Colchester Dialysis Unit

Quality Report

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

Ratings

Overall rating for this location

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

Overall summary

Colchester Dialysis Unit is operated by Diaverum UK Limited, who took over the service in October 2016. The service has 23 chairs, three of which are separate from the main unit and located in the renal ward of the subcontracting acute NHS trust.

The service treats NHS-funded patients only under a service level agreement with the acute trust in which the service is located. It operates from Monday to Saturday, from 6.30am to 11.30pm.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 27 April 2017, along with an unannounced visit to the service on 11 May 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

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needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

Services we do not rate

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

We found the following areas of good practice:

- The service had appropriate policies for infection prevention and control. Staff were compliant with infection control policy and best practice; for example, with regular hand washing and training in aseptic non-touch technique.
- The service had a comprehensive equipment maintenance schedule to ensure appropriate and regular maintenance of all equipment in the unit. All equipment was within date for maintenance testing.
- Patient records were complete, clear and stored securely.
- Staffing was sufficient to safely meet patient needs and in line with national guidance. There was a local roster policy to ensure appropriate skill mix, staffing levels and to provide for sufficient time off for staff between shifts.
- Local policies and procedures took account of national best practice, guidance and policy. For example, the policy on accepting patients for holiday dialysis was based on the Department of Health Good Practice Guidelines for Renal Dialysis/ Transplantation Units.
- Nursing staff completed a specialist renal course provided by the University of Sheffield prior to starting on the unit. New starters received a local induction on the unit and were required to have all competencies assessed and signed off as part of this.
- There were opportunities for additional staff training and development. For example, the unit was supporting a nurse to become a practice development nurse to support the training and development of other staff on the unit.
- There were two renal dieticians working part-time on the unit and nursing staff confirmed that there was good access to dietician input if required.
- Staff treated patients with dignity and respect and respected their confidentiality. Patient feedback about their care and treatment was consistently positive.
- Patients each had their own named nurse who would be their first point of contact to discuss any concerns.
- The service had links with peer support groups such as the Kidney Patient Association (KPA) to offer the patients, family members and carers access to support services.
- There was an appropriate and up-to-date complaints procedure and we saw two examples of complaints that had been responded to appropriately. Complaints were discussed at meetings, with any actions or learning shared. Staff were familiar with the complaints procedure.
- Staff were consistently positive about the culture and leadership at the service and felt engaged with their work.
- There was a provider-wide vision with which staff were familiar. At a local level, there were areas of innovation and improvement, such as opening a nurse-led satellite site in Clacton in; working towards repatriating patients from Ipswich and Chelmsford for home treatment and peritoneal dialysis (PD); and working on home care and shared care packages for patients.

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

- We were concerned that there was a risk of under-reporting of incidents because staff we spoke with were not clear on the incident reporting system or what would constitute an incident.

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- There was no clear system to ensure sharing of learning from incidents with all staff to reduce the risk of similar incidents reoccurring.
- Safeguarding training was not sufficient to support staff in recognising and reporting potential safeguarding concerns. The safeguarding leads had received training to level two in safeguarding adults. This was not in line with national guidance, which specifies that designated safeguarding leads should be trained to level three in safeguarding adults.
- The daily checks on the resuscitation trolley had not consistently been completed, with 13 gaps in the daily checks from February to April 2017.
- We had concerns about medicines management. There was no clear process for patient identification and matching when administering medications, and the process solely relied on the patient verbally confirming their name and date of birth. However, by the unannounced inspection, the service had begun to implement an appropriate identification system.
- A consultant told us they sometimes had difficulties accessing laboratory results for patients and frequently had to re-request tests to ensure they were reliable. This was raised as a concern in minutes from clinical governance meetings.
- Staff and patients told us that patient transport services were a major concern in meeting the needs of patients and consistently getting patients to their appointments on time.
  - There was no specific training to help staff meet the needs of patients with, for example, learning disabilities or dementia, although the unit did treat such patients.
- We were concerned that the risk register was not appropriate for the service as it was not being regularly updated and did not reflect the risks identified on inspection, for example the issues in relation to medicines management and delays with accessing laboratory results. There was only one item on the risk register which related to staffing levels on the unit. We did not see this as a risk on inspection as staffing levels were appropriate to safely meet patient need. Managers acknowledged the risk register needed to be updated.

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

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis Services		We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We found: • The service had appropriate policies in place for infection prevention and control. Staff were compliant with infection control policy and best practice. • All equipment was within date for maintenance testing. • Patient records were complete, clear and stored securely. • Staffing was sufficient to safely meet patient needs. • Local policies and procedures took account of national best practice, guidance and policy. • Nursing staff completed a specialist renal course provided by the University of Sheffield prior to starting on the unit and confirmed they received a local induction on the unit and all the competencies on this induction would all be signed off before they started. • There were opportunities for additional staff training and development. • Two renal dieticians worked part-time on the unit and nursing staff confirmed that there was good access to dietician input if required. • Staff treated patients with dignity and respect and respected their confidentiality. Patient feedback about their care and treatment was consistently positive • Patients each had their own named nurse who would be their first point of contact to discuss any concerns. • The service had links with peer support groups such as the Kidney Patient Association (KPA) to offer access to support services for the patient, family members and carers. • There was an appropriate and up-to-date complaints procedure and we saw two examples

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of complaints that had been responded to appropriately. Complaints were discussed at meetings and staff were familiar with the procedure.

- Staff were consistently positive about the culture and leadership at the service and felt engaged with their work.
- There was a provider-wide vision with which staff were familiar. At a local level, there were areas of innovation and improvement, such as opening a nurse-led satellite site in Clacton; working towards repatriating patients from Ipswich and Chelmsford for home treatment and peritoneal dialysis (PD); and working on home care and shared care packages for patients.

However:

- We were concerned that there was a risk of under-reporting of incidents because staff were not clear on the system for reporting incidents or what would constitute an incident.
- We were concerned that safeguarding training was not sufficient to support staff in recognising and reporting potential safeguarding concerns. The safeguarding leads had received training to level two in safeguarding adults. This was not in line with national guidance, which specifies that designated safeguarding leads should be trained to level three in safeguarding adults.
- We had concerns about medicines management. There was no clear process for patient identification and matching when administering medications, and the process solely relied on the patient verbally confirming their name and date of birth. However, by the unannounced inspection, the service had begun to implement an appropriate identification system.

- A consultant told us they sometimes had difficulties accessing laboratory results for patients and this was included in minutes from clinical governance meetings.
- Staff and patients told us that patient transport services were a major concern in meeting the needs of patients and consistently getting patients to their appointments on time.

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- There was no specific training to help staff meet the needs of patients with learning disabilities or dementia, although the unit did treat such patients.
- We were concerned that the risk register was not appropriate for the service as it was not being regularly updated and did not reflect the risks we had seen on inspection. Managers acknowledged the risk register needed to be updated.

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Colchester Dialysis Unit

Services we looked at
Dialysis Services

Summary of this inspection

Background to Colchester Dialysis Unit

Colchester Dialysis Unit is operated by Diaverum UK Limited. The dialysis unit has been operated by the current provider since October 2016. The dialysis unit is located in Colchester, Essex within the premises of the NHS acute trust and operates under a service level agreement with this trust to provide dialysis treatment for NHS patients in the local area. The dialysis unit primarily serves the communities of the Essex area.

The dialysis unit is consultant-led, with the consultants employed by the acute NHS trust and working for the unit under practising privileges.

The dialysis unit has had a registered manager in post since October 2016.

The service is comprised of the main dialysis unit with 20 dialysis chairs and three additional dialysis chairs on Langham ward within the acute NHS trust.

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspection manager, a CQC assistant inspector, and a specialist advisor with expertise in dialysis. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the main unit and the dialysis treatment area on Langham ward. We spoke with ten staff including; registered nurses, care assistants, reception staff, consultants, and managers. We spoke with five patients and one relative. During our inspection, we reviewed six sets of patient records. We also reviewed information provided by the service before and after the inspection.

Information about Colchester Dialysis Unit

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 service was last inspected in August 2013, when it was operating under a different provider.

Activity (January 2016 to January 2017)

- In the reporting period the service carried out 7,011 dialysis sessions.
- Of these, 4,503 were for patients aged 18 to 65, and 2,508 were for patients aged 65 and over.
- All dialysis sessions were for NHS-funded patients under a service level agreement with the local NHS trust.

Track record on safety (January 2016 to January 2017):

- No never events
- One patient fall
- No serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)

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- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired E-Coli
- Ten complaints

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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.

We found the following areas of good practice:

- There were appropriate policies in place for infection prevention and control. Staff were compliant with infection control policy and best practice; for example, with regular hand washing and training in aseptic non-touch technique.
- We saw a comprehensive equipment maintenance schedule to ensure appropriate and regular maintenance of all equipment in the unit. All equipment was within date for maintenance testing.
- Records were complete, clear and stored securely.
- Following a period of staffing shortages when the provider first took over the unit, by the time of our inspection, staffing was sufficient to safely meet patient needs. There was a local roster policy to ensure appropriate skill mix, staffing levels and to provide for sufficient time off for staff between shifts.

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

- We were concerned that there was a risk of under-reporting of incidents because staff we spoke to were not clear on the system for reporting incidents or what would constitute an incident. For example, we observed a near-miss in relation to medicine administration which should have been reported as an incident. We were told that 'near-misses' were not formally recorded as incidents.
- We were concerned that there was no clear system to ensure sharing of learning from incidents with all staff to reduce the risk of similar incidents reoccurring.
- We were concerned that safeguarding training was not sufficient to support staff in recognising and reporting potential safeguarding concerns. The safeguarding leads were trained to level two in safeguarding adults. This was not in line with national standards which specify that designated safeguarding leads should be trained to level three in safeguarding adults.
- We had concerns about medicines management. There was no clear process for patient identification and matching when administering medications, and the process solely relied on the

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patient verbally confirming their name and date of birth. This was not included on the service's risk register. However, by the unannounced inspection, the service had begun to implement an appropriate identification system.

Are services effective?

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

We found the following areas of good practice:

- Local policies and procedures took account of national best practice, guidance and policy. For example, the policy on accepting patients for holiday dialysis was based on the Department of Health Good Practice Guidelines for Renal Dialysis/Transplantation Units.
- Nursing staff completed a specialist renal course provided by the University of Sheffield prior to starting on the unit and confirmed they received a local induction on the unit and all the competencies on this induction would all be signed off before they started.
- There were opportunities for additional training and development. For example, the unit was supporting a nurse on the unit to become a practice development nurse to support the training and development of other staff on the unit.
- There were two renal dieticians working part-time on the unit and nursing staff confirmed that there was good access to dietician input if required.

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

- A consultant told us they sometimes had difficulties accessing lab results for patients. This was also raised at clinical governance meetings where consultants highlighted they were frequently having to re-request tests to ensure they were reliable. However, this was not on the service's risk register.

Are services caring?

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

We found the following areas of good practice:

- Staff treated patients with dignity and respect and respected their confidentiality. Patient feedback about their care and treatment was consistently positive
- Patients each had their own named nurse who would be their first point of contact to discuss any concerns.

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- The service had links with peer support groups such as the Kidney Patient Association (KPA) to offer access to support services for the patient, family members and carers.

Are services responsive?

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

We found the following areas of good practice:

- Patients who did not attend (DNA) their appointment were contacted to discuss reasons for this and DNA rates were discussed appropriately at meetings with input from the contracting acute trust.
- There was an appropriate and up-to-date complaints procedure and we saw two examples of complaints that had been responded to appropriately. Complaints were discussed at meetings and staff were familiar with the procedure.

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

- Staff and patients told us that patient transport services were a major concern in meeting the needs of patients and consistently getting patients to their appointments on time. The service had held meetings with the transport provider to try and improve timeliness for patients but told us there had been no improvement.
- There was no specific training to help staff meet the needs of patients with, for example, learning disabilities or dementia, although the unit did treat such patients.

Are services well-led?

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

We found the following areas of good practice:

- Staff were consistently positive about the culture and leadership at the service and felt engaged with their work.
- There was a provider-wide vision with which staff were familiar. At a local level, there were areas of innovation and improvement, such as opening a nurse-led satellite site in Clacton; working towards repatriating patients from Ipswich and Chelmsford for home treatment and peritoneal dialysis (PD); and working on home care and shared care packages for patients.

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

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- We were concerned that the risk register was not appropriate for the service as it was not being regularly updated and did not reflect the risks we had seen on inspection. There was only one item on the risk register which related to staffing levels on the unit. We did not see this as a risk on inspection as staffing levels were appropriate to safely meet patient need. Managers acknowledged the risk register needed to be updated.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- The service had reported no never events from February 2016 to January 2017.
- The service had reported no serious incidents from February 2016 to January 2017.
- There had been an unexpected patient death in February 2017. This was to be discussed at the next morbidity and mortality meeting for the service, which was held quarterly. Prior to this, there had been no patient deaths from February 2016 to January 2017.
- The service had an electronic incident reporting system. However, we were concerned that there was a risk of under-reporting of incidents because staff were not clear on the system for reporting incidents or what would constitute an incident. For example, one nurse told us about a fault with the water supply but that no incident form had been completed in this instance. Another member of staff told us they would report any incidents to their line manager verbally rather than putting it onto an incident reporting system themselves and that they had not had to report an incident since working in the unit. This was not consistent with the service's policy on incident reporting, which stated that 'all incidents should be reported online' and that 'on-line incident reports may be saved at the time of completion. When all information is entered correctly the incident report may be submitted'**.** Therefore, we were concerned that some staff, who were not new starters, were not familiar with the policy, although other staff told us about the online incident reporting form.
- We raised the concerns about incident reporting with managers, and were told that all staff had access to the electronic reporting system and they were confident in staff awareness about incident reporting. We were told that staff had recently attended a refresher training session on incident reporting.
- We reviewed the incident reporting system on site at the unannounced inspection and there was evidence of staff of different levels reporting incidents electronically within the previous month. Once submitted, managers could access the incident report and send it back to the staff member if more information was required.
- We observed a near-miss in relation to medicine administration (which we have reported on in full in the medicine management section of this report) which should have been reported as an incident. When we asked managers about this, we were told that there was no specific category of 'near miss' on the electronic incident reporting system and that the service would not report such incidents. This was a concern as it meant that there was no opportunity for further learning from near missed to reduce the risk of reoccurrence.
- Two nurses we asked recognised duty of candour as a need to be honest with patients but did not give any further explanation of it. They both said they had not been in a situation where it needed to be carried out. 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.
- We were concerned that there was no clear system to ensure sharing of learning from incidents with all staff to reduce the risk of similar incidents reoccurring. Two members of staff we asked were unable to give

examples of any feedback or learning from incidents within the service, although they said any learning would be shared in staff meetings. The clinic manager gave an example of an incident and lessons learned but we were not assured such learning was consistently shared with all staff to improve practice. The clinic manager and practice development nurse told us managers reviewed incidents monthly and shared learning with staff in meetings. We reviewed minutes of the clinical governance meetings in January 2017 and December 2016, which did not show any discussion of incidents.

- The clinic manager was trained in route cause analysis (RCA) and we saw an appropriate RCA that had been carried out in February 2017 following a medications error.

Mandatory training

- There was a provider wide policy on mandatory education and training, which was in date and appropriate for the service. It included, for example, how training records were to be maintained, who was responsible for ensuring staff were up-to-date, and the frequency of refresher training.
- Annual mandatory training included, but was not limited to, data protection, infection prevention and control, health and safety and fire safety. Bi-annual training included, but was not limited to, safeguarding, manual handling and sharps management.
- Mandatory training data provided prior to inspection showed that, of the 22 members of nursing staff working on the unit as of December 2016 (including two bank nurses), 19 were up-to-date with all their annual mandatory training (86.4%). None were completely up-to-date with bi-annual mandatory training; for example, all 22 nursing staff as of December 2016 were overdue refresher training in control of substances hazardous to health (COSHH). However, by the time of our inspection all permanent staff were up-to-date with mandatory training. The data highlighted members of staff who were coming up for renewal of specific modules.
- Two nurses told us they were always given the time to complete online training.

Safeguarding

- There was a local policy, 'Safeguarding adults with care and support needs and dealing with concerns, suspicions or allegations of abuse, harm or neglect', issued in September 2016 and due for renewal in September 2019. This included a flowchart to explain the referral process; however, it did not specify the required levels of safeguarding training. We were not assured that staff were familiar with the policy when we asked them.
- The unit manager was the safeguarding lead and there was also a provider-wide safeguarding lead. However, the leads were trained to level two in safeguarding adults. This was the same level of training as all other staff on the unit and was not in line with national guidance, which recommends that designated safeguarding leads should be trained to level three in safeguarding adults. We were therefore concerned that safeguarding training was not sufficient to support staff in recognising and reporting potential safeguarding concerns.
- However, one dialysis assistant we spoke with was able to clearly explain examples of safeguarding and showed awareness of recognising and escalating safeguarding concerns.
- Service managers confirmed that the service had not reported any safeguarding concerns from September 2016 to April 2017 (the duration so far of the service under the new provider).
- Data provided prior to inspection showed that 27.3% of staff were up-to-date with safeguarding adults training. However, by the time of our inspection, all staff were up-to-date with safeguarding training.
- Safeguarding children was not included in training as the service did not treat patients under 18 and also did not permit children in the unit (for example if their parent was a patient in the unit). However, this was not in line with national guidance from the Royal College of Paediatrics and Child Health that recommends staff are trained to level two in safeguarding children to help them recognise and escalate concerns even if they are not treating children (Safeguarding children and young people: roles and competences for health care staff, 2014)

Cleanliness, infection control and hygiene

- There were appropriate and up-to-date provider-wide policies in relation to IPC. For example, we reviewed policies for 'Hepatitis B testing, management of patients and vaccination' and 'Infection control surveillance - prevalence of hepatitis B, hepatitis C and HIV'. This specified the process for treating patients with these conditions, such as carrying out dialysis in an isolation room. Patients were screened for these conditions prior to accessing the service. Staff showed awareness of these policies.
- All areas we inspected were visibly clean.
- Personal protective equipment (PPE) was readily available throughout the unit.
- We saw staff were compliant with the service's infection control policy, for example by wearing aprons, gloves and visors and regularly using hand sanitiser.
- There were domestic and clinical waste bins in each four-bedded bay and we saw that sharps and clinical waste were disposed of appropriately and safely.
- Dialysis chairs and chairs in the waiting area were made of a wipe-clean material which was beneficial for infection prevention and control.
- The service carried out monthly hand hygiene audits which involved observing staff to identify any missed opportunities for hand washing. The audit results from April 2017 showed there was 96% compliance with hand hygiene on the main unit, and 100% on Langham ward, which met the trust target of 95%.
- There had been no incidences of MRSA, MSSA, or E.Coli from January 2016 to January 2017.
- There was daily testing of the water treatment plant, carried out by health care assistants (HCAs) to ensure there were no contaminants in the water. We checked the testing log for the period 27 March to 26 April 2017, and saw testing was documented daily with no gaps in the checking history.
- The service had a clear escalation plan in the event of contaminated samples and a change of patient treatments from haemodiafiltration (HDF) to haemodialysis (HD). Staff were aware of the escalation plan in the event of any issues. The provider had a water advisory board and accompanying policy, which followed the Renal Association Clinical Practice Guideline on water treatment systems, dialysis water and dialysis fluid quality for haemodialysis and related therapies.
- The service had access to the acute NHS trust's infection prevention and control (IPC) lead who carried out a full IPC audit once a month. We did not have access to this data because responsibility for this lay with the trust. The service also had their own IPC link nurse.
- Staff were trained in aseptic non-touch technique to minimise the spread of infection and we saw staff using this technique during our observations of care.
- However, the procedure for using the cleaning solution for dialysis machines was past the date for review (February 2016) and the safety data sheet for cleaning substances was also past the date for review (December 2015). Both of these were displayed in the sluice room. We raised this to managers at the time and were assured they would update these.

Environment and equipment

- The unit comprised 20 dialysis chairs in total, which included two isolation rooms for patients presenting an infection risk. There were an additional three dialysis treatment chairs on Langham ward (including one in an isolation room) which was the renal ward of the acute trust. Staff rotated between the main unit and this ward.
- Facilities in the unit included a designated waiting area within reception, a staff area with changing rooms, toilets and a staff rest room; a drinks preparation room; a technician workshop; a storage area; three consultant rooms; a sluice room; store room; and medications storage room. There was also a peritoneal dialysis (PD) training room that was being used for pre dialysis iron clinics (not carried out by this service).
- Individual areas were secure with either keypad code access or staff card access.
- There was a water treatment plant within the unit and we saw a maintenance programme for this, for both the unit and Langham ward. It had last been serviced in November 2016 and was next due for service in May

2017. There was step access to this room in order to prevent flooding. Maintenance was carried out by the manufacturer of the water treatment system, under the contract.

- All dialysis machines were new, commissioned andinstalled in October 2016, and all staff had been trainedon the use of these machines. There was an appropriate planned preventive maintenance (PPM)schedule to maintain the machines. There was a spare dialysis machine kept on the unit in case of a fault.
- Consumables such as syringes, needles, and connection and disconnection packs were packaged, stored appropriately, and in date. The provider retained copies of delivery notes and invoices from the manufacturers of these consumables. This was for tracking and traceability purposes, so that if there was a problem with one of the consumables, the service would be able to trace it to the batch number in the delivery note or invoice.
- We saw a comprehensive equipment maintenance schedule to ensure appropriate and regular maintenance and servicing of all equipment in the unit. All equipment was within date for maintenance testing.
- There was a minimum of 900mm space around each dialysis chair, in line with health building note (HBN) 07-01: satellite dialysis unit guidance regarding patient privacy and the risk of the spread of infection, and curtains could be drawn around each if required.
- There was a nurse call system at each dialysis treatment chair.
- There were oxygen cylinders in the unit and on Langham ward which we saw were all within date and stored appropriately in line with the service policy on storage of medical gases.
- We reviewed the resuscitation trolley and saw it was stocked appropriately with all equipment in date. However, the daily checks had not consistently been completed, with 13 gaps in the daily checks from February to April 2017.
- The store room was clean and organised, and staff carried out daily room temperature checks and signed off appropriately with no gaps for January and February 2017.
- The COSHH storage cupboard was securely locked and appropriate risk assessments had been carried out for the COSHH held in the unit.
- There was a monthly environmental audit overseen by the clinic manager which assessed factors including but not limited to fixtures and fittings, thermometers in each fridge, and appropriate labelling and use of waste bins. The results for April 2017 were 107 out of 147 overall (73%). There were actions to address shortfalls including reminders to staff, and replacing faulty equipment. Staff were familiar with the process for reporting and replacing faulty equipment.

Medicine Management

- The service did not have a Patient Group Direction (PGD) in place. PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.
- We had concerns about medicines management. During our inspection, we observed poor practice in administration of Tinzaparin (used to prevent blood clots in dialysis lines), which the nurse would routinely place into a plastic sleeve in the patient's record ready for administration, and sign at this stage as the first signature. A second nurse would then sign for the medication on administration. We found a 10,000 unit syringe of this medication in a patient folder, whose prescription was for 4000 units. The two nurses realised that there had been an error and amended this to the correct dose. This was a near-miss medications error, which should have been reported as an incident.
- There was no clear process for patient identification and matching when administering medications, and the process solely relied on the patient giving positive verbal confirmation of their name and date of birth each time staff administered medication, which was

not good practice. Managers confirmed that there was no corporate identification process. This was not included on the service's risk register. We raised this as a concern at the time of inspection.

- When we returned for the unannounced inspection, the service had started obtaining consent from patients to introduce patient photo identification. They were on track to have this new process of patient identification in place by the end of May 2017.
- The service had also changed the process of signing for the administering of medicines when we returned for the unannounced inspection. After carrying out the assessment of the patient prior to treatment, the nurse treating that patient would go directly, with the prescription and drug, to the second nurse for sign off. Then the nurse would prepare and administer the drug and bring it back to the clean utility room immediately afterwards. This meant the drug was only being prepared after assessment, so the syringes were no longer being put into patient folders before administration and sign off was done at the same time, which was improved practice to reduce the risk of errors.
- A doctor reviewed all prescriptions and any changes would be documented on both the patient's dialysis record and drug prescription. However, when drug changes were made on the prescription, a nurse would have to then make the changes on the online system to reflect this, which one nurse said was a frustration. No nurses on the unit had undergone the non-medical prescribing course.
- We checked four prescriptions and saw prescriptions were not consistently re-prescribed on a regular basis. For example, one prescription was dated 13 May 2013. We raised this with managers at the time of inspection and were told that re-prescription would not be done unless there were any changes, which did not comply with good practice.
- We inspected the medication storage room and a random sample of medicines which were all in date. We reviewed the checking logs for both the fridge temperature and the ambient room temperature for the previous two months (February – April 2017). The checks had been carried out and signed off appropriately, with no gaps.
- There were no controlled drugs stored on the unit.

Records

- Records for current dialysis patients were stored in a locked trolley on the unit with key code access. There was also a storage unit for archived records, which was securely locked.
- For patients being treated as renal inpatients on Langham ward, all dialysis notes were photocopied and added into the full notes kept by the trust to ensure they had access to all information.
- We reviewed six patient records. They were complete, legible and signed by the appropriate member of staff. They included prescription details and an overview of the patient's care plan.
- 'Flow sheets' were included in the patient records which were kept for one month to review the patient's condition and observations. These were then transferred to the electronic system in case staff needed to refer back to them.
- Assessment forms for arteriovenous fistula were checked monthly. An arteriovenous fistula is an abnormal connection or passageway between an artery and a vein, surgically created for haemodialysis treatments.
- The renal notes were kept separately from the trust's full medical notes for each patient. If the doctor required the full medical notes they could request them via the medical secretaries on the unit.

Assessing and responding to patient risk

- Nursing staff told us that they would escalate to the doctors in the event of a deteriorating patient and call 999 in an emergency, because the unit was located within the primary care centre in a separate building from the main hospital site.
- All staff were trained in basic life support.
- Comprehensive risk assessments were carried out, including assessments for risk of pressure ulcers, needle displacement and catheter-related infection risks.
- Waterlow scores for assessing patients' risk of developing pressure ulcers were reviewed and updated every six months, or more frequently if there

was a change in the patient's condition. If patients were considered at high risk of pressure ulcers they would be provided with a pressure relieving mattress during their dialysis session.

- Venous needle dislodgement assessments were completed for patients who may be agitated or otherwise at risk of the needle becoming dislodged.
- The service used an early warning scoring system to assess risk of patient deterioration, in line with national guidance. Patients had clinical observations recorded prior to commencing treatment, including respiratory rate, blood pressure, pulse and temperature.
- The service used the 'Mr Victor' (multi-racial visual inspection catheter tool observation record) scoring system for assessing catheter related infection risks. Staff showed awareness of this tool and how to use it. There was a chart with photographic examples for staff to access on the main unit and in the ward.
- Blood transfusions could not be done in the main unit but a patient would be transferred to Langham ward if they required a transfusion.
- The service used the acute trust's sepsis policy and procedure to respond to patients presenting a risk of sepsis. Staff we spoke with were familiar with the policy.

Nurse staffing

- At the time of inspection, there were four registered nurses (RN) and one dialysis assistant on every shift in the main unit and on the Langham ward there was always one registered nurse and a dialysis assistant. There were 17 registered nurses overall employed by the service, with four currently undertaking their training. This was sufficient to safely meet patients' needs and was in line with the Renal Workforce Planning Group guidance (2002) of one RN to four patients.
- There was no reliance on agency staff to fill nursing shifts at the time of inspection.
- At the time the unit was taken over by the new provider in September 2016 and shortly after, there were nurse staffing shortages. For example, in December 2016 there had only been 13 registered nurses employed by the unit. However, the unit had now recruited to full establishment for RNs following a recruitment plan which included recruiting from overseas, moving staff from other clinics run by the provider, and filling shortfalls using their own internal bank of staff. At the time of inspection there was one vacancy for a health care assistant. The deputy manager of the unit had recently resigned, and the clinic manager told us they were about to advertise to recruit to this post.
- The previous staffing shortages were discussed at clinical governance meetings. Minutes from the January 2017 meeting noted that they had not provided dialysis on Langham ward on Boxing Day as there had been no nurses to staff the ward. Staff shortage was still on the risk register at the time of our inspection, although the manager told us this could now be removed as the service had fully recruited.
- Nursing staff also told us they felt that staffing levels were now sufficient. Recent nurse recruitment meant that staffing levels would be sufficient to have a supernumerary nurse once induction and training of the new starters was complete. The unit manager told us they hoped this would be within the next month.

Medical staffing

- The unit was consultant-led with three consultants working on rotation. There was also an on-call renal consultant available for additional support. Staff confirmed, and our observations supported, that medical staffing was sufficient to safely meet patients' needs.
- There was a local, up-to-date roster policy to ensure appropriate skill mix, staffing levels and to provide for sufficient time off for staff between shifts. The clinic manager was trained in rostering and used the headcount guidance tool as specified in this policy to support with maintaining safe numbers.

Major incident awareness and training

- There was appropriate emergency equipment readily available on the unit such as fire extinguishers.
- There were individual business continuity plans for events including power supply shortages, staffing shortages and water treatment plant failure, and staff

were aware of these. There was an additional 'Procedure for Implementation of the Business Continuity Policy' which was in date and appropriate to the service, last reviewed February 2017.

- We were told about a recent failure of the water supply in the unit owing to a leak in the water treatment room. In this instance, the service had contacted the technicians and made the ward clerk aware. Staff said they contacted the patient transport service immediately, and updated patients about the issue, both those being treated in the unit at the time and those who had appointments scheduled later that day. Staff also contacted the dietician and pharmacist for additional support for patients while the issue was being resolved. There had been no impact on patient care and safety as staff were able to reschedule appointments within an appropriate timeframe.

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

Evidence-based care and treatment

- We saw that care was provided in line with guidance from the National Institute of Health and Care Excellence (NICE), for example, clinical guideline 174: Intravenous fluid therapy in adults in hospital.
- The unit was monitoring and recording patients' vascular access, in accordance with guidance from the National Institute of Health and Care Excellence (NICE), which states that adults receiving haemodialysis should have their vascular access monitored and maintained using systematic assessment (NICE Quality Standard 72: dialysis access and preparation).
- It was raised in the service's contract review meeting with the acute trust that access to vascular services was required in order to support use of fistula access. Service managers told us that the service were planning to work with the acute trust to provide this in the future.
- There was a comprehensive monthly local audit programme, which included, but was not limited to, records audits, vascular access audits and treatment adequacy audits.
- The service was not participating in any national audits although service managers told us they were hoping to start taking part in the National Transport Survey within the next year.
- Local policies and procedures took account of national best practice, guidance and policy. For example, the policy on accepting patients for holiday dialysis was based on the Department of Health Good Practice Guidelines for Renal Dialysis/Transplantation Units.

Pain relief

- Nursing staff provided simple analgesia to patients if they had a prescription, and could contact the consultant to prescribe pain relief if patients required it.

Nutrition and hydration

- The service provided patients with biscuits and tea during appointments. We were told that if patients required something more, they or their families were permitted to bring food and drink themselves for their appointment.
- The unit had access to two dieticians, employed by the acute NHS trust, to provide specialist dietary support and advice where required. Staff and managers reported they were easily accessible.

Patient outcomes

- The patient's dialysis treatment plan was defined by their renal consultant.
- The unit submitted data directly to the UK Renal Registry. Data provided prior to inspection showed that the provider was in the process of completing integration work with the Registry to ensure the delivery of the required data to benchmark their performance.
- By the time of our inspection, the service was able to provide data about patient outcomes as submitted to the Registry. The service was currently achieving a Kt/V of greater than 1.4 for 93% of its patients, which was above the national average, and compliant with professional guidance from the Renal Association.

- Electronic patient outcome data was available to the clinic manager and consultant, in order to monitor and audit individual outcomes and changes in condition, and identify possible areas for improvement.
- Out of a total 1,537 scheduled dialysis appointments in April 2017, 577 did not start within 30 minutes of the scheduled start time. Reasons for this were recorded, such as delayed transport. This was not in accordance with guidance from the National Institute of Health and Care Excellence (NICE), which states that adults using transport services to attend dialysis appointments should be collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis (NICE QS72, statement six). However, as the transport service was contracted by the NHS service, it was outside the remit of the dialysis unit itself.

Competent staff

- We observed the process of connecting the patient to the dialysis machine by a nurse who had recently joined the unit. The nurse carried this out competently with appropriate use of aseptic non-touch technique to prevent contamination, and they were able to explain the procedure in detail.
- Nursing staff completed a specialist renal course provided by the University of Sheffield prior to starting on the unit. Nurses we spoke with confirmed they received a local induction on the unit and all the competencies on this induction would be signed off before they started.
- There was a process in place to ensure any agency staff were competent to work in the unit, specified in their contract of employment, although there were no agency staff at the time of our inspection. This included local induction and senior staff stated they would review records of competency, provided by the nursing agency, for each individual.
- There was an agency staff checklist which agency staff were required to complete as part of their induction before commencing work on the unit. This included equipment training and electronic data training as well as familiarisation with relevant procedures and policies. Pre-employment checks were carried out to ensure agency staff had at least one year of renal experience.
- All staff had valid disclosure and barring service (DBS) checks carried out before commencing employment at the unit.
- There were opportunities for additional training and development. For example, the service was supporting a nurse to become a practice development nurse to support the training and development of other staff on the unit. Another nurse had recently undertaken a day of training in shared care, run by the University of Sheffield.
- The practice development nurse, who was employed directly by the unit, worked closely with the clinic manager to support staff competence.
- Staff were allocated mentors during their induction and training period for support. One dialysis assistant we spoke with said this had helped her develop skills and confidence working in the unit.
- Nursing staff confirmed they received training in (but not limited to) management of intravenous (IV) cannula, connection and disconnection of the dialysis machine. Training in administration of medications was refreshed every three years, and would be reassessed if any drug errors took place. However, owing to the medications near-miss we observed and our concerns over incident reporting (please refer to the Safe section of this report) we were not assured that this re-assessment would always be carried out when required to ensure ongoing competency.
- All nursing staff and health care assistants (HCAs) were competency assessed to test the water to ensure it was not contaminated.
- The service had a policy on 'Continuing education and training', the purpose of which was to ensure regular, planned education and training was provided for staff on relevant topics; and that education and training records were completed in a timely manner and filed appropriately. However, this policy was ratified in December 2015, with no review date stated.
- Data provided prior to inspection showed that no staff had received an appraisal in the past 12 months.

However, this data was not representative, as when we asked about this on inspection, we found out this related to staff being employed under the contract with the new provider since 3 October 2016 and appraisals were starting to take place in April 2017, with an extension until the end of May 2017 to complete these. Two nurses we spoke with confirmed they had a date for appraisal booked in.

- Validation of professional nursing registration with the Nursing and Midwifery Council (NMC) was monitored by the HR department. The manager told us, and staff confirmed, that reminders were sent to staff electronically when they were due for renewal of their NMC registration.

Multidisciplinary working

- The unit was consultant-led so consultants had overall responsibility for the patients' care, although nurses were able to independently assess patients.
- We received mixed feedback from nursing staff about their links to the consultant staff. Some nurses told us they found the medical staff unapproachable and intimidating. They told us they had raised these concerns at team meetings but that they had not seen any changes yet as a result. We did not see this raised as an issue in the meeting minutes we reviewed. However, the clinic manager and another nurse told us they had good working links with the consultants.
- Multidisciplinary team (MDT) meetings were held once a week, with consultant, nurse and dietician input. A nurse told us that the clinic manager attended multidisciplinary team (MDT) meetings but no other nursing staff attended, which was evident in the MDT meeting minutes we reviewed.
- The contract for the service was held by the acute trust and there were monthly meetings with the trust to review the provisions of the contract.
- One consultant told us they had good links with other acute trusts in the area, for example there was one trust they worked with to carry out transplant assessments.
- We saw from meeting minutes that a dietician attended MDT meetings and clinical governance meetings to provide specialist input.
- The pharmacist, who was employed by the acute trust, attended the unit once a week and staff told us they could access pharmacist support more frequently if required. However, although they were invited to attend MDT meetings, we were told they did not usually have the capacity to attend.
- Staff told us there were good links with district and community nurses. For example, one nurse told us that a patient had arrived for their appointment with an open wound and they had been able to refer them directly to the district nurses for wound dressing prior to dialysis.

Access to information

- Staff were able to access up-to-date policies, and other information they required, via the intranet.
- A consultant told us they sometimes had difficulties accessing lab results for patients. Minutes from the clinical governance meeting in December 2016 included discussion of delays to pathology results as consultants were concerned that by the time results came back from the laboratory they were too old to analyse. The minutes stated this could lead to abnormal results not being flagged-up in a timely manner. Consultants highlighted they were frequently having to re-request tests to ensure they were reliable. However, this was not on the service's risk register.
- At the time of our inspection the clinic manager told us that communication with the laboratory had improved as a result of ongoing discussion of the concerns detailed above. However, there was no formal monitoring to track improvement over time of response times for laboratory results.

Equality and human rights

- There was an appropriate and up-to-date provider-wide policy on equality and diversity and this was included in induction and training.

Consent, Mental Capacity Act and Deprivation of Liberty

- There was an appropriate and up-to-date provider-wide policy on gaining patient consent. Staff were familiar with this and knew how to access it via the intranet.

- We reviewed four patient consent forms. Consent was taken at the start of treatment and then yearly and this was documented in all the forms we reviewed. Consent was also taken on each occasion that a blood test was required. We observed staff obtaining verbal consent prior to patients commencing their dialysis session.
- There was an e-learning module on the Mental Capacity Act 2005 (MCA) included in mandatory training; however, staff showed limited awareness on the Mental Capacity Act and Deprivation of Liberty Safeguards, so we were not assured that training was sufficient to support staff in recognising potential issues of capacity to consent to care and treatment.

Are dialysis services caring?

Compassionate care

- We spoke with four patients and one patient's relative on the day of our inspection. They were all positive about the care they had received at the unit. Patients told us that staff introduced themselves, explained their role and that they took time to chat to patients. One patient we spoke to described their experience as "immaculate treatment", another patient described the staff as "wonderful".
- The provider ran a patient satisfaction survey for each unit every six months using an independent company. A survey had not yet been conducted for the unit, owing to the provider only operating the service since October 2016, so there were no results available for us to review. No other formal means of gaining feedback from patients had been undertaken in this time.
- Staff treated patients with dignity and respect and respected their confidentiality. All patient stations had curtains and we observed staff drawing curtains when disconnecting a patient from the dialysis machine.
- Patients we spoke to told us that they felt respected as individuals.One patient we spoke to told us that staff made sure to communicate with them when assisting them using a hoist and that staff shut the door when assisting the patient to the toilet.
- Patients each had their own named nurse who would be their first point of contact to discuss any concerns.

Understanding and involvement of patients and those close to them

- Nursing staff told us about shared care and self-care training so that patients and families can be more actively involved in their own long term care. Families could assist in care in the unit in a safe way if they wished, and were encouraged in this by nursing staff.
- All of the patients we spoke to informed us that they felt part of the decision making process about their treatment and that staff explained their treatment clearly. They felt able to ask nursing staff any questions.
- New patients were given a patient handbook that included information on the service, hygiene and infection control, how haemodialysis works, support and dietary information.

Emotional support

- The service had links with peer support groups such as the Kidney Patient Association (KPA) to offer access to support services for the patient, family members and carers. Nursing staff told us that, where any particular social needs were identified, the patient's GP and community social services would be contacted.
- The service did not have access to a renal social worker within the service; however, one member of staff we spoke to informed us that they have access to renal NHS counselling and explained how they would contact them for a patient if required. This was confirmed by a manager.
- All of the patients we spoke to told us that they felt supported by staff. We spoke to one family member who told us that they also feel supported by the staff at the unit.

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

Meeting the needs of local people

- The dialysis service was provided and managed under a service level agreement (SLA) with the local acute trust and the unit was within the trust premises.

- Staff and patients told us that patient transport services were a major concern in meeting the needs of patients and consistently getting patients to their appointments on time. The service had held meetings with the transport provider to try and improve timeliness for patients but told us there had been no improvement yet. This was a concern regularly raised at meetings.
- There was a patient transport user group which carried out patient transport surveys and gave feedback and recommendations to the commissioners about improvements that could be made to the service. However, this was led by the contracting NHS trust so we did not see any results or feedback from these as the service did not have responsibility for this.
- There were free parking facilities for patients and relatives that were joint with the acute trust premises.

Access and flow

- Patients accessed the service through referral from renal consultants at the referring NHS trust. For emergency admissions, the acute team would accommodate the treatment until a permanent slot was made available to the patient.
- However, due to high demand on the service and limited availability, patients could be transferred out to an alternative service for an undetermined period of time. A priority transfer list was agreed by the contracting trust's renal service managers and the lead renal consultant.
- The unit was at full capacity, running a total of 60 sessions per day (i.e. three patients a day for each bed). There were seven patients on the waiting list for dialysis treatment. The service was working alongside the NHS trust to improve capacity, for example discussing where home therapies could safely be carried out, or the potential for night shifts.
- Capacity issues were discussed at clinical governance meetings. The meeting minutes from January 2017 included considering introducing a twilight shift on Langham Ward for patients to help ease the pressures on the unit but concerns were raised about a lack of staff to cover an extra shift pattern because of the staffing issues at the time of this meeting. However, at the time of our inspection, managers told us that as staffing levels had reached a suitable level they were looking at this again to improve capacity.
- The minutes from the clinical governance meeting in January 2017 stated that capacity was on the service's risk register; however, at the time of our inspection this was not on the risk register, although service leads told us it was still a concern. It was anticipated that the opening of the Clacton satellite unit would help improve capacity.
- In April 2017 there had been 37 instances where patients did not attend (DNA) their appointment. This was recorded each time and included reasons for the DNA. The secretary for the service updated this data and sent weekly reports to the acute trust. The practice development nurse told us that it was usually the same few patients who regularly did not attend but that they always called the patient to find out why they had not attended and discuss any issues with them.
- We saw discussion of DNAs with the contracting acute trust from contract review meeting minutes in January 2017.

Service planning and delivery to meet the needs of individual people

- Due to the contracting structure of outsourced dialysis services, the scope of the work was defined by the local CCG, working with the local acute trust to meet the needs of local people through the service.
- The service was developing a nurse-led satellite site in Clacton to meet the needs of the local population, as at the time of our inspection, many patients were travelling from the Clacton area to the unit.
- As the service was operating at full capacity with a waiting list, it only offered holiday dialysis to patients if the dates coincided with one of their own patients going on holiday, which we were told was very rare. There was an appropriate and up-to-date provider-wide policy, which specified all the information required before accepting holiday dialysis patients, including a transfer letter and blood results within the required timeframe of four weeks. The clinic manager and holiday coordinator were responsible for

collecting and reviewing this information. All holiday patients were segregated in accordance with national guidelines and on admission, all patient information would be transferred to the service's electronic system.

- For their own patients wishing to go on holiday, it was the patient's responsibility to find a dialysis clinic to treat them while they were away. Once they had done this, the service would link with the chosen clinic and provide the patient with information in accordance with the receiving clinic's requirements.
- We saw leaflets in the waiting area informing patients about partner Diaverum services in other countries which patients could arrange to visit if they were planning a holiday.
- There was no specific training to help staff meet the needs of patients with, for example, learning disabilities or dementia, although the unit did treat such patients. We were concerned that staff did not have the appropriate knowledge and awareness to support them to meet these specific needs.
- However, we were told about one patient with learning disabilities who was repeatedly not attending appointments (they had residual kidney function and were assessed as having capacity to consent to treatment). After discussing this with the patient, the unit arranged with them to do flexible dialysis appointments on Langham ward rather than having fixed slots and they said the patient was happy with this arrangement.
- There were toilet facilities, including a toilet for disabled people, within the unit, for patients to use before dialysis, as they would usually be unable to do so during the procedure.
- Nursing staff told us they could access additional social or psychological support from the community if required, although they did not give any recent examples of where they had done this.
- The renal unit had televisions available at each station to provide entertainment for patients. Management staff informed us that these were being upgraded the week following our inspection. When we returned for the unannounced inspection, we saw this had taken place.

Learning from complaints and concerns

- From November 2016 to March 2017 there had been 15 patient complaints. Of these, seven related to transport. Service managers also confirmed that most patient complaints related to transport which the service could not have any direct impact on because the transport was provided under an external contract commissioned by the clinical commissioning group (CCG).
- The service complaints log documented whether the complaint had been actioned, although it did not specify in what timeframe.
- We saw two examples of complaints from family members that had been responded to in an appropriate way by the service.
- The service's complaints procedure was in date, next due for review in August 2018. This stated that acknowledgement of the complaint must take place as soon as possible and at a maximum of two days, and a full response must be given within 20 working days unless ongoing; then a response would be given within five days of the full investigation being completed. Staff were familiar with the complaints procedure.
- We saw from clinical governance meeting minutes from January 2017 and December 2016 that complaints were discussed at meetings.
- There were feedback boxes in the waiting area that patients and relatives could use to raise a complaint.

Are dialysis services well-led?

Leadership and culture of service

- The service was managed by the clinic manager, with oversight from the Diaverum UK areamanager. At a clinical level the service was consultant-led.
- Staff told us that managers were "supportive" and "helpful" and that managers had ensured a smooth transition to a new provider and that service was disrupted as little as possible. One member of staff told us how they had been supported in flexible working for personal reasons and that they had felt comfortable approaching service leads for this.

- The deputy manager of the unit had recently resigned, and the clinic manager told us they were about to advertise to recruit to this post.
- We saw, and staff confirmed, that there was a positive working culture among the team and staff supported each other.

Vision and strategy for this service

- Service managers told us their vision, at provider level, was to be the "number one provider" of dialysis services in the UK, with a patient-centred approach and a caring and compassionate team of staff.
- The unit had been taken over by Diaverum UK Limited in September 2016 and were still adjusting to the new provider. Service managers were positive about their progress, particularly as the staff were now established in post.
- The main focus for the service was to open a satellite site in Clacton. This would be a nurse-led clinic and the service was hoping it would improve patient experience as many of their patients were travelling from Clacton at the time of our inspection.
- The service was also working towards repatriating patients from Ipswich and Chelmsford for home treatment and peritoneal dialysis (PD) provided by Diaverum.
- The service also planned to start working on home care and shared care packages for patients.

Governance, risk management and quality measurement

- There was a clear governance structure set out in a provider-wide policy, which stated that all items for governance discussion, including (but not limited to) blood results, incidents and audit results, were to be reviewed as part of the quarterly management review meeting. The policy also stated 'Clinic Managers report and discuss outcomes with UK Clinical Operations and UK Manager. All Management review forms are communicated to Diaverum Chief Medical Officer when completed'. However, this policy had last been reviewed in December 2011 so was not up-to-date.
- Both the main clinic and the additional three beds on Langham ward were overseen by the same governance structure and processes. For example, at meetings they were discussed as one unit rather than two separate sites.
- The governance lead was one of the consultant nephrologists.
- We were concerned that the risk register was not appropriate for the service as it was not being regularly updated and did not reflect the risks we had seen on inspection. There was only one item on the risk register which related to staffing levels on the unit. We did not see this as a risk on inspection as staffing levels were appropriate to safely meet patient need.
- Risks that we identified on inspection were not recognised on the risk register, such as the lack of specific training in treating patients with learning disabilities or dementia, and the lack of clear process for patient identification and matching when administering medications. When we raised this with service managers they acknowledged that the risk register was out of date and required updating and that the risk relating to staffing was no longer applicable to the service.
- When we returned for the unannounced the entry in relation to staffing had been downgraded in degree of risk on the register but not removed. There had been no new entries added to the risk register despite feedback from the unannounced inspection. One manager could not tell us any specific risks for the service.
- On the unannounced inspection we saw evidence that the service was taking measures to assess and mitigate risk and improve oversight. For example, they had linked with other Diaverum services as well as the contracting acute trust to discuss at provider level the medication risk we had identified on inspection. Our concern was therefore that this was not being formally documented and monitored.
- Staff were clear about their roles and accountability, and to whom they would escalate any issues.

- All staff working under practising privileges had an appropriate level of professional indemnity insurance. This information was held and updated by the HR department.
- There were monthly area meetings, led by the area manager which provided an opportunity to discuss any concerns or trends between the services in the area.
- There were quarterly meetings for all UK clinic managers. The clinic manager told us these were useful for sharing concerns, feedback and best practice at a provider level.
- The area manager showed familiarity with the service and staff and visited fortnightly. The clinic manager confirmed they felt well supported by the area manager and had monthly one-to-one meetings.

Public and staff engagement

- The unit manager showed a commitment to supporting staff in the team and engaging them in decisions and work undertaken by the service. For example, nursing and medical staff were asked to contribute towards the plans for the Clacton satellite site development.
- All staff we spoke with felt engaged in their roles and enjoyed working for the service.
- The nursing director (provider level) told us the provider ran global networking events with nursing directors from Diaverum in other countries to share recent developments and updates.
- There was an annual staff survey. However, no results were available as this had not taken place since the provider took over in October 2016.

Innovation, improvement and sustainability

- The service was focusing on developing a nurse-led satellite site in Clacton to meet the needs of the local population by increasing capacity and reducing travel time for some patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must maintain an accurate and up-to-date risk register to ensure effective oversight and mitigation of risks in the service.
- The service must ensure that systems and processes around incident reporting are sufficient to support staff to recognise and report all incidents in the service. The service must ensure learning from incidents is consistently shared with all staff to reduce the risk of similar incidents reoccurring.
- The service must implement an effective medicines management procedure where prescriptions are clearly identifiable for individual patients, to reduce the risk of medications errors.
- The service must bring safeguarding training in line with national guidance, which specifies that designated safeguarding leads should be trained to level three in safeguarding adults, and ensure systems and processes are sufficient to support staff in recognising and reporting potential safeguarding concerns.

Action the provider SHOULD take to improve

- The service should ensure daily checks on the resuscitation trolley are carried out and recorded in line with policy.
- The service should ensure staff receive appropriate and comprehensive training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, to improve and maintain staff competency in recognising potential issues of capacity.
- The service should consider providing training or resources to help staff meet the specific needs of patients living with dementia or learning disabilities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) and (2) (g)** We were not assured there was a clear process for ensuring the safe management and administration of medicines. We observed poor practice in administration of Tinzaparin (used to prevent blood clots in dialysis lines), which the nurse would routinely place into a plastic sleeve in the patient's record ready for administration, and sign at this stage as the first signature. A second nurse would then sign for the medication on administration. We found a 10,000 unit syringe of this medication in a patient folder, whose prescription was for 4000 units. The two nurses realised that there had been an error and amended this to the correct dose. There was no clear process for patient identification and matching when administering medications, and the process solely relied on the patient verbally confirming their name and date of birth, which was not good practice. Prescriptions were not consistently being re-prescribed by consultants on a regular basis. Re-prescription would not routinely be done unless there were any changes which was not best practice.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (2)**

This section is primarily information for the provider

Requirement notices

The two safeguarding leads were trained to level two in safeguarding adults. This was not in line with national guidance, which recommends that designated safeguarding leads should be trained to level three in safeguarding adults.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1) and (2)(b)(e) and (f)** The risk register was not being regularly updated and did not reflect the risks we had seen on inspection. There was only one item on the risk register which related to staffing levels on the unit. This was out of date as the service had struggled with staffing around October 2016 - January 2017 but at the time of our inspection this was no longer a risk as staffing levels were appropriate to safely meet patient need. Risks that we identified on inspection were not recognised on the risk register, such as the lack of specific training in treating patients with learning disabilities or dementia, and the lack of clear process for patient identification and matching when administering medications. When we raised this with service managers they acknowledged that the risk register was out of date and required updating to reflect the current risks in the service. When we returned for the unannounced inspection, the entry in relation to staffing had been downgraded in degree of risk on the register but not yet removed. There had been no new entries added to the risk register despite feedback from the unannounced inspection and a manager could not tell us any specific risks for the service, despite the concerns we had raised, for example in relation to their medicines management practices.

This section is primarily information for the provider

Requirement notices

Although there was an electronic incident reporting system, we were concerned that there was a risk of under-reporting of incidents because staff were not consistently clear on what would constitute an incident or familiar with the local incident reporting policy.

We were concerned that there was no clear system to ensure sharing of learning from incidents with all staff. Two members of staff we asked were unable to give examples of any feedback or learning from incidents within the service. We reviewed minutes of the clinical governance meetings in January 2017 and December 2016, which did not show any discussion of incidents. Near-misses were not formally recorded as incidents on the electronic incident reporting system, which was a concern as they were therefore not being discussed with action and learning shared with all staff to reduce the risk of reoccurrence.