspection in relation to the incident of suspected patient exposure to a blood borne virus. A relative of one of the patients involved told us the clinic manager had spoken with them directly and had been honest and compassionate in providing an explanation of what had happened. They had also received a letter of explanation and apology from the provider.
- Senior staff in the unit were aware of the legislative requirements of the duty. Operational nursing staff we asked were able to describe the principles of the duty of being open and honest following incidents where moderate or severe harm or death had occurred.

Mandatory training

- Mandatory training was delivered through a mix of classroom and online training. A training matrix was held which identified which groups of staff required training for each module. The training matrix was updated every three months, and was overseen by the area head nurse.
- Mandatory training for staff included a range of subjects mandated by legislation and by the provider. These included life support training, moving and handling, safeguarding and infection prevention and control training. The provider's online learning system automatically flagged up out of date training modules, which meant that staff could easily identify training that needed to be completed.

- The mandatory training rates for staff were varied. For example, figures showed that all 17 staff were up to date with training in the control of hazardous substances and 15 out of 17 (88%) were compliant with infection prevention and control training. However, only 11 out of 17 (65%) staff were up to date with moving and handling training, six were up to date with data security awareness and no staff appeared to be up to date with Duty of Candour training.
- When we asked managers about training they confirmed the figures and said that these had improved since the previous manager left in October 2016.
- Of the remaining staff members who had yet to complete the training, one was expected to leave the unit imminently and another had a meeting booked with managers to go through required training in addition to formalising work requirements.
- Bank staff were supplied from the provider's in-house flexi bank directorate. Mandatory training for bank staff was monitored by the flexi bank administrators who held the training records centrally. Where training had lapsed, bank staff were suspended from shift allocation until proof of mandatory training completion was provided. This meant the clinic manager was assured that bank staff had completed all relevant mandatory training before arriving on site.

Safeguarding

- Staff only provided treatment to patients aged 18 and above. Safeguarding vulnerable adults training formed part of the mandatory training programme for all staff.
- At the time of the inspection, 15 out of 17 (88%) staff were compliant with safeguarding vulnerable adults training.
- Staff training on safeguarding vulnerable children was offered to level one as patients in the unit rarely had visitors in attendance during treatment and there was negligible chance for children to attend. Out of 17 staff 10 (59%) had received safeguarding children level one training. However, this did not reflect the Safeguarding Children and Young people: roles and competences for health care staff (2014) intercollegiate guidance document. The guidance indicates that clinical and non-clinical staff who have contact with parents and carers of children, should have received safeguarding level two training.

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- Of the remaining staff members who had yet to complete the training, one was expected to leave the unit imminently and another had a meeting booked with managers to go through required training in addition to formalising work requirements.
- Staff had contact details for the local safeguarding adults and children's boards to obtain further advice. Posters detailing the local authority safeguarding team's contact numbers were displayed on notice boards in the manager's office and in the staff room. Additionally, staff could approach the teacher practitioner or training and education manager who worked across the organisation. They were both trained to level three for children and adult safeguarding.
- The clinic manager was the safeguarding co-ordinator for the unit and there were clear instructions for staff to follow should they have safeguarding concerns about a patient.

Cleanliness, infection control and hygiene

- We observed staff carrying out their duties in line with the infection prevention and control requirements set out in the provider's Nephrocare hygiene plan policy. This policy helped support staff in adhering to the principles of infection prevention and control. It described requirements for hand washing, the use of personal protective equipment, and disinfection.
- We observed all areas of the unit including the waiting and treatment areas, and staff only areas including the waste and clean utilities, storage rooms, water treatment room, and the staff kitchen. All areas were visibly clean.
- Domestic staff, contracted by the host hospital, carried out the daily environmental cleaning of the unit to a fixed schedule. Although the domestic staff undertook the cleaning appropriately, they did not complete cleaning logs for each area cleaned. This meant the clinic manager had no documentary reassurance of completion of the daily cleaning schedule. However, the annual cleaning audit carried out in February 2017 indicated 98% compliance.
- The unit had an infection prevention and control (IPC) link nurse who led on IPC issues and undertook IPC audits in the unit.
- Staff wore personal protective equipment such as aprons, gloves and visors when cleaning the equipment, when undertaking the insertion and removal of dialysis needles, and when removing clinical waste. Each staff

member had their own visor. However, we observed one staff member not wearing an apron when setting up the treatment station for the next patient. This increased the risk of potential infection cross contamination.

- We observed staff following hand hygiene protocols, including 'arms bare below the elbows' and the aseptic non-touch technique, in line with the organisation's Nephrocare Standard Hygiene and Infection Control policy. Posters explaining hand washing techniques were displayed which helped make sure patients, staff and visitors adopted effective hand washing techniques. Between January 2017 and June 2017, the unit achieved an average of 94% compliance with hand hygiene procedures, which were above the target of 80% compliance. Areas of non compliance were discussed with the individual staff members involved.
- Antibacterial gel dispensers were located in the waiting room outside the doors to the treatment area, throughout the treatment area, and at each patient treatment station. Four sinks were located in the treatment areas with clear instructions displayed on the correct hand washing techniques.
- Fabric tourniquets were used at each treatment station and were used in line with the provider's Nephrocare hygiene plan policy.
- We observed that patients were given gloves to wear during the process of removing the needles, which reduced the risk of infection at the exit site.
- An overall environment hygiene audit was carried out monthly. Between January 2017 and May 2017 the unit achieved an average of 96% compliance.
- A health and safety audit was also undertaken by the provider annually. In the last audit the unit had poor outcomes where training issues were identified. An action plan was generated and completed within two months and a further audit was planned for July 2017.
- An incident had recently occurred whereby a patient returning from holiday had not been properly isolated prior to commencing treatment. However, we saw that an investigation was in progress at the time of inspection and that appropriate actions had been taken to prevent recurrence and minimise the risks to other patients such as isolating the machine used by this patient and contacting the commissioning trust microbiology team.

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- Dialysis needles and lines were single use only and were appropriately disposed of as clinical waste after use. Staff were observed using the appropriate wet-needling technique (priming the lines with saline) when connecting the dialysis lines to the patients' arms.
- Each machine underwent a heat disinfection cycle at the end of each treatment session, which was confirmed by a machine self-test at the end of the cycle. We observed staff cleaning the treatment chairs and associated equipment, and decontaminating each dialysis machine between patient treatments.
- The unit held a weekly manual log for the internal chemical disinfection and residual disinfection check. We viewed the logs between January and June 2017, which were fully completed.
- The unit had two side-room treatment stations. This meant that patients with identifiable infections were treated at the unit. Treatment was provided in line with the provider's Nephrocare standard hygiene and infection control policy process. This set out the steps to be taken to minimise the risk of infection from blood borne viruses such as hepatitis B and C, and HIV, and from bacteriological infections such as methicillin-resistant staphylococcus aureus (MRSA) and methicillin-sensitive staphylococcus aureus (MSSA).
- Patients were screened annually for hepatitis B and C and for HIV in line with the policy requirements. Patients who had hepatitis C that was under control were checked every three months with a polymerase chain reaction (PCR) test. We saw evidence that patients were also screened for MRSA/MSSA every three months. If a positive result was returned for any of these conditions, the patient was moved into one of the side rooms and treatment was commenced with medicines provided by the commissioning trust.
- Staff told us that if there was more than one positive result, this was investigated to understand if there might be a particular cause, for example if the patients were treated in the same chair or were in chairs next to each other. This process was followed in the on-going incident at the time of the inspection where it was suspected that up to six patients using the same machine had potentially been exposed to a blood borne virus. This enabled staff to identify the relevant patients, notify them of the incident, and take action to isolate and screen the patients.
- Existing patients returning from holiday in the UK or Europe were able to resume their treatment at the unit if

they had not contracted any identifiable infections. Patients returning from holiday in countries outside the UK and Europe were usually screened for infection and treated in the isolation rooms for a period of three months to ensure any risk of infection was minimised. However we saw one example where the process had not been implemented correctly and a patient had not been treated in isolation. This placed other patients at risk. The incident was being investigated at the time of our inspection.

- Records were in place to indicate that daily checks were carried out on the unit's water system with samples taken appropriately. These checks included, although were not limited to, the daily levels of chlorine in the water, the raw water pressures and the filtrated water pressures. We viewed the records for May and June 2017, which were fully completed. The records showed that staff had taken action as a result of abnormal readings; for example, changing the carbon filter.
- A legionella risk assessment was carried out on 3 April 2017. The overall risk score indicated the unit was at high risk and a remedial action plan was recommended. However, the report recognised this was primarily due to the susceptibility of the patients in the unit, and accepted it was unlikely the overall risk would reduce to below medium risk even if the remedial action plan was completed in full. The provider was in the process of developing an action plan to address the risks identified by the assessment.
- Weekly flushing of all taps in the unit was carried out. This reduced the risk of development of bacterial infections in water supplying sinks in the unit. We viewed the maintenance log for 11 October 2016, which detailed the work carried out to address a test failure of the showers in the staff changing rooms.

Environment and equipment

- The unit was located in a self-contained single storey building in the grounds of the host trust, and next to the host trust's car park. Access to the unit was via secure automatically locked doors, which led into the spacious waiting area. The doors into the treatment area were not locked, and we saw that carers were permitted within the treatment area.
- The treatment area included two nurses' stations, which provided good lines of sight to all patients within the 'L-shaped' room, and to the two side rooms. However, although all treatment stations were equipped with a

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patient call buzzer, we saw that none of the buzzers were placed within reach of patients. This meant there was a risk that patients would be unable to quickly alert staff if they, or another patient, needed urgent assistance.

- We raised this with the clinic manager who explained that patients chose not to have the call buzzers within reach. However, we remained concerned about the potential impact to patient safety. As such, the manager arranged for all patient call buzzers to be placed on a trolley next to each treatment station. We subsequently saw that this had been done.
- A separate corridor accessed from the treatment area included the water treatment room, the clean utility and sluice room, the storeroom, the maintenance room, and the kitchen. Although there were staff members located in the treatment area at all times, none of these ancillary rooms were locked during our announced and unannounced visits. This meant there was a low risk that a patient, carer or other unauthorised person could potentially access all the rooms in this area including sensitive equipment stored within them.
- During the cleaning and changeover of the dialysis machines we observed staff leaving open, used containers of dialysate solution next to the hand washing stations within the treatment area, prior to disposal. This posed a potential risk for patient or staff falls and, as the containers were open, a potential risk of spillage of a hazardous substance. We raised this immediately with the clinic manager, and we later observed that all containers had been removed. The clinic manager also confirmed the purchase of a central delivery system for dialysate solution had been approved and would be installed within the next few weeks. This would eradicate the issue of having smaller bottles by beds.
- A maintenance room was used to store the two spare dialysis machines; however, only one spare machine could be connected to the unit's water supply at any one time.
- A resuscitation trolley, owned and stocked by the unit, was located within the treatment area. The trolley was checked on a daily basis. We reviewed the log, which had been completed and checked a random sample of equipment held in the trolley. All equipment we checked was within the manufacturer's recommended expiry date. The anaphylaxis box was sealed and within

the recommended expiry date and an oxygen cylinder was also within the recommended expiry date.

However, although the pads on the automatic external defibrillator were checked; the battery was not.

- However, the trolley was not sealed with tamper tags, which meant there was a risk that unauthorised persons could potentially open and tamper with the equipment. This was not in line with the provider policy, which stated "all approved emergency drugs must be...stored securely within the emergency trolley". We discussed this with managers at the time of the inspection and they immediately acted to ensure the issue was rectified. This included ordering seals for the trolley.
- Facilities management was provided by a dedicated in-house team consisting of a Facilities Manager and two helpdesk co-ordinators. Contractors were designated specifically to the unit to undertake reactive and planned maintenance work. A reserve technician was also in place should this be required. Staff used a central telephone number to report faults, which included an on call facility for out of hours emergencies. The technician confirmed that the majority of spare parts were carried on vehicles should these be required. They also told us they had access to the entire service history for each machine which helped them undertake maintenance work more effectively.
- Staff had a maintenance and calibration schedule and records for each dialysis machine, patient treatment chairs, water treatment and other auxiliary clinical equipment including patient thermometers, blood pressure monitors and weighing scales. The schedule recorded equipment by model and serial number. All records were up to date.
- Dialysis machines, chairs, beds, and the water treatment plant were maintained by the provider's technicians. The remaining additional dialysis equipment was maintained and calibrated under contract with the individual specialist equipment providers.
- We reviewed the maintenance and calibration records used in the unit. The unit had 22 machines in total; 20 in use at the treatment chairs with two spare machines. The dialysis machines underwent regular maintenance and servicing. Records showed these were done annually and staggered across the year to minimise the impact on services day to day. The records confirmed

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that all equipment had been serviced in 2016 and future dates were scheduled in 2017 on the anniversary of the previous check. Machines were replaced every seven to ten years or between 25,000 and 40,000 running hours.

- In the event of a patient cardiac arrest or death, a process was in place to take the dialysis machine out of service and to store it until the relevant data could be downloaded from the machine. Any consumables used in the treatment were also retained, labelled and stored for further analysis.
- The water plant room met the Department of Health's building notes requirements. Equipment within the water treatment room was clearly labelled with the last maintenance check and next maintenance check dates. All the equipment, including the power system, had been checked and maintained during the appropriate dates. We reviewed a number of water plan test and maintenance reports, including the annual disinfection reports for 2016 and 2017.
- Portable equipment was routinely tested in line with the annual testing schedule. A portable appliance test register was held on site. We reviewed the register, which showed that all portable electrical equipment had been tested, and passed, on 10 January 2017. Only one piece of office equipment failed the test and records showed this had been replaced. This was supported by the test record sticker on all the equipment we observed.
- The dialysis machines sounded audible alarms to alert staff for a range of reasons during treatment such as issues relating to patient movement, leaks, or other changes. We observed staff responding to audible alarms from the dialysis machines in a timely manner. We did not observe alarms being overridden inappropriately. Transparent guards were in place at the front of the machine to reduce the likelihood of the machine being tampered with. It was theoretically possible for a patient to override an alarm; however we did not observe this occurring.
- There was sufficient space between the treatment chairs to enable patients to mobilise easily into and out of the chair, and for staff to attend to the patient during treatment or emergencies. This was in line with the Department of Health's Health Building Note 07-01: Satellite Dialysis Unit guideline.
- There were two trolleys within the treatment area that held ancillary equipment such as specimen tubes,

needles, syringes, dressings, and saline. We checked a range of items stored in both trolleys. All items we checked were within the manufacturer's recommended expiry dates.

- Sharps boxes were available throughout the treatment area on equipment trolleys used by nurses when setting up or attending to patients. The type of sharps boxes used displayed a barcode system but did not provide information on the date of construction or enable staff to otherwise identify them. However, those we observed were part closed when not in use. This meant the risk of injury was reduced. Closed boxes were kept in a separate waste storage room.
- Boxes of equipment used for dialysis, such as the single used dialysis needle packs were held in the store room on shelving off the floor. We checked a range of equipment held in the store room; all equipment checked was within the manufacturers recommended expiry dates.
- Stock was labelled with the received date; however, we found several examples of boxes of equipment including dialysis needles, where older stock was stored behind newer stock. This increased the risk of ineffective stock rotation. The clinic manager acknowledged this was a known issue, and was partly caused by the temporary storage of large stocks of acid.
- Large stocks of acid for use with the machines was stored on pallets in the middle of the store room. The clinic manager told us this was a temporary measure and would be resolved when work was carried out to remove redundant equipment from the storeroom.
- A locked cupboard within the clean utility was used to store hazardous cleaning materials. On checking, we found two containers of disinfectant granules and tablets. One of these was outside the manufacturer's recommended expiry date. We also identified containers of chemical disinfectant stored on the floor in the waste storage room. We raised both issues with the clinic manager to arrange appropriate storage and disposal.
- External disinfection of dialysis machines was carried out with a prepared solution of strong disinfectant. The solution was made up each day from concentrate, using appropriate personal protection. Each batch was recorded by staff on a checklist.
- Clinical waste was labelled, segregated, transferred and disposed of through a service level agreement with the

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host trust in line with the unit's waste separation policy. We viewed the logs of the disposal of hazardous and clinical waste, including sharps, and domestic waste between January and June 2017.

- Weighing scales were used to monitor patients both before and after treatment and calculate how much fluid to remove each session. However only one set of scales was owned by the unit. Managers told us that if the scales became faulty there was no other way to monitor a patient's weight. Instead staff used other clinical observations such as blood pressure (which rises or falls based on the amount of fluid in a patient) to help calculate how much fluid to remove. However, we were concerned that using blood pressure as an indicator, was not an accurate or reliable method for deciding the amount of fluid to be extracted and represented a risk to patients.

Medicine Management

- The unit had a medicines management policy, which was supported by staff training in the prevention of medicines errors. The clinic manager was responsible for the safe and secure handling of medicines within the unit.
- There were no medicine errors reported at the unit in the period March 2016 to February 2017.
- Staff did not administer or store any controlled drugs. Medicines used in the unit that were not required to be refrigerated, were stored in locked medicines cupboards. The cupboards were located within a temperature-controlled room, which reduced the risk of extremes in temperature affecting the medicines. The room temperature was checked and recorded daily using a maximum/minimum thermometer. We reviewed the logs, which confirmed that daily temperature checks had been carried out; the temperatures were within the appropriate ranges.
- Keys for the cabinet were held by the nurse in charge for each shift. This meant the lead for secure handling of medicines varied with each shift; however, the clinic manager assured us this was always a senior member of staff.
- Medicines were organised to ensure the oldest medicine was used first. We checked a sample of twelve different medicines stored in the cupboards, all of which were

within their manufacturers' recommended expiry dates. The unit did not hold oral liquid medicines. An oxygen cylinder stored in the room was also within the recommended expiry date.

- Medicines that required refrigeration were held in a locked fridge. The maximum and minimum temperature of the fridge was recorded daily on the logs that we checked. The temperatures recorded were within the appropriate ranges. We checked a range of medicines held in the fridge which were within the manufacturers' recommended expiry dates. These were stored to ensure that the oldest medicines were used first.
- Nursing staff liaised with the NHS pharmacy at the host trust for any general medicines enquiries. Medicines stock was checked monthly by pharmacy staff, and we saw evidence of this in the log for January 2017. Any medicines that passed the recommended expiry date were returned to the host trust's pharmacy for destruction. Additional pharmacy support was available from the head of regulatory and pharmacy services at the provider's head office.
- A monthly medicines checklist was in place. We viewed this for the period February to June 2017 and saw that it included logs of the expiry dates of medicines held by the unit.
- Staff had put in place a temporary process for collection and storage of pre-prepared injectable medicines. Such medicines required for each shift were collected prior to the shift from the medicines cupboard and stored in a plastic container within an unlockable cupboard by the nurses' station. The clinic manager explained this was to reduce the risk of infection from staff leaving the treatment area to collect individual medicine from the storage room for each patient. The clinic manager acknowledged that a permanent solution was needed and told us a lockable medicines cabinet had been ordered for temporarily storing this medicine within the treatment area.
- Any medicines needed were prescribed by the patient's consultant nephrologist. The unit did not use non-medical prescribers. The unit did not hold any medicines that could be administered under a patient group direction protocol. A patient group direction, signed by a doctor and agreed by a pharmacist, enables an authorised nurse to supply or administer prescription-only medicines to patients using their own assessment of patient need, without referring back to a doctor for an individual prescription.

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- A process was in place to fax urgent prescriptions to the unit with the signed hard copy of the prescription forwarded to the unit within 24 hours (or a maximum of 72 hours for bank holidays and weekends. This was in line with the provider's medicines management policy.
- We reviewed medicine prescription and administration cards held in six patient paper records. These were clearly written out, legible, and including relevant information such as the dose, frequency of administration and initials of the staff member administering the medicine. We could see that medicines were administered in line with the prescription instructions.
- However, we saw there was missing information in four of the prescription records we looked at. Three of the six records did not have the prescriber's signature on continuation records, while two of the six records did not include the patient's details at the top of each page. These issues were mitigated to a degree in that prescriptions were written in a pre-printed, stapled booklet, which meant the risk of loose pages being lost was minimised. When we told managers about this they formulated an action plan to ensure that incomplete prescriptions were corrected, that staff were reminded of their responsibilities and that audits were implemented to monitor progress.
- Staff held a log for medical safety alerts, which included alerts for medicines. The clinic manager reviewed each alert to determine if it applied to the unit. We saw evidence that relevant alerts were forwarded to staff, who signed to confirm they had received and read the information.

Records

- All staff were trained in the provider's record keeping policy, which included nursing documentation. The deputy clinic manager was the unit's information management systems representative.
- Staff used a mixture of electronic and paper records. Paper records, held in colour-coded files for each treatment shift, were stored in filing cabinets next to the nurses' stations in the treatment area. However, although staff were always present within the treatment area, the cupboards did not have locks available. This meant there was a small risk of unauthorised persons being able to access patient confidential information.
- Patients' clinical measurements, vital observations and treatment variations before, during and after treatment

were recorded and held within the unit's electronic system. This automatically transferred treatment data to the patient's main electronic hospital record at the commissioning trust. Pre dialysis, post connection, mid dialysis and post dialysis observations were also recorded within the patient's paper records.

- We reviewed six sets of patient paper and electronic records. All six sets of paper records were legible and included the observation readings on the flow sheet for each patient treatment session.
- However, we found examples in each of the records of information that was missing. For example, in one record for a patient with a central venous catheter temperature was not recorded, despite this being a requirement of the care pathway. In two records the patients' names and unit identification numbers were not always written at the top of each medicines prescription page, and the prescriber's signature was not always included on continuation sheets.
- A communications file was held on the unit for each consultant to assist in the handover of information. This included copies of the consultants' letters, GP clinic letters and patient blood results for review. The patient's named nurse updated the patient's dialysis records with any relevant information that was received.
- Staff carried out a monthly nursing documentation audit of ten per cent of records (approximately eight records per month). We reviewed the audits for between January and April 2017. All audits indicated an average of 77% compliance with the provider's requirements. Each of the four audits identified repeated deficiencies with record keeping in a number of areas including referral and admission documentation, present and correct revisions of the care plan, manual handling and waterlow scores (assessment of risk for developing pressure sores), and pre- and post-dialysis temperature checks for patients with a central venous catheter.
- Although an action plan was completed to highlight areas of improvement for each staff member, the actions and the wording used was consistently the same across all four audits. We were concerned that this highlighted ongoing and repeated problems with record keeping without any improvements made.
- Information about patients on holiday who received treatment at the unit was transferred to the unit's

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electronic record system prior to attendance. This included ensuring any relevant medicines were prescribed and prepared for the patient's arrival at the unit.

Assessing and responding to patient risk

- Staff undertook a detailed assessment of patients prior to commencement of their treatment at the unit. This reviewed each patient's admission form which included their clinical details, primary and renal diagnoses and vascular access type, past medical history, their existing medicines and current prescription and medicine administration chart, special needs or mobility requirements, information relating to activities in daily life, and the patient's emotional and religious needs. Patients were already established on dialysis before attending the unit.
- Flowchart algorithms on the use of anaphylaxis medicine, the automatic external defibrillator and the management of choking in an adult patient were displayed behind the nurses' station.
- The clinic manager told us there was no process in place for the identification or management of sepsis. The unit did not currently use any form of early warning score (EWS) system which can help identify deteriorating patients including those who may be developing sepsis. The manager told us the unit was waiting for an updated sepsis policy to be provided by the commissioning trust. In the meantime this had been identified as an issue on the unit's risk register.
- Staff could be alerted to a patient's deterioration in a number of ways, including machine alarms, the patient alerting staff, and visual signs of deterioration. In addition, each dialysis machine allowed staff to pre-programme the frequency of observations to ensure they were completed as regularly as needed for the patient's presentation and condition. However, in the absence of a policy and EWS system, there was a risk that staff may not readily identify the early indications of sepsis in a deteriorating patient.
- Staff used a tool for all skin colours to help identify signs of infection on skin for patients with central venous catheter lines. This meant early signs of infection could be promptly identified using a recognised system.
- Intravenous antibiotics could be administered if prescribed by the consultant nephrologists. The unit accepted faxed prescriptions; however, these were followed by a hard copy written prescription within 24 hours, or a maximum of 72 hours over a weekend or bank holiday. This was in line with the provider's medicines management policy.
- Between March 2016 and February 2017, eight patients were transferred from the clinic to another health care provider. The appointment slots for these patients were held for two weeks to enable them to return to their regular treatment regime after discharge from hospital. If the transfer extended beyond two weeks then the patient's care was referred back to the commissioning trust's unit.
- Each patient had an individual identification card for use with the unit's equipment. Each card was labelled with the patient's name and was inserted to the relevant equipment to identify the patient, for example on the weighing scales and the dialysis machine. Any measurements or other patient information collected by each piece of equipment was stored on the service's computer system and not on the card. This meant that if the card was lost or misplaced, no patient information could be read from the card itself.
- Prior to commencement of dialysis treatment, staff inserted the patient's identification card into the dialysis machine. The machine automatically required the staff member to confirm the name of the patient by pressing the relevant on-screen button. Staff then cross referenced the electronic information record on the machine with the patient's paper session treatment record. In many cases, staff had known their patients for a long time and the process of cross checking the details held on the machine reduced the risk of misidentifying patients. However, we were not assured that patient ID checks were always being carried out.
- We observed two staff members asking patients to confirm their name and date of birth. This was in line with the provider's medicines management policy, which requires staff administering medicines to "clearly identify the patient for whom the medicine is intended". However, we also observed a staff member connecting a patient to the dialysis machine, and administering a medicine, without requesting this information.
- We raised this with the clinic manager who was aware of the issue. The clinic manager told us this had been discussed at the regional meeting and patient name tags had just been delivered to the unit to assist in more formal and robust identification of patients receiving treatment. They also described a pilot study which was

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in progress at another clinic to potentially address the issue of patient identification. The pilot related to photographic ID being taken with the consent of the patient and held in their patient file.

- We saw evidence that patients were assessed at the start, during and after dialysis to ensure they were fit to commence treatment and following treatment. Vital observations were automatically recorded on the unit's electronic patient record.

Staffing

- At the time of our inspection, the unit employed 9.24 (whole time equivalent) dialysis nurses including the clinic manager, deputy clinic manager, two team leaders and five nurses. A further 7.72 (whole time equivalent) dialysis assistants and one secretary were also employed.
- The clinic manager used an e-rostering system to ensure a minimum of two registered nurses were scheduled for each shift. The nurse to patient ratio was 1:4 with a skill ratio of 60% nursing staff to 40% non-registered clinical staff. This was in line with the recommendations of the National Renal Workforce Planning Group 2002.
- The unit had one nursing vacancy at the time of the inspection.
- The unit did not have any healthcare assistant staff at the time of the inspection. One nursing staff member told us they felt additional staff would enable nursing staff to spend more time with patients when disconnecting them, and to update records and paperwork.
- In the period between December 2016 and February 2017, staff sickness rates were 18% for nursing staff and 16% for dialysis assistant staff. However, the rates reported are reflective of the overall low numbers of staff in the unit. During the same period bank staff provided cover for 63 shifts and agency staff covered a further 40 shifts.
- The unit did not have any on-site medical staff. However, staff were supported by two consultant nephrologists from the commissioning trust, who visited the site once a week. An on call system was also available to the renal registrar at the commissioning trust if advice was required out of hours. Staff were aware of how to obtain advice if needed.
- Two dietitians were based at the unit.

- The unit did not have any on-site technical staff; however, staff were able to request urgent unscheduled visits from the provider's technicians to carry out work on the equipment if needed.
- Staff in the unit undertook other roles such as the link nurses for health and safety, infection prevention and control and the prescription system.
- Handovers took place each morning using a set agenda. Some of the items were linked to the Care Quality Commission questions, which covered safety, effectiveness, caring, responsiveness and well led elements of the service. A communications book was held at the nurse's station to assist in handovers and to ensure all relevant information was passed to the incoming staff. We saw that during, and following, our inspection reminders about handing call bells to patients were included in the safety aspect of the handover. Other individual handovers took place between nurses on a one to one basis as shifts changed over.

Major incident awareness and training

- The unit had an emergency preparedness plan for the prevention and management of emergency situations. It defined roles and contact details for the emergency, public, and utility services. It also set out detailed instructions for staff to follow in various scenarios including fire, power failure, minor and major water leaks, storm damage, and release of toxic fumes or gases. Staff were aware of the plan and of their roles in an emergency.
- In the event of a major incident, which affected the operation of the unit, patients could be referred back to the renal unit at the commissioning trust or to other satellite units within the region to continue with their treatments.
- The unit did not have an emergency evacuation 'grab bag'. We discussed this with the clinic manager who told us staff would take the equipment trolley with them in an emergency evacuation situation. This was because staff could be sure it held all the relevant equipment and that the equipment was in date.
- Personal emergency evacuation plans were in place for all patients attending the unit. These included assessment of each patient's individual physical, mobility, and medical needs; identification of any need to use the internal refuge point; and, identification of the number of staff needed to support the patient

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within the refuge point. However, although a central summary document of the personal plans was easily accessible in the filing cupboard in the treatment area, only four of the six patient paper records we reviewed held a copy of the individual plan.

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

Evidence-based care and treatment

- The provider developed a Nephrocare Standard Good Dialysis Care that took into account professional standards and guidance from the Renal Association, the National Institute for Health and Care Excellence (NICE), best practice and research literature from a range of sources. The standard addressed the processes to follow immediately before, at the beginning, during and at the end of haemodialysis treatment, and provided a guide for all staff to follow to ensure safe care and treatment for patients receiving treatment at the unit. The standard provided a framework against which the provider's other policies and procedures were linked.
- Treatment to patients was provided by staff in line with their individual treatment prescriptions, which were based on the Renal Association Haemodialysis guidelines (2009) and the National Institute for Health and Care Excellence (NICE, Quality standard QS72, 2015). Prescriptions were reviewed and amended by the multidisciplinary team following monthly monitoring of patients' individual blood results. This enabled the medical team to review the effectiveness of treatment and to make improvements or changes to a patients care plan.
- Patient treatment data was recorded by an electronic information management system. The live data was available for review by the clinic manager and the consultant nephrologists, and the system was able to produce customised analysis and reports. This meant that opportunities to improve individual patient outcomes were easily identifiable, and performance against the provider's national standards could be assessed.
- NICE Quality Statement (QS72, 2015) was followed with regard to how staff monitored and maintained each patient's vascular access (for treatment). Between January 2017 and May 2017, an average of 82% of patients in the unit received dialysis through an arteriovenous fistula (AV fistula – a surgically created connection between an artery and vein). This was better than the target of 65% of patients commencing treatment with a fistula. Experienced nurses on the unit cannulated patients with new or less established fistulas. The remaining patients received dialysis through a central venous catheter.
- Assessment of patients' vascular access was carried out before and during treatment. Continuous monitoring by the dialysis machine meant that nurses were alerted by a machine alarm to any potential issues that could relate to poorly functioning fistula. Fistulas were also monitored every three months using an ultrasound monitoring device; if any problems were identified the patient was referred to the vascular consultant at the commissioning trust. Staff were preparing to change to a new type of ultrasound monitoring device and, at the time of the inspection, five staff had already received training on the new device.
- At the time of the inspection, 18 patients had been identified as needing additional vascular access support. These patients were reviewed monthly by the vascular team.
- Vascular access review meetings were held quarterly. These were attended by the renal consultants, a vascular consultant, a consultant radiologist, and a member of the unit's nursing team. The meeting reviewed patient X-rays and vascular access problems for individual patients. In between this, any vascular issues were reported on a monthly basis to the commissioning trust.
- Patients' weight, temperature, pulse, and blood pressure were checked before dialysis commenced, after the patient had been connected to the dialysis machine, and after dialysis ended. Additional readings were taken during dialysis if clinically required and if the patient requested this. The readings were automatically transferred to the patient's electronic record. We observed patients and staff undertaking these observations.
- The centre met the national recommendations outlined in the Renal Association Haemodialysis Guidelines (2011). For example, Guideline 2.3: 'Haemodialysis equipment and disposables' and Guideline 6.2: 'Monthly monitoring of biochemical and haematological parameter (blood tests)'.

Pain relief

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- None of the patients we spoke with told us they had experienced significant pain during their treatment sessions. However, the patients confirmed that pain relief would be provided by nursing staff if they were feeling mild pain or headaches.
- Topical anaesthetic cream could be used, if needed, before the insertion of the dialysis needles into the vascular access site if this had been prescribed for patients.

Nutrition and hydration

- The unit provided refreshments, including sandwiches, biscuits and drinks to patients during treatment. Patients were able to choose in advance the type of sandwich they wanted, including vegetarian options. Patients were able to request changes, but this needed to be done a week in advance.
- Two dietitians were based at the unit which meant that dietetics cover was available Monday to Friday. The dietitians formed part of the multidisciplinary team who reviewed patients' care and treatment. Patients we spoke with confirmed they received regular information and advice from the dietitian. Staff had a communications file to enhance communication between the dietitian and staff.
- An information notice board within the waiting area included helpful information for patients on foods with high potassium levels and changes to recommendations on snack foods including those to avoid. One patient we spoke to told us the dietitian had recently discussed the changes in recommendations on snack foods.

Patient outcomes

- Information about the outcomes of patients' care and treatment was collected and monitored by the service to ensure good quality care outcomes were achieved for each patient. The unit measured and reported to the commissioning trust on its effectiveness against the quality standards of the Renal Association Guidelines. Electronic treatment data collected by the dialysis machines was submitted to the commissioning trust for inclusion in its overall submission to the UK Renal Registry.
- The registry collects, analyses and reports on data from the UK adult and paediatric renal centres. The data submitted included patients under the direct care and supervision of staff; it did not include information on

patients undergoing dialysis elsewhere during holiday periods. As the unit's data was combined with the trust's data, the unit was unable to benchmark its outcomes against other providers' clinics.

- The service used standard methods of measuring dialysis dose. Urea Reduction Ratio (URR) is the most widely used index of dialysis dose used in the UK. URR is the percentage fall in blood urea achieved by a dialysis session and studies have shown the URR should be at least 65%. Data showed that between January 2017 and May 2017, an average of 95% of patients achieved the Renal Association target of more than 65% reduction. In the same period, 89% of patients achieved the equilibrated urea reduction value of Kt/V greater than 1.2 calculated from pre-and post-dialysis urea values. This was in-line with Renal Association guidelines. (Guideline 5.3 - HD: Minimum dose of thrice weekly haemodialysis).
- Patient blood was tested for potassium, phosphate, calcium aluminium concentrations in-line with the renal association guidelines. Pre dialysis serum potassium in patients' blood was monitored on a monthly basis. Renal Association guidance suggests that pre-dialysis serum potassium should be between 4.0 and 6.0 mmol/l in HD patients. Between January 2017 and May 2017, an average of 85% of patients maintained their potassium levels within this range. Patient haemoglobin (HB) levels were measured to ensure that they remained within 10.5-12.5g/dl target range. In the same period, an average of 61% of patients remained within the recommended range.
- Patients' blood results were monitored and available within the commissioning trust's electronic system for review each month by the consultant nephrologists. Hard copies of all patients' latest blood results were held for discussion in the monthly multidisciplinary team meeting. This enabled staff to review the effectiveness of treatment and implement changes to patient's prescriptions and care plans to improve outcomes.

Competent staff

- Five staff members, including the clinic manager and deputy manager held renal nursing qualifications. The provider supported opportunities for other staff to undertake renal qualifications, and a further staff member was due to commence study for this.

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- Staff underwent annual competency checks, which were signed off by the clinic manager. We reviewed five staff training files which included, a competency record and annual staff reassessment record, infection prevention and control annual assessment, individual training and education plan, training certificates and employee notification of risks.
- All staff were expected to have an up to date disclosure and barring service certificate. These were held centrally by the provider's human resources department, and the clinic manager told us they were assured that all appropriate checks had been carried out.
- Existing staff were supported in maintaining their professional development and in revalidation with their professional body. One staff member noted that, due to the nature of the work, they do not always experience the scenarios required as part of the revalidation reflective practice.
- New staff members underwent a training and education progression plan, which included four to six weeks of supervised practice under the guidance of a supernumerary mentor. During this period new staff were able to consolidate their skills and clinical practice, and completed their competency checks.
- The clinic manager was relatively new to role but was being monitored and supported by the area head nurse who had significant management and renal experience. The clinic manager also had structured development in place such as a competency document which covered elements of management including sickness management, appraisals and stock control.
- Staff had the opportunity to complete training for some topics on a voluntary basis. We saw records, which confirmed out of 17 staff, eight (47%) had completed additional training in chronic kidney disease, six (35%) had completed training in blood borne viruses and four (24%) in blood pressure measurement.
- All staff were trained in the provision of basic life support (BLS). A life support simulation was carried out in May 2017.
- The clinic was notified of any updated policies and procedures by the corporate training team. The clinic manager reviewed each new policy and, using the training matrix, identified which staff members were required to read the updated document. Staff signed to

confirm when they had done so. We saw evidence of completed sign-off sheets for a range of policies include the Nephrocare hygiene plan, resuscitation policy, and retention of records policy.

- Bank and agency staff were informed of any updates through a different system where the corporate training team notified the relevant organisations.
- Bank staff were provided by the provider's in-house agency: Renal Flexi bank. All bank staff underwent an induction programme, which included competency assessment to the same standards as permanent staff. Bank staff were provided with key clinical policies and work instructions as part of their induction training. This reduced the time taken to orientate bank staff to the unit and minimised any disruption to patients.
- New bank and agency staff were required to undertake a health and safety temporary worker induction checklist, which included orientation to the unit and the use of emergency equipment.
- The provider's specification for agency staff required staff to have renal experience and, where possible, a renal qualification. The provider worked closely with the agency to use nurses who had previously covered shifts at the unit. Any concerns about the competency of new bank or agency staff were fed back to, or checked with, the relevant organisations.
- Staff we spoke with confirmed they had received an appraisal in the past 12 months. Records indicated that 13 out of 17 staff (76%) had received an appraisal by the time of the inspection, with the remaining staff scheduled to undergo appraisal at a future date in line with the 12 month rolling appraisal plan.
- Checks of the Nursing and Midwifery Council nursing validation registration PIN numbers for all nursing staff at the unit were carried out monthly. We reviewed the check log for June 2017 which was fully completed.
- All staff had access to the provider's online learning centre, and staff told us managers supported further development through this.

Multidisciplinary working

- We observed nursing and dialysis assistant staff communicating effectively in providing care and treatment for patients during our inspection.
- Different staff worked together to provide care for patients in the clinic. These included consultants,

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dietitians, nurses, assistants and administrators. Overall responsibility of care of the patients remained with the consultant nephrologists, who visited the unit twice weekly.

- Dietitians were based on site five days a week and saw each patient at least once a month. They adjusted their hours to ensure they saw patients during twilight sessions as well as those who attended early in the morning.
- A communication book was used to enhance communication between the consultants and the named nurses for the patients.
- A multidisciplinary meeting (MDT) was held monthly to review each patient's blood results, progress and general condition. This meeting included the consultants, dietitian and the clinic manager. Additional vascular, psychological and social work support could be accessed by the MDT team if needed, although these individuals did not routinely attend MDT meetings.
- The MDT reviewed the patient's treatment records and care plan. Any changes to patients' care and prescriptions were recorded and subsequently entered into the communications book for each named nurse to initiate the agreed actions. Outcomes and changes were discussed with all patients by the named nurses and dietitian.
- Reports from the MDT meetings were sent to the commissioning trust each month, which included the details of any treatment variances and reasons for the variance.

Access to information

- Staff told us they had access to all the relevant information they needed to provide effective care to patients. This included previous treatment records and current observation records, up to date prescriptions, and patient's clinic letters from the renal team to their GPs.
- Patients' blood results were held on the commissioning trust's electronic computer system, which was accessible by all staff including the consultant nephrologists. This meant the medical and nursing teams had the latest information available for patients undertaking dialysis.
- Clinic letters from the medical team were copied to the unit and the patient's GP.

Consent, Mental Capacity Act and Deprivation of Liberty

- The provider had a policy for consent to examination or treatment. The policy provided guidance to staff on seeking consent to treatment. This included seeking advice from or assessment by, the commissioning unit when a patient lacked capacity to consent to treatment.
- Patients who lacked capacity were generally not referred to the unit for treatment. Instead they were treated by the commissioning trust. Existing patients who developed capacity issues were discussed with the commissioning trust so that a suitable plan for future care could be made.
- All staff received mandatory training in the Mental Capacity Act 2005, the Guide to the Deprivation of Liberty Safeguards (DoLS), and an Introduction to Dementia for Health and Care Professionals. The training matrix indicated that all nursing staff were required to undertake training in the provider's consent policy.
- Consent forms were held within all six paper records we reviewed. The form detailed the type of treatment including the risks and benefits, confirmation of any advance directives or do not attempt cardiopulmonary resuscitation orders, confirmation of agreement to data protection and research analysis, and any requirement for interpretation. Two of the consent forms were completed in 2014 and 2015 respectively, and we could find no evidence to indicate these had been reviewed. One other consent form did not include the patient's full name and was not signed.

Are dialysis services caring?

Compassionate care

- We observed staff interacting with patients in a friendly, compassionate and caring manner.
- The unit had a named nurse for each patient, which helped to ensure continuity of care. All patients in the unit knew who their named nurse was.
- We spoke with five patients and one carer during the inspection. One of the patients we spoke with expressed their view that the appointment of the current clinic manager had had a positive impact on the patients, staff and the general atmosphere of the clinic.

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- One staff member showed us a statement received from one of her patients. It said the staff member “is an excellent nurse, who goes above and beyond her duty...to care for others. She is very caring and one feels safe with her.”
- Disposable privacy curtains were available around some, but not all, treatment stations to provide privacy for patients if required. All the available privacy curtains had been marked with the date of last replacement, and were within appropriate timescales which reduced infection risk. The clinic manager explained their concerns about staff safety in using step-ladders to replace privacy curtains. The manager told us they had ordered and were awaiting delivery of mobile privacy screens which would replace the use of privacy curtains.
- All 37 patients who responded in the 2016 patient survey said they felt their confidentiality was respected; however, only 24 patients felt their privacy was respected when discussing their treatment with nurses. One patient told us they were concerned about the lack of privacy when discussing care and treatment with their doctor in the treatment area. The patient told us they would prefer to speak with a doctor in the consultation room.
- Thirty-two patients said in the survey that unit staff were caring and 33 said that support staff were helpful and friendly. One patient told us they “can’t fault staff” although they reflected that the dialysis assistants “don’t quite get it and don’t listen to patients when needling”. Another patient told us they were happy with their care and spoke highly of the staff stating “staff are wonderful”.

Understanding and involvement of patients and those close to them

- Of the 37 patients that responded to the 2016 patient survey, 29 (78%) said they were treated with dignity, 27 (73%) said they were kept well informed by nurses about decisions taken about their treatment, while 26 felt nurses explained things in a way they could understand. However, comments we received during the inspection indicated that patient satisfaction had increased following the appointment of the new clinic manager.
- These scores indicated an improvement in the same questions from the previous survey. However, the survey action plan identified this as an area for improvement

with a reminder to staff that all named nurses should discuss patient care and blood results on a monthly basis using the monthly feedback report available on the unit’s electronic records system.

- Staff encouraged ‘self-care’ with all patients in the unit, and took opportunities to discuss this with patients. However, the unit did not support any patients who provided self-care at home.
- All of the patients we spoke with told us their named nurses involved them in discussion and explanations about their care, including their blood results. However, one patient told us they did not always understand the results they were given, and did not often get to speak with the doctor.

Emotional support

- Staff operated a named nurse system and this was clearly noted in the records for each patient. This system helped to ensure continuity of care for each patient. Patients in the unit knew who their named nurse was.
- Staff understood the importance of building a strong and friendly rapport with the patients in their care, a number of whom had received care at the unit for many years. Staff were aware of the impact of chronic kidney disease on their patients and how long-term dialysis affected their individual needs.
- A separate consultation room was available for patients to discuss confidential information with staff or the medical team.
- The clinic manager told us they supported patients and staff to attend funerals. One carer told us staff had accommodated a change of appointment slot to enable them to attend a funeral.

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

Service planning and delivery to meet the needs of local people

- The unit’s contract, and service specification, was defined and agreed directly with the commissioning trust’s renal team. As such the unit had no direct link with the commissioners in planning its services. However, performance against the contract was

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monitored through the quarterly meetings between the provider's business manager and the commissioning trust and in the submission of monthly renal key performance indicator data.

- The design and layout of the unit adhered to the recommendations of the Department of Health's Health Building Note 07-01: Satellite dialysis unit. The entrance to the single-storey building, which housed the unit, was through a secure door into the waiting area. An accessible unisex toilet was available within the unit's waiting area for patients to use if needed prior to commencement of treatment.
- Access to the treatment area was off the waiting area. One nursing staff member was assigned to each group of four patients. There was sufficient space between, and around, the treatment beds for patients and staff to move safely. The treatment chairs included pressure relieving mattresses.
- The unit had 15 car parking spaces which were available for use by patients and staff with an identification badge. There was adequate space for patient transport vehicles to deliver patients to the front door.
- Staff requested detailed information about patients prior to acceptance of their care. This was to ensure the patient met the admission criteria and that the unit could meet their individual care needs in a safe and effective way. Staff were able to accommodate visits by new patients and their relatives prior to the start of treatment. This meant that patients were familiar with the unit, its facilities and the staff.
- Staff accepted patients living with dementia or learning disabilities subject to assessment of the individual's needs during the transfer process. If necessary, this included undertaking best interests meetings.
- The allocation of appointment slots for dialysis treatment took into account patients' individual needs, including any social care or work commitments, the number of hours and days for the prescribed treatment, and the length of the patient's journey to the unit. Staff also aimed to provide daytime slots for elderly and vulnerable patients, or those with more complex care needs.
- The clinic secretary was responsible for co ordinating, and preparing the relevant paperwork, for holiday treatment for the unit's existing patients. Consultant to consultant agreement for holiday treatment was obtained and patients were screened for infection before confirmation of the treatment.

- We saw that the unit's policies and procedures took into account relevant policies and guidance from the commissioning trust.

Access and flow

- The unit opened six days a week Monday to Saturday and had capacity to provide three dialysis treatment sessions for each treatment station per day (maximum of 330 sessions per week) at 6.45am, 12.15pm and 6pm.
- Between January and March 2017, the unit had an average utilisation rate of 90%. This meant the unit did not hold a waiting list, was not normally affected by seasonal pressures, and was able to offer flexibility to patients with appointment times.
- Responsibility for the management, referral and prioritisation of new patients requiring dialysis remained with the commissioning trust. However, the criteria for referral and acceptance of new patients were set out in the 'Patient Referral and Acceptance for Treatment' policy. Patients were assessed for suitability prior to acceptance to the unit.
- The acceptance criteria included, although were not limited to, patients being stable with established and functioning venous access, independently mobile, and no recent cardiac, cerebrovascular or psychiatric history, no ongoing medicines through infusion pumps, no wound dressings required, and copies of last blood results.
- Staff aimed to accommodate patient requests or to co-ordinate swapping treatment sessions were possible. This included adjusting treatment session duration or frequency to accommodate patient requirements if required. For example, staff told us they had agreed a shift change and shorter treatment times for one patient who needed flexibility to receive treatment around their working pattern.
- Between March 2016 and February 2017, staff did not cancel or delay any treatment sessions as a result of non-clinical reasons or machine breakdown. However, the unit had arrangements in place to ensure continuity of patient treatment where treatment sessions had to be cancelled. This included opening the unit on Sundays and/or referring patients to treatment sessions in the provider's other satellite units or NHS dialysis units.
- Staff did not monitor patient waiting times for connection to dialysis machines. This meant we were unable to confirm that patients were connected

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promptly when they arrived for treatment. However, we did not witness any delays during our inspection and none of the patients we spoke to raised concerns about delays.

- Between January 2017 and May 2017, patients did not attend for a total of 405 treatment sessions. Staff recognised the majority of non-attendances related to four individuals with whom it was working closely to improve attendance. However, this figure is not able to reflect how many alternative appointments were made for patients following staff intervention.
- For each session missed, staff followed the unit's protocol to contact each patient to determine a reason for the non-attendance and, if appropriate, to encourage the patient to come in. Where patients were unable to attend renal advice was given in relation to fluid and diet; this included advice to contact medical services if the patient began to feel more unwell.
- If staff were unable to contact the patient, a process was available to contact the commissioning trust to check if the patient had been admitted to hospital, the patient's next of kin or the police to request a welfare check.
- The unit did not have separate treatment beds for patients on holiday. However, staff were able to accept patients on holiday if there was capacity for the dates required. This was subject to approval from the commissioning trust, receipt of fully completed documentation, and medical approval and acceptance. This included consideration of any risk posed by the incoming patient on the resident patient cohort, for example isolation requirements.

Meeting people's individual needs

- Patients were seen based on their clinical condition (such as infection status) and whether there was space on the unit to accommodate them, irrespective of backgrounds such as race, religion, sexual orientation or marital status.
- The demographics of the local population and patients meant the unit did not routinely hold printed information in languages other than English or required access to interpretation services. However, staff reviewed the communication needs for new patients as part of the patient acceptance and transfer process.
- Staff were able to request copies of the patient guide and information leaflets in a range of other languages including Welsh, Punjabi, Filipino, Arabic, Hindi and Urdu. Information could also be provided in braille on

request. Interpretation services, including British sign language, were available through the commissioning trust. A poster within the waiting area reminded patients to ask staff if they needed information to be translated.

- The consultation room was available to any patients that wished to pray.
- There was adequate patient parking within the grounds of the host trust; the unit was located next to the main hospital carpark. Approximately 15 designated dialysis parking bays were also located outside the unit for patients who were able to drive. For patients who required transport, this was arranged through the local ambulance service, which contracted the service to a local taxi firm. Of the five patients we spoke with only one raised concerns about the patient transport noting that occasionally transport was delayed between twenty minutes to an hour. Another patient told us they had no problems with the taxi transport service. Transport waiting times were not monitored by staff.
- Unisex accessible toilets were available for patients to use. Staff explained that this was useful for transgender patients and gave us an example of a transgender patient who had received care at the unit.
- Access to the unit was via a ramp and the entrance door was secured with a remote locking system which could be opened by staff at the reception desk or nurse's station. The clinic office was located adjacent to the waiting area, and afforded staff good visibility of both the waiting area and the treatment area. However, there was no separate changing area for patients or lockers for patients to store outside clothing; coats were stored in the waiting area.
- The unit did not support any patients who received care at home. However, staff encouraged patients to be involved in their own care, or to self-care. One patient told us they were happy to set up the treatment station themselves.
- A register was held by the clinic manager to capture details of any patients staff felt may need additional support; for example patients approaching the end of life, or those who repeatedly did not attend.
- Staff aimed to assist patients with other healthcare needs where possible. One staff member described an example of a patient with a suspected ear infection. The staff member attempted to arrange a GP appointment; however, as this was not successful, the staff member arranged for the patient to be seen in the walk-in centre.

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- A Wi-Fi system enabled patients to connect to the internet during their treatment. However, although each treatment station was equipped with a TV, patients told us they had experienced a number of faults and did not always work. The clinic manager was aware of the issue but, although faults had been reported and technicians had attempted to fix the problem, the issues appeared to be recurrent.
- Staff provided new patients with a patient guide. The guide included information on how to use the electronic patient record card, health and safety information, safeguarding information, hygiene and infection control advice, understanding dialysis including the various types of venous access, diet information, holiday information, how to complain, and other sources of information.

Learning from complaints and concerns

- The provider's policy set out the process and staff responsibilities for handling compliments, comments, concerns and complaints. Feedback from patients was received verbally, in writing, through the patient satisfaction survey, or through the unit's 'Tell us what you think' leaflet. The policy and the unit's statement of purpose were displayed within the unit's waiting area. The clinic manager was responsible for investigating complaints.
- The policy set out a 20 working day timescale for complaints and concerns to be responded to, and included a risk assessment to determine the severity of the concern. The assessment level identified which staff needed to be made aware of, investigate, and subsequently approve the response to the complaint. The clinic manager was responsible for ensuring complaints were responded to within the policy's timescales.
- Managers told us that no formal complaints had been reported in the period March 2016 to February 2017. This meant we could not comment on the unit's timeliness for responding to complaints, or the sharing of learning from complaints. However, two of the patients we spoke with described concerns they had raised in the past. Both patients told us the concerns had since been addressed and they had seen improvements on the unit as a result.

- Staff confirmed that learning from complaints was shared within the unit. This included retraining for individual staff members involved in a complaint or review of policies and procedures if the complaint was related to systemic issues.
- Staff told us they aimed to identify and respond to patient concerns face to face, and recorded informal complaints they had been able to resolve in the patients notes. This meant concerns were dealt with before they escalated to formal complaints or required formal investigation. This was a positive and proactive approach; however, it also meant that low level concerns were not always recorded in a way that would enable staff to identify trends.
- Although no formal complaints were received by the unit, patients and staff we spoke with reflected on the significant improvements in the culture of the unit following action taken by the provider to appoint the new clinic manager. This action was taken following concerns raised by patients' petition, and the results of the 2016 patient survey.
- We reviewed a file that contained a significant number of thank you cards staff had previously received. However, as none of these were dated it was not possible to determine if any had been received during the twelve months prior to our inspection. The clinic manager acknowledged that compliments had not been formally logged when received.

Are dialysis services well-led?

Leadership and culture of service

- There was a clear leadership structure which helped staff undertake their roles in caring for patients. The clinic manager was supported by a deputy clinic manager and a team leader in leading the unit. The clinic manager also undertook clinical duties (approximately 25% of their time). Whilst this was a relatively new managerial appointment, the manager did have experience as a team leader and was being closely monitored and supported by the area head nurse.
- The area head nurse, who had responsibility for the performance of a number of clinics in the region, reported through the regional business manager to the clinical services director. The area head nurse had 30 years renal nursing experience including the

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management of clinic and community based renal care, acute renal care, care based in satellite clinics and home care teams, as well as experience establishing dialysis unit and working with commissioning teams.

- Other corporate teams supported the staff in the unit including a clinical incident team and regional training centres.
- Staff had been through a period of what they described as poor management, which patients described had a negative impact on the culture and general atmosphere. However, following the appointment of the new clinic manager the situation was much improved. This was evident in a Kidney Patient Association nomination for the new manager for nurse of the year in November 2016 which resulted in the manager achieving second place.
- The manager had an understanding of the challenges to providing good quality care and was able to tell us how these were being addressed. For example, the manager and area head nurse described short notice staffing issues and the increasing challenges of managing psychological aspects of renal care which were increasing over time.
- Staff told us that local senior staff were visible and approachable. Staff were aware of the clinic services director and confirmed he had visited the unit on a number of occasions. Staff said they felt they could contact the clinical services director or regional managers if required.
- We observed a supportive atmosphere within the unit and this was reflected in comments we received from staff. One staff member told us “it’s like one big family. My patients are my family.” Staff acknowledged there had been a significant number of changes in the unit over the past year. One staff member told us the clinic manager was “trying to implement change for the better” and that all staff members were “getting a new mind set”.
- The clinic manager described the culture within the team with confidence having been a member of the team prior to taking on the management role. She told us that staff had not been completely aware of the requirements of their role or accountability. To improve this the manager was defining roles and inviting staff to develop in areas such as infection control, through the formation of ‘link’ roles (roles where staff have an

expertise in different topics). The area head nurse had been asked to contribute to a talent management project to identify any rising stars which was due to begin in July 2017.

- Staff were governed by a corporate code of ethics and business conduct which described the company values in relation to equality and human rights. Specifically, the code of conduct prohibited staff from discriminating people on the grounds of race, gender, marital status, age, disability or nationality. We saw that members of staff in employment came from different ethnic, cultural and religious backgrounds.

Vision and strategy for this core service

- The provider’s strategy was “to provide safe, effective quality care for adults with end stage renal disease.” This was supported by a mission statement, which was set out in the employee handbook and detailed its “commitment to providing high quality products and services and bringing the optimal sustainable medical and professional practices to patient care. We are committed to honesty, integrity, respect and dignity in our working and business relations with our employees and business partners.”
- The provider had three core values of quality, honesty, and integrity; innovation and improvement; and, respect and dignity. The provider’s had four objectives focused on patients, employees, shareholders and the community: to improve life expectancy and quality of life for patients; to promote staff professional development; to ensure continuous development of the company; and to reflect social responsibilities, legal and safety standards and contribute to maintaining the environment. The provider’s vision and objectives were clearly displayed within the unit’s waiting area.
- Staff we asked were aware the provider had a strategy and values. Staff were unable to discuss these in detail; however, they were able to describe the objective of improvement life expectancy and quality of life for their patients. Staff were aware of how their roles contributed to achieving this objective.

Governance, risk management and quality measurement

- The unit had a clear staffing structure. This included the clinic manager, deputy manager, team leaders, nursing and dialysis assistant staff. Other corporate teams supported staff such as a clinical incident team.

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- The unit had a clinical governance strategy document, which supported the organisation's strategic aims and a statement of purpose which was displayed for patients attending the unit.
- The strategy document set out the roles and responsibilities of the Clinical Governance Committee; its membership including the medical director, director of clinical services, and regional manager; its five objectives; and the clinical governance reporting structure from the NHS nephrologists through to the board.
- The statement of purpose listed aims and objectives for a range of stakeholders including patients. Employees, shareholders and the local community. These included aims to increase life expectancy, professionally develop staff, provide good financial returns for stakeholders and adhere to legal and safety standards which could affect the community.
- The chief executive retained overall responsibility and accountability for clinical governance. Individual clinic managers had responsibility to ensure their unit established and implemented the clinical governance plan to improve the quality of care provided; facilitate the delivery of the clinical governance plan, and to submit monthly clinical governance reports.
- The consultant nephrologist was the clinical governance lead for the unit, while the clinic manager was the lead for overall governance in the unit, and was responsible for collating and submitting governance data, reviewing updates in policies and ensuring these were disseminated to staff.
- Staff we spoke with were clear about their roles in providing care and treatment for patients, and in supporting staff in their additional link roles. However, we were concerned that there appeared to be no improvement in the repeated errors highlighted by the nursing documentation audit despite action plans being put in place.
- There was a close working relationship between the unit and its NHS stakeholders; the commissioning trust. Contract meetings were held quarterly and the commissioning trust matron visited regularly with the latest visit in May 2017. Patients who attended the unit were referred to the specialist renal and dialysis services provided by the commissioning trust. The unit functioned as a satellite unit for, and under contract to, the commissioning trust.
- The unit was included in the provider's monthly benchmarking audit of performance against other clinics. The December 2016 review looked at effective weekly treatment time (63%), infusion blood volume (71%), single pool Kt/V (54%), vascular access (74%), albumin levels (27.6%), haemoglobin (56%) and phosphate levels (47%). In all but one measure (vascular access) the unit performed within the lower 50% of the provider's clinics. The review also calculated each unit's percentage change over a six month period between June 2016 and December 2016. Over this time period the unit only improved in one measure: effective weekly treatment time.
- The provider had achieved ISO 9001 accreditation for its Integrated Management Systems (IMS). The IMS system, which all staff had access to, held current and previous versions of all the organisation's policies and procedures. This meant staff were able to access the most up to date policies. The system also included a document version control facility, which tracked the review of documents including previous versions. Staff had the ability with the system to highlight any errors or issues with documents to the relevant document owner. The review date on some of the hard copy policy documents provided to us was not clear and seemingly out of date; however, we saw evidence on the system that these documents had been recently reviewed and re-ratified.
- The unit had achieved OHSAS 18001 accreditation for its health and safety management system.
- Managers used a risk register, which separately held 21 clinical, 22 operational, and 22 technical risks. The register was reviewed each month and during quarterly clinic reviews by senior managers in the organisation. The risks included on the register reflected the risks we expected to see during the inspection.
- Each risk was categorised with a description of the risk, who the risk was raised by, which regions or clinics the risk affected, a calculation of the risk score/level by impact and likelihood, current controls, and additional controls needed, an action owner, planned and actual completion dates. The register named the person who had identified each risk but only those risks where additional controls were identified had an action owner. The corporately identified risks reflected the risks we would expect to see in this clinic; however, although the register was new and had yet to be fully embedded, it only included two locally identified risks.

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- Despite the risk register being very new, other risk management tools had been in place for some time. These included using risk assessments to capture existing risks and look at ways to manage or reduce the risk. For example the risk of handling and disposing of waste and the handling of sharps (needles).
- Managers also held a risk register for patients. This included details such as patients who did not attend, or had suicidal risks. The register was discussed at multidisciplinary team meetings but was relatively new having only been introduced in the last two months.
- Senior managers told us that details pertaining to race, ethnicity, marital status and religion were all removed prior to managers reviewing application forms and stored by human resource staff, which ensured recruitment was not based on these factors. The provider did not publish data relating to the NHS Workforce Race Equality Standard (WRES); however, this was recorded as a risk by the provider on its risk register.
- WRES is a requirement for organisations which provide care to NHS patients. This is to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. We acknowledged the local area had low numbers of black and minority ethnic population (BME).
- WRES has been part of the NHS standard contract since 2015. NHS England indicates independent healthcare locations whose annual income for the year is at least £200,000 should have a WRES report. This means the provider should publish data to show they monitor and assure staff equality by having an action plan to address any staff profile gaps in the future.

Public and staff engagement

- All the patients we spoke with expressed their views that patient and staff morale in the unit, and the care provided, had significantly improved with the appointment of the current clinic manager. The clinic manager told us (and patients confirmed) they made a point of speaking with every patient, including those on twilight shifts, at least weekly.
- The unit carried out an annual patient satisfaction survey. The results of the 2016 survey, which had a low response rate of 37%, were published in January 2017.
- Of those who responded to the survey, 97% of those who responded felt the atmosphere in the unit was friendly and happy, which was an increase from the

2015 survey result of 74%. Eighty-five per cent (increased from 71%) had confidence in the nurses. Seventy-three per cent (increased from 55%) would be likely to recommend the unit to friends and family; and 81% (increased from 33%) felt the unit was well run.

- Managers developed an action plan to address areas highlighted by the survey. The plan, which was displayed within the waiting area of the unit, aimed to improve patient knowledge in the differences between treatment modality, the use of personal emergency evacuation plans, to improve communication by named nurses in discussing monthly bloods and treatment with patients, steps for improvements in cleaning and decoration of the unit, and the provision of a tour of the unit to all new patients on their first day.
- Patients were able to provide anonymous feedback through the provider's free-post 'Tell us what you think' leaflet system. Completed forms were sent directly to the clinic services director for review.
- One patient on the unit attended the provider's patient group, which met twice a year. The group looked at issues affecting patients, including improving patient hand hygiene, communication with patients and education around the importance of completing four-hour dialysis treatments.
- Another patient we spoke with noted that, due to the similarity of uniforms, it was difficult to differentiate between nursing staff and dialysis assistant staff.
- The unit did not have any patients who received home treatment. However, the clinic manager told us the unit recently hosted a 'home dialysis roadshow' for patients to learn more about the possibility of home treatment.
- Information about and contact details for a range of patient support organisations were displayed within the waiting area. These included the Polycystic Kidney Disease Charity's telephone befriending and peer support service, and 'young at NKF' a version of Kidney Patients UK
- The provider's fistula care poster was also displayed to help patients understand how to look after their fistula.
- Staff we spoke with appeared to be engaged with the unit and the service as a whole. They had staff meetings monthly and also had the opportunity to meet with staff from the provider's other units at staff meetings and conferences.
- Staff participated in the annual staff survey. Ten staff responded to the 2016 survey published in January 2017 and, of these, nine staff said they would

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recommend the organisation as a place to work. All ten staff said their manager encouraged them to work as a member of the team, could be relied upon to help with difficult tasks at work, was supportive, accessible and visible on the unit.

- However, of those that responded, eight staff said that care of patients was the organisation's top priority; seven staff felt that the organisation acted on patient concerns, and six staff would recommend the organisation as a place to work.
- A staff rewards scheme was in place at the unit to support staff attendance. Staff received vouchers in recognition of no sickness absence and referral schemes were in place should employees identify friends that go on to make successful employees as qualified nurses.

Innovation, improvement and sustainability

- Improvements were implemented when issues were highlighted. For example, a new clinic manager was recruited to improve the service when patients began to voice concerns about the culture. Patients told us the situation had improved greatly since that time.
- Staff took responsibility for environmental improvement. For example, they were working to switch to a higher concentrate acid in smaller bottles to reduce the amount of plastic used. Used needles, plastic and cardboard were recycled and the weight of waste per patient was also monitored with an aim that it did not exceed 1kg.

Outstanding practice and areas for improvement

Outstanding practice

We found the following areas of outstanding practice during our inspection:

- The clinic manager was nominated and gained second place for Nurse of the Year by patients in the clinic in November 2016.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure it has systems and processes in place to support staff in the identification and management of potential sepsis in a deteriorating patient.
- The provider must ensure staff are compliant in required mandatory training.
- The provider must ensure processes are put in place to provide safeguarding level two training to all clinical and non-clinical staff who have contact with parents and carers within the unit.
- The provider must ensure systems and processes for improving repeated record keeping errors are operated effectively.

Action the provider **SHOULD** take to improve

- Continue with the action plan to ensure patient prescription continuation records include the patient's details at the top of each page and the prescriber's signature.
- Ensure alternative arrangements for accurately weighing patients before and after dialysis are in place in the event of a breakdown or malfunction of weighing scales.
- Ensure that improvements are made following audits which have identified repeated issues in audits undertaken in 2017.

- Continue with the action plan to introduce seals to prevent unauthorised access to equipment within the resuscitation trolley.
- Ensure checks of the resuscitation trolley include checks of the battery on the automatic external defibrillator.
- Consider how it can improve security of paper records held within cabinets in the treatment area.
- Ensure valid consent forms are held for all patients and reviewed in line with the provider's policy.
- Ensure an individualised copy of the personal emergency evacuation plan is held in each patient's paper file.
- Consider how it can improve patient privacy and confidentiality when discussing their care and treatment.
- Consider how it can record low-level informal concerns or complaints in a way that could more easily enable staff to identify trends.
- Consider how it can more effectively record compliments and thank you cards received.
- Consider how it can obtain evidence of and assurances for the completion of daily environmental cleaning by domestic staff.
- Consider how it can implement the requirements of the workforce race equality standards.
- Consider how it can fully embed the risk register and include additional information such as who is responsible for managing each individual risk.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>(1) Care and treatment must be provided in a safe way for service users.</p> <p>(2) Without limiting paragraph</p> <p>(1), the things which a registered person must do to comply with that paragraph include—</p> <p>(a) arrangements to respond appropriately and in good time to people's changing needs</p> <p>(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely</p> <p>How the regulation was not being met:</p> <p>There were no systems or processes in place to support staff in the identification and management of potential sepsis in a deteriorating patient</p> <p>Regulation 12(1)(2)(a)</p> <p>Staff were not fully compliant with mandatory training requirements.</p> <p>Regulation 12(1)(2)(c)</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.</p> <p>(2) Systems and processes must be established and operated effectively to prevent abuse of service users.</p>

Requirement notices

(3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

How the regulation was not being met:

The provider had not established systems and processes to effectively investigate any allegation of abuse or to prevent abuse of service users.

This was because:

The provider had not delivered safeguarding vulnerable children level two training to all clinical and non-clinical staff.

Regulation 13(1)(2)(3)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

(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—

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider was not operating systems and processes effectively to improve the quality of services provided, to maintain accurate, complete and contemporaneous records in response of each service user, and to evaluate and improve practice in the processing of information.

This was because:

Within the record keeping audits, we found evidence of consistently repeated record keeping errors despite action plans being put in place.

Regulation 17(1)(2)(a)(c)(f)