

# Broadgreen Dialysis Unit

## Quality Report

Broadgreen Hospital  
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Date of inspection visit: 19 June 2017 and an  
unannounced inspection on 26 June 2017  
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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

## Overall summary

Broadgreen Dialysis unit is operated by Fresenius Medical Care Renal Services Ltd. The unit has 22 dialysis stations. The service provides dialysis services for people over the age of 18, and does not provide treatment for children.

Patients were referred to the unit via the Royal Liverpool and Broadgreen University Hospital Trust.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 19 June 2017, along with an unannounced visit to the unit on 26 June 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

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.

### Services we do not rate

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

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

- We observed some of the privacy screens were being stored on the main ward and would be difficult to access due to being stored behind a dialysis chair and equipment.
- There were no call bells available for patients to use if they required assistance or emergency. This did not comply with the health building note (HBN) 07-02 main renal unit.
- One of the nursing stations was located facing away from the main ward. This meant that staff using the station would not be able to view patients whilst receiving care. The computer screen also faced a dialysis chair, which could pose a data confidentiality issue.

# Summary of findings

- Several of the dialysis machines had been reported to have media data port faults. This meant that staff were required to input data into the dialysis machine manually. This increased the risk of data being inputted incorrectly and had not been risk assessed.
- We found that emergency equipment was not consistently checked daily as we found six omissions throughout the month of May 2017.
- We found that fridge temperatures were not consistently recorded to ensure they were all within normal ranges. We found six omissions throughout the month of May 2017.
- We observed 13 prescription charts and found from May to June 2017 there were seven occasions where signatures were missing to indicate whether medication had been given.
- We looked at 13 patient records and found there were omissions in recordings
- The service does not have a policy or provide training for nursing staff with regards to identification or process for sepsis management
- Not all staff competency files were fully completed and up to date.
- From the 10 patients we spoke with, seven told us that their clinic appointment did not start on time.
- Not all risks associated with the unit had been risk assessed. For example, there was no risk assessment completed for there not being any call bells for the patients to summon help in an emergency.
- We did not see any evidence that patient concerns raised from the 2016 patient survey had been suitably addressed.
- Mandatory training was made available to all staff to enable them to provide safe care and treatment to patients.
- We observed cleaning logs were kept for the weekly disinfecting of the dialysis machines.
- All areas of the unit were tidy and well maintained; they were free from clutter and provided a safe environment for patients, visitors and staff to move around freely.
- The service had developed a Nephrocare standard for good dialysis care based upon standards of best practice.
- All patients we asked reported the staff were caring and respectful.
- Every patient had an individualised treatment prescription to ensure effective dialysis treatment.
- Parking facilities were available for patients, and we saw there were free dedicated spaces outside the unit and transport was arranged for those who needed it.
- Patients were supported to have holidays away from the unit.
- There was no waiting list for treatment. This meant that there were no patients waiting to start treatment.

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. We also issued the provider with a requirement notice. Details are at the end of the report.

**Ellen Armistead**

Deputy Chief Inspector of Hospitals

However, we found the following areas of good practice:

# 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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# Location name here

**Services we looked at**

Dialysis Services

# Summary of this inspection

## Background to Broadgreen Dialysis Unit

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The service provides haemodialysis treatment to adults. The Broadgreen dialysis unit opened in 1999 and primarily serves the Merseyside area population, with occasional access to services for people who are referred for holiday dialysis.

The current registered manager (clinic manager) had recently stepped down to become the deputy manager.

The service had started the process to deregister the current registered manager and appoint a new registered manager.

The area head nurse and the regional business manager from Fresenius attended the inspection.

The clinic is registered for the following regulated activities - Treatment of disease disorder or injury.

The CQC have inspected the location previously in 2012 and there were no outstanding requirement notices or enforcement associated with this service at the time of our comprehensive inspection in June 2017.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors. The inspection team was overseen by Lorraine Bolam, Interim Head of Hospital Inspection.

## Information about Broadgreen Dialysis Unit

Broadgreen dialysis unit is operated by Fresenius Medical Care Renal Services Ltd. The service opened in May 1999. The unit primarily serves the communities of the Merseyside area.

The Broadgreen dialysis unit is a standalone unit located within the grounds of Broadgreen hospital in Liverpool. It provides treatment and care to adults only and the service runs over six days, Monday to Saturday. There are no overnight facilities. There are two main dialysis treatment sessions per day starting at 7am and 1pm. The service also offered a twilight dialysis sessions three times week (Monday, Wednesday, Friday) starting at 6pm.

The clinic has 21 stations, or chair spaces and one hospital bed in the main treatment area.

Access to the unit and free car parking was available directly outside the unit.

A security system was in place to access the unit.

Patients were referred to the unit by a local NHS Trust. The trust provided the unit with two consultant nephrologists and a dietician to visit the dialysis unit weekly. The consultants held monthly quality assurance meetings to review their patients.

The unit was situated in the grounds of Broadgreen hospital. Service level agreements were in place with the referring trust for example fire safety, water supply, and medical emergency response.

The unit on average over the past year provided 6366 treatment sessions to adults aged between 18-65 and 5525 treatment sessions to adults over 65. No services were offered to people under the age of 18.

During the inspection of Broadgreen dialysis unit, we spoke with a range of staff including, registered nurses, dialysis assistants, reception staff, medical staff, senior managers and managers from the referring trust. We

# Summary of this inspection

spoke with 10 patients. We also received three 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed 13 sets of patient records.

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection. The most recent inspection took place in 2012. This was the clinic's first comprehensive inspection against the new methodology.

The dialysis unit is registered to provide the following regulated activities: Treatment for disease, disorder and injury.

In the reporting period February 2016 to March 2017 there were 11891 day case episodes of care recorded at the unit; of these 100% were NHS-funded.

Within this reporting period, 68 people received care and treatment at the unit. 32 people were aged 18 to 65 and 36 were aged over 65. At the time of inspection we were informed that there were now 78 patients currently receiving dialysis, 10 of which were receiving dialysis on a daily basis.

There were 11 nursing staff including the deputy clinic manager, and in addition, three dialysis assistants and a team secretary based in reception area.

There were no reported never events. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

One unexpected patient death was reported to the CQC in the past 12 months.

There were no incidents that were classed as moderate or above that triggered a duty of candour process.

There was one inpatient falls reported in the past 12 months.

There were no incidences of healthcare acquired Methicillin-resistant *Staphylococcus aureus* (MRSA).

There were no incidences of healthcare acquired Methicillin-sensitive *Staphylococcus aureus* (MSSA).

There were no incidences of healthcare acquired *Clostridium difficile* (C.diff) and no incidences of hospital acquired E-Coli.

There was no incidence of other bacteraemia associated at the unit.

There was one formal written complaint made by patients at the unit.

## **Services accredited by a national body:**

The clinic is accredited against both ISO 9001 & 14001 systems.

## **Services provided at the hospital under service level agreement:**

Clinical and or non-clinical waste removal, interpreting services, linen, fire, water, gas and electricity supply and 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

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

- There were no call bells available for patients to use if they required assistance. This did not comply with the health building note (HBN) 07-02 main renal unit – which states one emergency call button (with an audible and visual alarm) per station should be provided.
- Several of the dialysis machines had been reported to have media data port faults. This meant that staff were required to input data into the dialysis machine manually. This increased the risk of data being inputted incorrectly and had not been risk assessed.
- One of the nursing stations was located facing away from the main ward. This meant that staff using the station would not be able to view patients whilst receiving care. The computer screen also faced a dialysis chair, which could pose a data confidentiality issue.
- We observed 13 prescription charts and found from May to June 2017 there were seven occasions where signatures were missing to indicate whether medication had been given.
- We looked at 13 patient records and found that in six records there were omissions in the recording of pre and post patient temperatures. We also found two patients had been recorded as needing pressure relieving equipment and monthly review but this had not happened. We also found two records where midway observations had not been completed for four days in June 2017.
- The service does not have a policy or provide training for nursing staff with regards to identification or process for sepsis management. This was not in line with the NICE guideline (NG51) for recognition, diagnosis, or early management of sepsis. (Sepsis is a life-threatening illness caused by the body's response to an infection).

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

- We saw there was an electronic incident reporting system that captured details regarding clinical, non-clinical and treatment variance incidents that occurred on the unit.



# Summary of this inspection

- Mandatory training was made available to all staff to enable them to provide safe care and treatment to patients. Some of the training was completed through e-learning which staff could access at a time to best suit their needs.
- We reviewed that weekly disinfecting of the dialysis machines took place. We reviewed the cleaning logs and found for May and June 2017 the logs were completed, signed, and dated.
- All areas of the unit were tidy and well maintained; they were free from clutter and provided a safe environment for patients, visitors and staff to move around freely.
- Patients used nominated dialysis machines to aid tracking and traceability.

## Are services effective?

We found the following areas of good practice:

- 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 service had developed a Nephrocare standard for good dialysis care based upon standards of best practice.
- 100% of patients were receiving Hi Flux dialysis. This is considered a better form of dialysis for patients.

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

- The service did not have or maintain a Workforce Race Equality Standard (WRES) action plan or publish data with regards to monitoring staff equality.
- Not all competency files were fully completed and up to date. We found five competency files where the peer review sections of their annual reassessment had not been completed, and in one file, medication competencies had not been completed or annually reassessed since 2015.

## Are services caring?

We found the following areas of good practice:

- We observed that nurses had close working relationships with their patients. Interactions were positive, friendly and professional.
- All patients we asked reported the staff were caring and respectful.
- In the reception area, we observed there were many thank you cards from patients expressing their gratitude to the care and treatment from the staff team.

# Summary of this inspection

- Patients told us that the nursing staff checked on them regularly during their treatment to ensure they were well.

## Are services responsive?

We found the following areas of good practice:

- Every patient had an individualised treatment prescription to ensure effective dialysis treatment.
- Parking facilities were available for patients, and we saw there were dedicated spaces outside the unit and transport was arranged for those who needed it.
- Patients were supported to have holidays away from the unit
- Patient information was provided in English, however could be obtained in other formats if required
- There was no waiting list for treatment. This meant that there were no patients waiting to start treatment.

## Are services well-led?

We found the following issues that the service provider needs to improve: areas of good practice:

- Not all risks associated with the unit had been risk assessed. For example, there was no risk assessment completed for there not being any call bells for the patients to summon help in an emergency.
- We did not see any evidence that patient concerns raised from the 2016 patient survey had been suitably addressed. For example, patients informed us that the dialysis chairs were uncomfortable yet this had been highlighted in the 2016 survey.
- We found there was no management oversight to ensure all daily checks completed by the staff had been completed.
- Quality assurance meetings regarding patient outcomes were not being held consistently on a monthly basis.

However, we found the following areas of good practice:

- We saw there was a clear clinical governance strategy policy that set out the strategic aims of the service. The aims included continuous improvement in patient care and promote evidence based clinically effective care.
- There was a clear leadership structure from unit level to senior management level.
- All staff we spoke with reported they had a good relationship with their managers.
- We observed that managers were visible and approachable on the unit and provided support to staff as required.

# Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Are dialysis services safe?

### Incidents

- The unit had an up to date clinical incident reporting policy for staff to follow, which was available to them through their intranet. The policy set out the accountability, responsibility and reporting arrangements for all staff in relation to incidents.
- We saw there was an electronic incident reporting system that captured details regarding clinical, non-clinical and treatment variance incidents that occurred on the unit.
- All staff we spoke with had a good understanding of the reporting system and could access the system.
- In the 2016 staff survey, 100% of staff that responded (four out of 11 staff) reported that when errors or near misses occur Fresenius medical care takes action to ensure they do not happen again.
- Treatment variances were recorded using an electronic patient record system. A treatment variance is any factor that is different from the normal treatment procedure. An example of treatment variance included when a patient did not receive the full dialysis session as per their prescription. Dependent on the nature of a treatment variance, a clinical or non-clinical incident form was completed. We saw evidence that incident forms were completed following a fall on the unit and a central venous catheter dislodgement.
- Between May 2016 to May 2017 the unit reported a combined total of 647 treatment variances. Of these incidents, only three incidents were categorised as moderate or above and required a clinical or non-clinical incident report form, and triggered a full investigation and root cause analysis.
- Any variances to treatment required staff to complete a treatment variance record. This included any cannulation problems and any symptomatic effects of dialysis. We saw from treatment variances reported a broad spread of variances was recorded. For example, staff recorded variances for itching, poor blood flow, blood clotting and cannulation problems.
- We saw that incidents were reviewed and investigated by the appropriate manager to look for improvements to the service. Moderate and severe incidents were investigated through a process of root cause analysis (RCA), with outcomes and lessons learned shared with staff.
- Seven of the dialysis machines had media data port faults which we were informed required replacing. We did not see any evidence that each dialysis machine fault had been raised as an incident.
- The service followed their duty of candour policy following an incident or complaint. We saw evidence that written apologies from the area head nurse were sent to patients with actions to resolve problems. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of their duty of candour regulatory duty and reported that duty of candour training was available through on line learning as part of the fundamental nursing skills training. The training record from the provider showed that all but one member of staff had completed this training.
- The clinic manager, area head nurse and regional business manager had oversight of any incidents that occurred within the unit. Once the incident form had been completed, the clinical incident forms were sent to the clinical incident team for triage. This team screened

# Dialysis Services

the incident to ensure that the detail and quality of the incident report was sufficient. If required a safety bulletin could be produced to share across the organisation to aid learning.

- Non-clinical incidents were reported to the health and safety team. We were informed that they could also produce a safety bulletin to aid shared learning.
- We saw that following an incident where a dialysis line had become disconnected, a safety bulletin and a poster had been placed on the notice board to remind patients that they should refrain from covering their vascular access site with clothing or blankets, and staff were to check all lines were securely fastened. We saw that staff checked to ensure patients were not covered over and their connection lines were suitably fastened.
- Clinical, non-clinical and treatment variance incidents were reported into the clinical governance framework to monitor numbers and themes of incidents. We saw that these were reported to the trust and the corporate Fresenius senior managers had oversight.
- The service had reported no 'never events' from February 2016 to March 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There had been one unexpected death that had been reported to the CQC and nine expected deaths in the last two years. We were informed by the referring trust that mortality and morbidity reviews had taken place.

## Mandatory training

- Mandatory training was made available to all staff to enable them to provide safe care and treatment to patients. Some of the training was completed through e-learning which staff could access at a time to best suit their needs.
- Mandatory training included fire training, moving and handling, adults and children's safeguarding, and evacuation training.
- We saw evidence of training records on a database that indicated whether staff had completed their mandatory training modules. The system used a colour coding system that highlighted in red if a staff members training had expired.

- The training records database showed that 100% staff had completed their statutory mandatory training and their training record was up to date. The training matrix highlighted in amber those staff (three) whose training was nearing updating.
- The electronic database showed that all staff (100%) had completed basic life support training (BLS). This training provided staff with the knowledge and skills to be able to respond to patients requiring resuscitation. We saw that all staff had also completed their training on the use of the automated external defibrillator for use if a patient suffered a cardiac arrest.
- Staff training was co-ordinated and monitored by the unit manager to ensure staff training was completed.

## Safeguarding

- All staff we spoke with were aware of their safeguarding adults and children responsibilities and who to contact if guidance was required.
- Advice and support regarding safeguarding concerns were available from the referring trust. We saw that names and telephone numbers were posted on the wall in the office, within the clinical area, and displayed on the staff room notice board.
- Staff were trained to recognise adults at risk and were supported with a safeguarding policy, which they could access via the intranet.
- Data provided by the service showed that all staff had completed safeguarding adults level 2 and children level 1 training. The area head nurse informed us that level 3 training was not currently available within Fresenius. However, training dates on site with the trust were now available to access, and this would be explored.
- There were no services delivered for persons under the age of 18 years. However, staff received safeguarding children training as they may visit the unit.

## Cleanliness, infection control and hygiene

- We saw that there was an Infection Prevention and Control (IPC) policy in place to maintain a safe environment for patients, visitors and staff.
- Between February 2016 and March 2017, the service reported no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) and Meticillin-Sensitive Staphylococcus Aureus (MSSA). MRSA and MSSA are

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infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated.

- All staff used an Aseptic Non Touch Technique (ANTT). This minimised the occurrence of infection transmission between patients. Aseptic technique is used during clinical procedures to identify and prevent microbial contamination of aseptic parts and sites by ensuring that they are not touched either directly or indirectly.
- We observed that staff used appropriate personal protection and drapes were used to minimise cross infection. However, on two occasions we observed that staff did not wear gloves whilst setting up intravenous medication. This was reported to the area head nurse and regional business manager.
- We observed that staff cleaned and disinfected each dialysis machine and chair/bed area between uses to ensure good standards of hygiene. This included all medical devices that were used. We saw competencies in staff files to show that staff were trained in cleaning procedures for the dialysis machines.
- We found that weekly disinfecting of the dialysis machines took place. We reviewed the cleaning logs and found for May and June 2017 the logs were completed, signed, and dated.
- The service had a contract with an external cleaning partner to provide cleaning services outside of the unit working hours. Patient's we spoke with told us they thought the unit was clean and they saw staff wash their hands between attending to patients. We were informed a housekeeper was in the process of being employed to support the staff in ensuring all areas of the unit were clean.
- We saw Personal Protective Equipment (PPE), and hand sanitising gel was available across the unit. We observed staff were compliant with 'bare arms below the elbow' guidance and that PPE was used on a regular basis in line with their policy.
- The service had an IPC lead within the organisation to provide staff with advice and support with infection control issues and to support infection prevention audits. The IPC lead carried out internal unannounced infection prevention audits. From the audit completed in March 2017, it highlighted areas of hygiene standards to be improved; this included the cleanliness of the toilets and the technician's room. We saw on inspection that these areas were visibly clean.
- The service completed hygiene and infection control audits on a monthly basis. Results from January to April 2017 were good and ranged from 95% to 98% compliance with the audit. Findings included a sharps bin that was over two thirds full and a faulty clinical bin. We saw the audit contained immediate actions to fully comply with the audit findings.
- Observational hand hygiene audits were completed on a monthly basis. Audit results for January to May 2017 ranged from 88% to 95% compliance against the audit. We found audit finding results posted in the staff areas to inform them of their compliance every month. We saw from our observations that staff adhered to good hand hygiene principals.
- In the 2016 patient satisfaction survey, 71% of patients thought the unit was well maintained and clean, which was a reduction on the 2015 survey which stated 75% thought the unit was well maintained and clean. From our observations, the unit appeared visibly clean.
- Procedures were in place to screen patients monthly for blood born viruses (BBV) such as Hepatitis B, C and HIV.
- There were no side rooms on the unit to be able to dialyse patients who required isolation. This did not meet the Health Building Note 07-01: Satellite dialysis unit best practice that states there should be one to two isolation rooms per 12 dialysis stations.
- There were no patients on the unit that had a BBV. Any patients screened to have an infection were dialysed at the referring trust renal unit.
- There were procedures in place should a patient inform staff they had an infection. This medical review and dialysis to continue at the referring trust until the infection was clear.
- Procedures were in place for those patients who had recently returned from holiday. This included being dialysed at the referring trust renal unit until three clear blood results (12 weeks) were obtained to ensure the patient did not have a BBV.
- We saw evidence that all staff had completed training in infection control and prevention and all staff were conversant with infection control principles.
- We saw evidence that chemical contaminants in water used for the preparation of dialysis fluid was monitored. Chlorine levels in water were tested daily and other contaminants such as nitrates tested monthly to ensure the quality of the water used. This testing was in-line with the Renal Association guideline 3.3 – HD: Chemical contaminants in water used for the preparation of

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dialysis fluid. We saw that records of compliance and a standard operating procedure was in place for staff to follow to ensure the procedure was completed accurately.

- We saw that dialysis fluid was produced by the mixing of treated water, acid (dialysate) and bicarbonate concentrates to provide ultrapure dialysis fluid, free from microbiological contaminants. This was in-line with the Renal Association haemodialysis guideline 3.5. We saw evidence that an audit programme was in place and contaminants were monitored. We saw that the chemical contaminants within the water had been tested in May 2017 and met the relevant international standards organization (ISO) 13959 standard.
- Following a water test fail we saw that a corrective and preventative action report (CAPA) had been completed. The report provided a root cause analysis and corrective actions to take to ensure water compliance which included sanitise the pre-treatment system and replacement of the supply hoses and retesting. We saw from the water testing reports that the water had been retested to ensure compliance.
- We observed that all dialysis lines were pre-packed and were for single use only. Once dialysis treatment was completed, we saw that all used lines were disposed of in clinical waste bags and any needles placed in sharps bins. The use of single use only lines prevents the spread of infection between patients.

## Environment and equipment

- All areas of the unit were tidy and well maintained; they were free from clutter and provided a safe environment for patients, visitors and staff to move around freely.
- All doors were unobstructed and fire escapes were clear.
- In the reception area, we saw that there were easy clean chairs for patients to use whilst waiting for treatment. Chairs had arms to aid patients to stand with mobility difficulties.
- All corridors were wide to provide ample access to the main ward treatment area and were suitable for wheelchair use.
- All areas of the unit flooring were easy clean surfaces in case of spillages and appeared free of dirt and staining.
- The unit had recently taken down all the curtains and tracks which were used for privacy and dignity. These had been replaced by screens that could be used. Some screens were stored outside of the main unit and others on the ward so staff could access them if needed.

However, the screens on the ward were placed in the corner of the unit and would be difficult to access due to the proximity of the dialysis chair and equipment. In the 2016 patient survey, only 58% of patients reported that their privacy was respected in the dialysis treatment area.

- There were no call bells in operation at the unit. Call bells are used to enable patients to summon help from staff. This includes in an emergency. If patients required assistance they needed to call out for assistance. We saw that nursing staff attended patients quickly if they called and regularly checked on patients. Patients told us that they were able to summon help if needed and there was always staff on the ward. However, this did not comply with the health building note (HBN) 07-02 main renal unit – which states one emergency call button (with an audible and visual alarm) per station should be provided.
- The nurses' stations were located so that staff were able to maintain visual contact with patients. However, one of the nursing stations was located in the corner and faced away from patients, and so nurses had their back to patients whilst using the computer. This meant that patients were not observed whilst the nurse used the computer. The computer screen also faced a dialysis chair so the patient on the nearest dialysis chair could view information being displayed. This could pose a data confidentiality issue due to the proximity of the computer screen to the patient.
- Access to the unit was controlled. Patients and visitors were required to press a call bell to gain access.
- There was a receptionist to welcome patients and visitors to the unit, and visitors were required to sign in. We observed that the receptionist was professional and friendly.
- All storage areas, including the dirty sluice room were well organised and tidy. Stock was placed on shelving and we observed that stock was rotated.
- We observed equipment stock in the storage areas was CE marked. For example, dialysis needles. This ensured that all dialysis equipment was approved and compliant with relevant safety standards and met the Renal Association guidelines. Guideline 2.2 - HD: Haemodialysis equipment and disposables.



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- We saw that all dialysate was CE marked in accordance with the Renal Association guidelines. Guideline 3.1 - HD: Concentrates for haemodialysis. This ensured that the dialysates used met the required standards for safe patient treatment.
- All equipment stock packaging contained lot numbers. This ensured that stock could be traced and removed if was deemed unsuitable for dialysis use following a recall notice.
- We saw that the water treatment plant was organised and appeared clean and tidy.
- We were informed that seven (28%) of the dialysis machines had media data port faults. Nursing staff informed us they needed to manually input some of the information regarding the patient treatment into the dialysis machine. Information included the dialysis time, urea reduction clearance, fluid to remove, dialysate used, and prescribed bicarbonate. The nursing staff informed us that they double checked the information to ensure the data inputted was correct. However, we saw that there were no formal work instructions or risk assessment to outline to staff the steps they should take to ensure the data entered was correct. As staff were required to input more data into the treatment parameters, this increases the likelihood of inputting errors. The surveillance audit completed in 2016, highlighted that there had been errors made in the setting up of patients for dialysis. This included incorrect input of bicarbonate, and incorrect dry weight. This meant that staff had not followed the patient prescription fully and had not double checked to ensure the information was correct. This confirmed that processes were not in place to ensure information inputted was always correct.
- We observed that spare dialysis machines were kept on site. The unit had three spare dialysis machines in case a fault developed on any of the machines on the main ward. We saw that these machines appeared visibly clean and ready for use.
- There was adequate space between dialysis chairs to allow for privacy, but also space for staff to be able to attend to patients.
- We observed that a program of maintenance for the equipment was place to ensure continuity of service. Technicians that visited the unit carried out the maintenance. Staff we spoke with reported that technicians provided a good service and attended quickly if a fault developed.
- We saw from staff files that competencies were in place for all medical devices. This included the use of the dialysis machines and safety equipment. For example the defibrillator.
- We saw evidence that electrical safety testing was being completed across the service. We reviewed six items of electrical equipment including fridges and scales and saw that they had been tested and safe for use in 2017.
- A calibration maintenance program was in place. We saw from records the scales and medical device calibrations had been completed. This meant that the devices had been checked to ensure they were accurately recording information for patient safety.
- Emergency equipment was checked, with items appropriately packaged, stored and ready for use. However, we did see that there were six omissions in the checking of the resuscitation equipment through May 2017.

## Medicine Management

- The service had a corporate medicines management policy that was available to all staff through the service intranet. Staff were aware of where to find it should they need guidance.
- All staff completed training in preventing medication errors. The area head nurse reported that if a medicine error occurred the staff member is required to retrain in medicine management.
- We saw that every patient had an individualised treatment prescription. Any changes to these prescriptions were made by the nephrologists who visited the unit weekly. On going monitoring of the treatment ensured that the needs of the patient at the unit could be met. If a patient became medically unstable, they were referred back to the NHS trust for treatment.
- The nurse in charge held the keys for the medicine cabinet. We observed that medicines cabinet was kept locked.
- We saw that all medicines in the medicines cabinet were in date and records kept of expiry dates.
- The unit did not store or administer any controlled drugs.
- The service did not use any patient group directions (PGD's) and none of the nurses were trained in non-medical prescribing.
- The service monitored fridge and room temperatures to ensure all within normal ranges, which meant that

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medicines were stored at the correct temperature. An internal surveillance audit completed in 2016, showed staff had raised issues where fridge temperatures had been out of range, which resulted in a fridge and thermometers being changed. This demonstrated staff were aware of the importance of fridge temperature monitoring and escalation process to ensure compliance. We checked fridge temperature records and found six omissions for May 2017. This meant there was no assurance on the missed recording dates in May 2017, fridges stored medicines at the correct temperature.

- Staff had access to pharmacy support from the local NHS trust pharmacy for additional advice relating to dialysis drugs and the service head office had pharmacy support for staff to access.
- The NHS consultant completed all medication prescriptions. We saw that the medicines prescriptions were kept on the electronic system and were printed out into the paper patient records.
- We observed during the inspection, staff checked identity of the patient against the prescription and signed the prescription chart.
- An internal surveillance audit took place in December 2016 to audit documentation and data. The audit found that there were many omissions where drugs administration signatures for medicine administration and checking were missing. We looked at 13 prescription charts and found that nursing staff did not always administer medication following the NMC standards for medicines management. From the 13 prescription charts, we found from May to June 2017, there were seven occasions in five (38%) of the prescription charts where signatures were missing from the charts to indicate whether the medication had been given or checked. This did not provide assurances that actions and lessons learnt from this audit had taken place.

## Records

- The dialysis unit used a combination of electronic and paper records. Paper records were completed throughout the patient's dialysis and then entered onto the electronic system to provide a comprehensive data record of the patient's treatment. The consultant nephrologist had access to this system to provide an overview of the treatment for each patient.

- Staff were competent in using the electronic records and all had received training in order to effectively use the system.
- We saw that a referral form was completed by the trust for all new patients requiring treatment. The referral form included patient demographics, treatment required and medical history. This referral form was required prior to commencement of treatment. This ensured the unit had the necessary information regarding the patient to ensure their needs could be met.
- The records contained all patient demographics including height, weight, allergies along with the patient prescription and blood results.
- We reviewed 13 patient paper and electronic records to observe the accuracy of recordings. We found that patient demographics, weight and allergies were recorded. We saw that staff used the paper record to monitor patients whilst on dialysis and then transferred this information into the electronic record. We did see on one occasion that the temperature of a patient was mis-scribed when entered in to the electronic system. The paper record recorded the patient temperature as 36.2°C yet this was entered on the electronic system as 36.3°C. We saw that one set of patient observations had been written onto a paper towel prior to be recorded on either the paper record or the electronic record. This is not part of the policy guidance for staff to adhere.
- As the electronic system was used across the organisation, this enabled other dialysis units to share information if a patient moved area to access treatment.
- Staff completed a patient concerns record that was shared electronically with the nephrologist. The record highlighted any problems encountered in treatment and further advice and support required. The patient concern record had been introduced in May 2017 and was shared with the nephrologists when they visited the ward to review their patients.

## Assessing and responding to patient risk

- Prior to commencement of treatment, patients were assessed for their suitability for treatment at the unit. Only once the patient was deemed stable for treatment was a referral made to the unit for their treatment. We saw that referrals also contained relevant past medical history, medical conditions, and infection status to support staff with care and treatment.



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- Nurses clinically assessed patients on each visit and any issues highlighted to the clinic manager and to the nephrologist. We were informed urgent issues were discussed immediately with the nephrologist or registrar. All other issues were documented using a patient concerns register for review when the nephrologist visited the unit. We saw that this had been recently introduced in May 2017 and was completed for discussion with the nephrologist. As this had been recently introduced, we were not able to comment on its effectiveness.
- Any patients whose health condition deteriorated were referred back to the local NHS trust to receive their treatment until clinically stable.
- Routine monthly blood samples were taken to screen blood for blood borne viruses, and further blood samples could be taken if necessary between the monthly routine blood samples.
- We saw that prior to dialysis needle insertion; needles were primed using a syringe with saline. This is considered best practice and we observed that this process was outlined in the Nephrocare standard for good dialysis care procedures for the staff to follow. We also saw that this had been raised in a safety bulletin to ensure that staff followed this process.
- We observed that each dialysis machine had an alarm guard so that significant risks such as detection of a dislodged needle could be identified to prevent significant blood loss. We saw nursing staff attended promptly when the alarm sounded to ensure the safety of patients. The dialysis machines also automatically monitored patient blood pressure and pulse in order to maintain patient safety.
- Patients used nominated dialysis machines to aid tracking and traceability.
- We observed that patient fistula's or central venous catheters were assessed pre and post dialysis for infection, with any variances recorded via the electronic system
- We observed that for patients with a central venous catheter (CVC), a multi-racial visual inspection catheter tool (Mr Victor) was used. This guide provided nursing staff with a consistent and recognised description of the condition of the CVC using a score of 0-4. The assessment tool provided nurses with pictures and guidance on the assessment and monitoring of CVC's to quickly highlight signs of infection. We saw that the guide was on the wall for staff to reference.
- We saw that care plans were completed to ensure that care was individually tailored to meet the needs of patients these included manual handling, Waterlow (pressure area scoring), falls, and a personal emergency evacuation plan (PEEP). However, from the 13 records we observed, two patients scored high risk for pressure sores (both scored 12). Guidance given on the Waterlow scoring chart reported that these patients should have a 100mm foam mattress to avoid pressure sores and the Waterlow score should be reviewed every month. These patients had not been reviewed monthly nor did they have a 100mm foam mattress. A further three Waterlow assessments and manual handling assessments required updating as they had passed the review date set by the nursing staff. Our findings were consistent with a records audit completed in May 2017, which highlighted areas of non-compliance including two out of four records sampled did not contain all relevant fields completed in the manual handling and Waterlow assessment. This did not provide us with reassurance that lessons learnt or actions taken from the audit had taken place.
- We reviewed patient records to see if pre and post treatment patient temperatures had been recorded. We found pre and post temperatures were not always recorded for patients with fistulas or with central venous catheters (CVC). We saw in one record for a patient with a CVC that a pre or post temperature had not been recorded for 10 days in June 2017. We saw omissions in five other patient records who had CVC's where either pre, post or both temperature recordings were missing for multiple days. We were informed by nursing staff that temperature recording was mandatory for those patients with a CVC and not for patients with a fistula unless they feel unwell.
- Patients on the shared care pathway used their electronic card, which was picked up on arrival to the main ward to record their weight. Prior to commencement of the treatment staff checked patient identity and prescription. This process ensured that patients received the correct treatment. Patients we spoke with confirmed that their identity was confirmed prior to treatment.
- Patients were monitored throughout their dialysis treatment. We saw that nurses remained on the ward to monitor their patients. We were informed that there was

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always two members of staff on the ward at all times for patient safety. We saw that nurses responded quickly to patients needs and often checked on patients even though they had not called out for assistance.

- There was no formal early warning score system in place. However, staff reported that observations could be increased to suit the individual need of the patient. All staff we spoke with confirmed that they checked to ensure patients remained stable and explained the process to follow if a patient condition deteriorated. We found that although staff carried out observations of their patients entries in the electronic system did not always show that midway observations had been completed. For example, in two patient records we saw that in four days in June 2017, neither patient had midway observations completed, yet both these patients dialysed three times a week for four hours and 5 minutes on each session.
- The dialysis unit was situated within the grounds of a district general hospital, so in an emergency if a patient required immediate escalation then help could be sought from a medical team. For example, if a patient suffered a cardiac arrest. Staff were aware of the need to telephone for an emergency response should a patient deteriorate, and were aware of the contact numbers.
- The unit did not have a policy or training for staff with regards to identification or process for sepsis management. This was not in line with the NICE guideline (NG51) for recognition, diagnosis, or early management of sepsis. Sepsis is a life-threatening illness caused by the body's response to an infection. However, staff had a good understanding of sepsis and patients could be transferred to the referring trust accident and emergency department should sepsis be identified. Senior managers we spoke with were looking at a process to support staff with sepsis management that included adopting a sepsis process. We saw this was on the newly developed risk register. However, we did not see that a formal risk assessment at the dialysis unit had been completed and staff had not received a formal training.
- From March 2016 to June 2017, 21 patients were transferred to the referring trust. This included those patients that attended the accident and emergency department whilst receiving treatment on the unit due to their health condition deteriorating. Data provided by the service showed the service had transferred patients

back to hospital due to various medical conditions. This included patients with respiratory related problems, investigations for confusion, and deteriorating health conditions.

## Staffing

- Staffing levels and skill mix were planned and reviewed so that patients could receive safe care and treatment at all times. The unit was contracted to provide a staff to patient ratio of 1:4, staff with a skill mix of 70% nurse staff and 30% dialysis assistants. We observed that the service provided 70% nurse staff to 30% dialysis assistants.
- We observed that staffing rotas were based upon the numbers of patients requiring treatment to ensure there were adequate staff to the numbers of patients. We were informed that the clinic would not start unless there were two trained staff on shift to maintain patient safety. Staff confirmed this process, and staffing rotas we looked at confirmed there were always two trained nurses on shift.
- The service employed 11 qualified nursing staff, three dialysis assistants, and a secretary on the main reception.
- Information provided by the unit showed that there was one team vacancy for a clinic manager, as the current clinic manager had recently stepped down to be the deputy clinic manager. The unit employed four team leaders and the area head nurse reported that she was completing visits to the unit three times a week to ensure the unit had adequate management cover. All staff we spoke with reported that they found the area head nurse to be supportive and approachable.
- From January 2017 to March 2017, the service reported there had been five shifts covered by bank and agency workers to ensure the skill mix and numbers of staff were appropriate to provide safe care and treatment for patients.
- Sickness levels in the same period were low at 2.7% for nursing staff and 1.6% for dialysis assistants. Managers reported that sickness was monitored monthly. The area head nurse and regional business manager both were aware of the current sickness levels within the department and sought cover to ensure the unit had enough staff to cover any sickness.
- We saw evidence that duty rotas were completed up to eight weeks in advance and monitored staffing levels based upon the numbers of patients requiring dialysis.

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- Bank and agency staff were arranged by a renal flexi bank team to support co-ordinating staff across the organisation.
- The dialysis unit was a nurse led service, with two nephrologists visiting weekly to review patients. Staff and managers reported they were able to access the nephrologist or registrars through the trust if they needed advice and support and were contactable via phone, email or through the consultant's secretary.
- The unit did not employ any service technicians. Technicians employed by the provider organisation, completed routine maintenance, and provided both telephone support and on-site support as necessary. Staff we spoke with told us that any queries were quickly dealt with.

## Major incident awareness and training

- The service had an Emergency Preparedness Plan. This highlighted the actions taken in event of an emergency. This included actions to take in the event of a fire, water loss or loss of electricity.
- Staff understood their responsibilities in relation to major incidents and received training in evacuation.
- We saw that the emergency plan contained relevant emergency telephone numbers to contact in the event of an emergency.
- We saw in patient records that a personal emergency evacuation plan (PEEP) was recorded. The plan included any patient mobility issues in order to evaluate the level of help required in the event of an emergency evacuation.
- We saw the unit had fire extinguishers that were secured to the wall and within their service date, and were ready for use in the event of a fire.

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

### Evidence-based care and treatment

- Care and treatment was delivered to patients' in line with the National Institute for Health and Care Excellence (NICE) guidelines. For example, we saw all patients receiving treatment had their vascular access site monitored and maintained prior to dialysis. We observed nurses to visual monitor the access site and record any variances using the electronic system. A

- patient concerns record was also used to raise any issues with the nephrologist. This was in line with the National Institute for Health and Care Excellence (NICE) QS72 statement 8.
- The service had developed a Nephrocare standard for good dialysis care based upon standards of best practice. The standards 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 staff with a standard working instruction to ensure best practice was followed and all staff completed treatment the same way to the same standard. Staff were aware of the guidance and we observed staff to follow the guidance.
  - Policy and procedures were linked to the Nephrocare standard for good dialysis care. The Nephrocare standard set out procedures for staff to follow with a rationale for the process in place. For example, the standard provided information to perform hand hygiene, put on a plastic apron and wear a visor. This was linked to a local hygiene policy (UK-CI-09-04) with the rationale to prevent contamination risks. We observed that staff followed this practice.
  - Patients receiving care at the unit were carefully screened and accepted to ensure their needs could be met. As the unit was a nurse led unit with nephrologists visiting weekly, the referring trust renal unit treated patients with complicated medical histories and problematic dialysis access sites. This ensured that patient care needs were planned and delivered safely.
  - We saw evidence that the service had an audit schedule to ensure compliance with the corporate policies. For example, audits were undertaken with regards to infection control, records and hand hygiene.

### Pain relief

- Local anaesthetics prior to dialysis needle insertion were available if required by the patient as part of their prescription written by the nephrologist.
- Staff we spoke with informed us that pain relief medication such as paracetamol was written on the patient prescription by the consultant as PRN medication (as required). Once pain relief was given this was recorded using the drug administration record.

### Nutrition and hydration

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- A dietician visited the dialysis unit on a weekly basis to see patients with regards to their nutritional and hydration needs. We were informed that summaries of their plans were recorded in separate patient records on the referring trust computer system. Staff we spoke with confirmed that they were not able to access the dietician notes due to problems accessing all areas of the referring trust system. This meant there was a reliance on the dietician informing staff of any changes in the nutritional status of the patients, and for staff to record the information in the clinic diary during weekly clinic sessions with the consultant and the dietician.
- Patients we spoke with confirmed they had access to the dietician as needed. One patient reported that the dietician has been beneficial, as they have received support in eating properly to support a healthy weight.
- Patients were provided with hot drinks, biscuits whilst receiving treatment and were able to bring in their own food if needed.
- In the 2016 patient survey, 79% of patients reported they had discussed what to eat and drink now they were on dialysis. This was an improvement of 3% over the 2015 patient survey.

## 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. This data was monitored via a clinic review report and shared with the area head nurse to be able to support the unit to achieve expected results and outcomes for patients.
- Results and treatment data were captured by the service electronic system, which fed into the trust database for inclusion to the UK Renal Registry.
- Submission of data to the UK Renal Registry was undertaken by the parent NHS Trust. The unit data was combined with the parent NHS Trust data and submitted as one data set. This data set only included patients under the direct care and supervision of the trust.
- As the UK Renal Registry data is representative of all parent NHS trust patients this does not permit the review of patients and outcome trends specifically treated within Broadgreen dialysis Unit. Therefore, data

specific to the unit and available via the electronic database was used to benchmark patient outcomes at clinic level and nationally against all Fresenius Medical Care UK clinics.

- We were informed by the area head nurse and the referring trust that there were issues regarding the interface of the trust data system and the system used at the Fresenius dialysis unit. The data captured, intermittently did not transfer across to the trust system and so the data for patient outcomes could not reliably be interpreted. The software used by the trust required updating to allow this transfer of data. We were informed that this update was due in September 2017.
- Consultants reviewed patient blood results to ensure effective dialysis treatments for each of their patients and adjusted their prescriptions to ensure effective outcomes. We saw treatment prescriptions were individual to each patient based upon their specific needs.
- Data provided by the service showed that 100% of patients were being dialysed using Hi Flux Haemodialysers. This provides higher rates of removal of small and middle molecules and may lower the risk of developing complications due to dialysis related amyloidosis (a group of diseases in which abnormal protein, known as amyloid fibrils, builds up in tissue). In patients with established renal failure if it was shown in randomised controlled trials to provide better patient outcomes. This was in-line with Renal Association Guideline 4.3 - HD: High flux HD and haemodiafiltration.
- Dialysis treatment times (frequency of haemodialysis) were monitored by the service. Data supplied by the service showing the quality standard 90 days after admission to the unit showed from January to June 2017, the range of patients receiving haemodialysis (HD) three times per week was 80% to 86%.
- 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%. Due to the trust IT data transfer errors, we were unable to see the full data from January to June 2017. However, data provided by the service showed that in February 2017, 94% of patients and in March 2017, 100% of patients achieved a URR above 65%. This was in-line with Renal Association guidelines. Guideline 5.3 - HD: Minimum dose of thrice weekly haemodialysis -

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recommends that every patient with established renal failure receiving thrice weekly HD should have consistently either urea reduction ratio (URR) > 65% calculated from pre- and post-dialysis urea values.

- Patient blood was tested for potassium, phosphate, calcium aluminium concentrations in-line with the renal association guidelines. Guidelines 6.4 to 6.7. We saw that blood results were contained in the electronic records so the nephrologist could review them. The renal association sets out guidelines for dialysis units to follow based on evidence and research. The guideline promotes the adoption of a range of standardised audit measures in haemodialysis; promote a progressive increase in achievement of audit measures in parallel with improvements in clinical practice, to achieve better outcomes for patients.
- We saw patients' blood results were monitored each month as per a defined schedule provided by the NHS trust consultant. These bloods were individually reviewed monthly to audit the effectiveness of treatment and define/action improvements and changes to care provision to improve outcomes.
- Pre dialysis serum potassium in patients' blood was monitored on a monthly basis. The Renal Guidance 6.4 – HD: Pre-dialysis serum potassium concentration suggests that pre-dialysis serum potassium should be between 4.0 and 6.0 mmol/l in HD patients. Audit data from the quality standard 90 days after admission, showed that from January 2017 to June 2017 the percentage range of patients whose pre dialysis serum potassium within these parameters was 77% to 100%.
- We saw that key performance indicators (KPIs) were set for patient outcomes. Patient KPIs were based upon the renal association guidelines for improving dialysis process and outcomes. For example, weekly dialysis time and urea reduction rates. We saw that KPI's were monitored and reported through a quarterly clinic review report.
- The unit monitored the numbers of patient did not attend (DNA) dialysis through reporting as a treatment variance. In 2016 there were a total of 392 patient failed to attend dialysis session treatment variance reports completed. We were informed that for any patient that did not attend, staff would make contact with the patient or family member, and treatment variance in relation to DNA's were highlighted to the

nephrologist. We saw that DNA's were recorded using the electronic system and reports of who did not attend, and how often, could be produced for discussion with the consultant nephrologist.

## Competent staff

- Staff were able to access training internally and externally. There was an online learning system across the organisation where staff could access additional training opportunities.
- The service had a number of link nurses to provide advice and guidance to others. This included health and safety, training and education, electronic records and holiday co-ordinator.
- Two members of nursing staff had a renal dialysis qualification and a further seven staff had more than five years renal experience. We were informed that opportunities were available for staff to complete their renal qualification through the organisation. This training supports nurses to enhance their knowledge and practice in order to lead and deliver care and treatment to patients with a range of renal conditions.
- New staff completed a training and education progression plan. This included a wide range of essential training such as vascular access techniques, management of intravenous cannulas and dialysis machine use and decontamination. Following the supernumerary period staff commenced a probationary and supervised period that was individually tailored to them.
- We reviewed 10 staff competency files and saw that courses certificates were included, and an integrated competency document with dates and signatures of competencies completed. Competencies included medical devices, infection control and medicines management. However, not all certificates held in the files were still in date and needed archiving or moving to a separate area within the competency file.
- From reviewing the competency files, we saw that not all files were complete and up to date. We saw in one file that the job description had not been signed and dated, we found that in five files, the annual reassessment of competencies were not fully completed as the peer review section had not been completed. In one file the medication competencies had not been completed and their last annual competency sign off had been completed in 2015. This did not provide an assurance



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that the staff member was competent in medicine management. We raised this with the team leader at the time of inspection so this could be completed on the staff members next working day.

- Evidence provided by the service showed that all staff had received an appraisal within the last 12 months. We reviewed that appraisals included a review of current objectives and set future objectives to aid development. For example, available courses and training.
- In the staff survey 100% of staff reported their manager supported their training, learning or development.
- We were informed that all staff had undergone a disclosure and barring service (DBS) check. Managers informed us that this was completed on commencement of employment but was not routinely done thereafter by human resources. However, the employee handbook did state the any new convictions should be disclosed to the employer.
- We saw evidence that the service had a nurse revalidation log. This supported the clinic manager to ensure that all staff had gone through the revalidation process. This meant the service conducted annual checks to make sure all the nurses are registered with the Nursing and Midwifery Council (NMC) and is considered good practice.
- We observed that an electronic training database provided information as to training completed by the staff. The database included dates that training needed to be completed and any out of date training was highlighted red.
- The area head nurse informed us during unannounced internal inspections, simulation resuscitation training is completed. Staff confirmed that they had completed this simulation training.
- Staff at the unit had not received training on the recognition and management of sepsis. However all staff we spoke with reported that any signs of patient deterioration was immediately recorded, observations increased, and escalated for a senior to review. This included phoning for emergency assistance or transferring the patient to the accident and emergency department at the referring trust.
- Managers informed us that poor or variable performance was monitored. This included sickness absence. Where staff underperformed, then improvement plans were implemented and further training supported. We saw from the area head nurse internal unannounced inspections that staff

performance was observed to ensure that good practice was followed. We saw from the inspection completed in April 2017, all areas of the dialysis process were covered including correct connection to dialysis machines and infection control procedures.

## Multidisciplinary working

- The nephrologists had overall responsibility for the care and treatment of the patients on the unit and visited weekly to review their care. We saw evidence of patient reviews and changes in prescriptions within the patient records.
- The nephrologist provided the GP with the necessary information as to the patient's current treatment.
- We were told the clinic manager or deputy clinic manager held monthly quality assurance meetings with the nephrologist to discuss patient's treatment plans and any treatment variances. We saw that following each quality assurance multi-disciplinary meeting a clinic diary was kept with all changes to patient care for all staff to view. The diary highlighted any concerns from staff and actions taken.
- We saw there had been four quality assurance meetings held in 2017. These meetings had taken place between March 2017 to May 2017. This was an improvement on the previous year where only three formal quality assurance meetings had taken place in the whole year. Although there had been an improvement in the number of meetings in 2017, it did not provide assurance that regular monthly discussions would be sustained to discuss patient outcomes throughout 2017.
- We were told that the dietician routinely provided input into the patient treatment plans and when available attended the multidisciplinary meetings. We were unable to see the dietician notes as these were kept on the trust database and not within the patient record held by Fresenius. However, we saw from the quality assurance meeting that the consultant, dietician and senior nursing staff attended this.
- Patients could access psychological, counselling or therapy services through a referral process to the referring trust.
- A vascular access nurse provided advice and guidance to the unit as and when required. This included referring the patient for an access site scan and referral back to the renal surgeon.

## Access to information

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- We observed that staff had access to policies and procedures through the electronic database.
- Patient records were easily accessible via the computer terminals. All staff had secure, personal log in details to access the system.
- We observed on one occasion that a computer terminal was left unattended displaying confidential information. We raised this with the team leader at the time of inspection to ensure all computer terminals were locked when not in use.
- We saw that there were standard operating procedures (work instructions) for staff to follow. The instructions provided systematic instructions in areas such as water testing, and good dialysis care the instructions ensured that staff maintained the safety of patients at all times.
- The nephrologist was able to access both the trust database along with the dialysis unit database to ensure they were informed of the treatment outcomes for each patient.
- The nephrologist provided the necessary information for the staff on the unit to be able to provide the correct treatment for each patient through their individual prescription. We saw prescriptions were printed out and kept as a paper record in the patient file.
- We saw that all relevant care plans took into account the mobility of the patient and pressure areas.
- Patients were able to access their blood results in order to remain informed about their condition.
- Patients were actively encouraged to take part in shared care. We saw that patients weighed themselves upon arrival to the ward. This information was captured on the patient identification card and used to start the dialysis process.

## Equality and human rights

- From 1st August 2016 onwards, all organisations that provide NHS care were legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment, or sensory loss are provided with information that they can easily read, understand or with support can communicate effectively with health and social care services.
- We saw that the service was aware that they currently did not fully meet this standard and was listed on the risk register.

- The risk register highlighted the actions Fresenius planned to take which included a full assessment of accessible information criteria, so Fresenius can understand their NHS partner approach, policy, procedures and services.
- We were informed that prior to attendance to the unit for treatment, all patients would be assessed to ensure their needs could be met and language interpreters could be accessed via the referring trust if required. We observed that reading materials could be ordered in other languages to support patients to understand their care.
- The Workforce Race Equality Standard (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.
- 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 produce and publish WRES report.
- Fresenius Broadgreen did not have or maintain a WRES report or action plan to monitor staff equality. We saw that this was on the risk register and reported that it was part of their wider approach to ensure equality for all employees.

## Consent, Mental Capacity Act and Deprivation of Liberty

- The unit had a current policy for consent to examination or treatment. This was available for staff on the intranet.
- Staff were able to demonstrate their knowledge of consent and mental capacity and staff told us if there were concerns over a patient's capacity to consent, they would seek further advice and assistance from their manager or referring trust.
- Patient records contained a consent to treatment record. We reviewed 13 patient records and found they all contained completed consent forms. We found one consent form that required updating. The patient consent form was signed to consent to three dialysis sessions per week. However, in June 2017 the dialysis sessions had increased to five sessions and required a new consent form to be signed. We raised this with the team leader on duty so this could be rectified prior to commencement of the patient's next treatment.

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- At the time of inspection, all patients receiving treatment had capacity to consent to treatment.
- Patients who lack the capacity to consent to treatment would be referred to the referring NHS trust. Any new patient attending the clinic who lacked the capacity to consent to treatment would need to have been assessed and best interests decisions made prior to treatment. This ensured that the service was able to best meet the needs of the patient. We saw from data supplied by the provider that in 2016/2017, three patients were referred back to the trust due to confusion.

## Are dialysis services caring?

### Compassionate care

- We spoke with 10 patients and we received three CQC comment cards. From our conversations and the comments received, patients informed us that nurses treated them with dignity and respect and were caring.
- Comments included 'care from staff is fantastic' and 'staff are kind caring and competent'. All comments regarding the care and treatment from nursing staff were positive.
- We observed that nurses had close working relationships with their patients. Interactions were positive, friendly and professional. It was clear that staff knew their patients well. For example, we saw a staff member reminded a patient that their favourite programme was due to start so they would not miss it.
- In the 2016 patient survey, 80% of patients reported that the unit staff were caring and 70% of patients reported they were treated with dignity and respect. These scores were an improvement over the 2015 patient survey.
- All patients we asked reported they felt safe having dialysis at the unit.
- We saw that staff greeted patients as they arrived for treatment, and explained if their treatment was running late.
- Private conversations were difficult to have on the ward due to the close proximity of the dialysis chairs and there were no curtains. However, private conversations could be had in the clinic room or the manager's office.

- The service completed a patient satisfaction survey in 2016. Results from the survey showed that 67% of the respondents would recommend the service to family and friends and 93% thought the unit was a happy unit with a friendly atmosphere.
- We saw that newsletters and 'Tell us what you think' cards were available in the waiting area so that patients could inform the team of any concerns or compliments.
- In the reception area, we observed there were many thank you cards from patients expressing their gratitude to the care and treatment from the staff team.

### Understanding and involvement of patients and those close to them

- We observed that staff spoke to the patients to explain the treatment they were going to receive. We observed that staff discussed patient's prescription with them.
- We saw that patients were involved in their care, and weighed themselves in readiness for their treatment.
- Patients had a named nurse to provide their care and treatment. The named nurse approach fosters good relationships and communication between patients and staff. However, from the 10 patients we spoke with, three reported they did not see their named nurse often and one patient was unclear who their named nurse was.
- For those patients with additional care needs, carers were able to stay during treatment in order to provide the support they need.

### Emotional support

- Staff we spoke with were able to tell us that extra support was available to patients via the referring NHS trust in Liverpool. This included access to social services and psychological services.
- We observed that staff monitored patients throughout their treatment, and informed us that if a patient was not well they offered more support to alleviate any anxieties. For example, we saw that following the dialysis machine alarm alert, staff responded quickly and provided reassurances to patients as to the reason why the alarm had sounded.
- Patients told us that the nursing staff checked on them regularly during their treatment to ensure they were well.
- Patients told us that if they had any concerns and worries they felt they could speak to the nursing staff who would support them.



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

### Service planning and delivery to meet the needs of individual people

- The dialysis unit followed their corporate patient referral and acceptance to treatment policy. The policy outlined the criteria for acceptance to the unit. This included, established functioning access for dialysis, haemodynamically stable, and blood borne virus (BBV) status. Approval to the unit was completed by the clinic manager or deputy manager in consultation with the nephrologists to ensure care and treatment could be safely managed.
- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. This was highlighted in the care plan so reasonable adjustments could be made. For example, patients with hearing difficulties.
- Patients were referred for haemodialysis treatment from the local NHS trust renal unit. The referral was based upon the patient being medically suitable for treatment in a satellite renal unit, and living within 30 minutes travel time from the unit. Renal association guidelines indicate that except in remote geographical areas the travel time to a haemodialysis facility should be less than 30 minutes; or, a haemodialysis facility should be located with 25 miles of the patients' home. We were informed that the unit did not audit patient travel times as the referring trust made the decision on patient travel times.
- Transport of patients was arranged as part of the NHS contract. Transport for the unit was organised with transport services, and offered ambulance and taxi services to enable patients to access their care and treatment.
- Free parking facilities were available for patients, and we saw there was dedicated parking outside the unit.
- Access to the unit was safe and convenient, and all on one level to aid access for those patients with mobility problems.
- A full range of dialysis sessions were available for patients, taking into consideration working, cultural needs and family responsibilities. We saw that the unit

offered two dialysis sessions per day over a six day period and three twilight dialysis sessions. Staff informed us that they were flexible to change appointment times to meet the needs of the patients.

- At the time of inspection there were 10 patients receiving daily dialysis to meet their care and treatment needs. This highlighted the flexibility of the service to accommodate patients on going needs.
- The service used an appointment system to plan patient appointments and track available capacity to allow flexibility for patient choice.

### Access and flow

- The dialysis unit reported there was no waiting list for treatment. This meant that there were no patients waiting to start treatment.
- The service measured the utilisation of capacity. For the reporting period from April to May 2017, the utilisation capacity was 84%. This meant that there were usually vacant appointments available for patients.
- From February 2016 to March 2017, the service reported there were no cancelled appointments by the unit.
- Dialysis sessions were based upon availability either in the morning, afternoon or twilight sessions. Staff informed us that every effort was made to accommodate patients expressed wishes.
- The service did not participate in audits of travel time or waiting time pre and post dialysis.
- Results from the patient survey in 2016 showed that only 29% of patients reported that dialysis sessions began on time, although the response rate to this survey was low at 15 respondents. We saw that an action plan had been developed to address the patient survey and staggered dialysis start times had been implemented. However, the problems of clinic starting late still existed. This was consistent with our findings. We spoke with ten patients and seven (70%) told us the clinic, still did not start on time and there were often delays. One patient informed us that this was disruptive to their everyday life.

### Meeting people's individual needs

- There was good access to facilities in the unit. The unit was spacious and offered good provision for people with individual needs. For example, corridors and doorways were wide to offer wheelchair access.

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- There were two separate toilets. One toilet was situated in the main reception and the other just off the main ward. We saw the toilet in reception had wheelchair access and grab rails to support patients with mobility issues.
- We were informed that treatment could be suspended should a patient require the toilet during treatment.
- We observed that patients were encouraged to participate in their care. We saw that patients weighed themselves prior to treatment.
- In conjunction with the referring trust, patients were supported to receive home dialysis. At the time of inspection, two patients were transferring to receive home dialysis.
- The unit was able to accommodate patients with central venous catheters (CVC) and fistulas. We saw that staff were trained to be able to support their specific needs. Those patients with CVC's were only dialysed by the qualified nursing staff on the unit.
- Patients had access to television with separate headphones in each bed space, and were able to bring in their own reading material if required.
- In reception, there was a range of reading material for patients to use whilst having dialysis, which included reading books and information and magazines relating to renal care.
- We saw that patients were offered hot drinks and biscuits whilst receiving treatment.
- Patient information was provided in English, however could be obtained in other formats if required. We saw for example, literature could be provided in Arabic and Urdu if required.
- Access to interpreter services were available to those patients whose first language was not English. Interpreters were arranged by the referring trust to aid communication and understanding of treatment.
- There were no patient representative groups that visited the unit on a regular basis. However, there was literature for patients in the waiting area for if they wished to contact them.
- Signage around the unit including exit and toilet signs were bold and contained braille to aid those patients with sight impairment.
- Access to ongoing care was arranged through the referring trust. We were informed that access to social workers and other support services were available if required by the patients.
- Patients were supported to have holidays away from the unit. We saw there was a file in the reception that provided information regarding holiday dialysis and there was a link nurse on the unit to provide support. Referrals for holiday dialysis were sent to the referring trust to ascertain the stability of the patient's health to ensure safe care and treatment away from the unit. One patient reported they had used the holiday dialysis service regularly without any problems and another patient reported 'it works well'.
- Patients were allocated a dialysis machine prior to receiving treatment. Patients usually used the same dialysis machine on each visit to the unit unless the machine was not available due to maintenance.
- We observed there was no hoist available for those patients with mobility problems. We were informed that there were no patients that required a hoist to transfer, and if a hoist was required then this could be sourced to accommodate their needs.
- Not all dialysis specific chairs had pressure relieving mattresses. The patient survey in 2016 highlighted that from the 15 respondents, only 14% of patients felt that the chair they used for treatment was comfortable. An action plan had been developed to ascertain the reasons patients were not comfortable. We observed that there was only one mattress being used on the dialysis unit. This was consistent with our findings. We spoke with 10 patients on the unit and eight reported (80%), the chairs used for dialysis were uncomfortable.

## Learning from complaints and concerns

- The dialysis unit followed their corporate feedback policy that covered compliments, comments, concerns and complaints. The policy was available to all staff via the intranet and was known as the 4C's.
- The service received one written complaints in the 12 month reporting period February 2016 to March 2017. This related to waiting times on the unit. There had been no formal written complaints in 2017. We saw that the complaint was dealt with by the area head nurse to address all concerns raised.
- The clinic manager was responsible in ensuring all complaints were dealt with within 20 working days. We did not see any evidence on inspection of any current open complaints.

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- Complaints could be raised to the management team either verbally, written, satisfaction surveys or through 'tell us what you think' leaflets. Patients informed us that they could raise any issues with the staff at any time.

## Are dialysis services well-led?

### Leadership and culture of service

- We were told that the service was currently in the process of deregistering the current clinic manager who had stepped down to be the deputy clinic manager. We were informed that the process had been started to appoint a new clinic manager who would become the new registered manager. A registered manager is the person appointed by the provider to manage the regulated activity on their behalf. This is a requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 7. We informed the area head nurse that the service was required to have a registered manager.
- Due to there not being a clinic manager at the time of inspection, the area head nurse supported by the unit team leaders was responsible for monitoring and leading on delivering effective governance and quality monitoring on the dialysis unit. All staff on the unit we spoke with reported they were well supported by the area head nurse. The area head nurse reported that she was able to spend up to three days per week at the unit to provide the necessary management and leadership to the service.
- The area head nurse reported that she was well supported by a knowledgeable wider management team that included a regional business manager, chief nurse and clinic services director.
- There was a clear leadership structure from unit level to senior management level. Within the unit, there were four team leaders, to support the area head nurse with the daily operation of the unit.
- We observed that relationships throughout the unit were positive, professional and friendly. This included the relationships between the unit staff and those at a senior management level.
- All staff we spoke with reported they had a good relationship with their line manager and area head nurse.

- The regional business manager and area head nurse provided the overarching management to the unit. Roles were distinct in that the area head nurse was responsible for the clinical areas of the business, with the regional business manager having overall responsibility with regards to the dialysis unit performance. Throughout the inspection, the management team showed they were knowledgeable and well sighted on the performance of the unit.
- We observed that managers were visible, friendly and approachable on the unit and provided support to staff as required.

### Vision and strategy for this core service

- The vision of the service was set out in the corporate code of ethics and conduct document and within the employee handbook. The vision set out the business commitments and core values of the business.
- We saw that the mission and values were posted on the wall of the unit to remind all staff of the core values. These included quality, honesty and integrity, innovation and improvement and respect and dignity. Managers were able to describe clearly that they were focused on providing high quality care for all patients and strived for continual improvement through auditing of patient outcomes, infection prevention, and environmental savings. For, example corporate recycling contracts that included the recycling of cardboard.
- Staff we spoke with understood their roles and responsibilities in meeting the core values of the service.

### Governance, risk management and quality measurement

- We saw there was a clear clinical governance strategy policy that set out the strategic aims of the service. The aims included continuous improvement in patient care and promote evidence based clinically effective care. We saw from evidence supplied by the service that this was a priority for the service and monthly monitoring of patient dialysis outcomes were assessed and shared with the trust and the wider governance team.
- There was a committee structure to support quality and governance. Quality assurance meetings were held with the nephrologist from the local NHS trust. This meeting fed into the wider governance team to ensure oversight by the Fresenius senior management team and the referring trust. However, only three quality assurance

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meetings had taken place throughout 2016, and there were no quality assurance meetings from January to March 2017, which did not provide assurance that multi-disciplinary discussions regarding care and treatment would be attained throughout 2017. We did not see any plans on how the managers were going to improve the performance in relation to ensuring these meetings took place monthly.

- Managers monitored service performance through key performance indicators (KPI) contained within the clinic review report, each service was benchmarked against all of the other Fresenius dialysis units. We saw that the document provided bar graphs showing all Fresenius dialysis units against a number of patient outcome measures such as effective weekly treatment time scores and infusion/blood volume scores. The benchmarking document also contained graphs of improvement or deterioration so that senior managers could act quickly to rectify poor performance.
- The area head nurse monitored the performance of the dialysis unit using a clinic review report. The report contained objectives to ensure patients received effective treatment outcomes, which were monitored on a quarterly basis.
- The service had set out corporate objectives to improve performance of the unit. We saw that the objectives focused on patient outcomes, employees and the community with planned actions the unit was to deliver. We reviewed the objectives and saw that it contained objectives for patients, staff and the community. However, the patient objectives only addressed one issue relating to the patient survey, which was to increase the response rate by 5%. The actions taken were to place the survey results in the waiting room and the action plan. This did not address how they intended to increase the response rate. We saw no other areas of the patient survey were addressed by the corporate objectives.
- The corporate objectives also contained a section in relation to the surveillance audit (quality management audit) completed in 2016, to reduce the number of major and minor non-compliance with corporate policies and procedures by 20% and 10% respectively. For example, the audit highlighted there were issues relating to omissions where drug administration had not been documented using the patient prescription chart. We observed the corporate objectives did not contain

any planned actions or actions taken in relation to the audit findings. This did not provide assurance that actions had been taken to improve the performance of the unit.

- We did not see any evidence that managers of the unit were performing formal internal checks on a daily and weekly basis to ensure they had oversight of the performance of the unit. For example, there was no formal oversight by managers for the monitoring of fridge temperatures, prescriptions charts, and emergency equipment to ensure the daily checks and recording had been completed appropriately. This did not provide assurance that managers were always aware of any non-compliance issues with corporate policy and procedures.
- We saw evidence that the service had risk assessments in place. Risk assessments included use of clinical equipment and environment areas. These were kept on file in the manager's office. We saw that these assessments contained the hazard or risk with the current controls and additional controls required to minimise or mitigate the risk with a review date. We saw the risk assessments had been reviewed in April 2017. However, we did not see that all risks on the unit had been risk assessed. For example, no risk assessment had been completed due to there being no call bells for patients should they need to summon help urgently. Curtains had been removed from the unit, however we saw no evidence that this was risk assessed to protect patient privacy and dignity and infection control.
- A risk register had been newly developed to provide an oversight of risks associated in renal dialysis practice and the dialysis environment. The register was split to contain operational risks, clinical risks and technical risks. We saw that risks were rated red to green with current controls in place to support the rating.
- Senior managers recognised the need to develop a sepsis pathway, and included it on the risk register. They told us they would develop this with the local referring NHS trust. A sepsis pathway provides staff with the necessary steps to take to detect a patient with sepsis.
- We saw evidence that performance reports were produced by the clinic manager and sent to the local trust to support evidence of patient outcomes, including incidents and complaints. The trust reported they had meetings with the unit senior management every two months and also received feedback from the nephrologist.

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- We saw evidence that the area head nurse completed unannounced inspection visits quarterly to ensure service quality standards. We reviewed the inspection report from April 2017. The report covered staff observations of practice and infection control. The area head nurse informed us that on each inspection different areas were covered including a resuscitation simulation. We saw that following the internal inspection an action plan had been developed to address the findings, which included extra training. The report highlighted non-compliance relating to infection control principles and mid-way patient treatment observations had not been taken. This is consistent with our findings during the inspection, and did not provide us with assurance that appropriate actions or training had been taken to minimise risks to patients.
- We observed that an audit plan was in place that included patient outcomes, water testing, and infection control. The auditing was systematic and followed renal association guidelines to ensure patients received safe care and treatment.
- The service used a clinic communication matrix, which showed where information from the unit was to be reported to and by when. The matrix included where incident reports, audits and managerial paperwork were to be sent. From the matrix, it was clear that all information relating to the unit filtered up through the Fresenius corporate management structure and to the referring trust. The matrix provided clear guidance on when, and who was to report the information.
- The service had developed clinical work instructions to ensure that staff carried out their duties in-line with corporate policy and legislation. For example, we saw there were comprehensive work instructions for the management of blood borne viruses, complications, reactions and other clinical event pathways such as needle dislodgement. The work instructions provided staff with flow diagrams to follow. A folder with the work instructions file numbers was kept in the manager's office for staff to review. We saw that staff had signed to say they had read and understood the work instructions.

## Public and staff engagement

- The service performed annual patient surveys. The response rate in the 2016 survey was poor at 20% (15 respondents). The average response rate across the

Fresenius units was 55%. We saw that an action plan had been developed in response to the survey but did not include any actions to how they were going to engage with patients to increase the response rate.

- Although the patient survey was completed in 2016, we saw no evidence to suggest that the action plan in place addressed the patient concerns. For example, only 14% of respondents in the survey thought the chairs used during treatment were comfortable. From our conversations with 10 patients, we found that this had not been addressed, as eight patients reported they found the chairs uncomfortable. The survey also found that only 29% of patients reported dialysis usually begins on time. We found from our conversations with patients that this was still an issue that had not been suitably addressed, as seven out of the 10 patients we spoke with reported their appointment did not start on time.
- The service also performed annual staff surveys. In the 2016, staff survey the response rate was low at four responses. Although statistically the representative group of respondents was small to provide sufficient evidence, the survey showed that only 50% of staff in 2016 would recommend the unit as a place to work. We saw an action plan had been developed to address the issues raised in the survey that included offering staff internal and external professional development and training. However, we saw that the action plan did not address why the response rate was so low or how the service would engage with the staff to increase the low response rate.
- We saw that 'Tell us what you think' cards were available in the main reception for patients to raise issues or compliments if they did not want to raise them directly with the staff.

## Innovation, improvement and sustainability

- The service followed its clinic environmental plan set out in the corporate environmental policy statement. The policy statement set out what the company will do to reduce their environmental impact and improve environmental performance. For example, general waste was separated from cardboard so could be recycled other than going to landfill. We saw evidence

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that environmental factors were included on the clinical review reports for review by the senior management team and actions to improve environmental performance.

- The service aimed to move appropriate patients onto dialysate that was stored in a large central delivery

system (CDS). This large tank held dialysate rather than using small plastic drums. This would reduce costs to the service, and reduce the amount of plastic used in the dialysis process.

- The unit supported eight athletes from the British transplant games in 2016, which were held in Liverpool. We were told the unit provided dialysis sessions for the athletes to enable them to take part in the games.



# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure that all patient observations are accurately completed in respect of each patient receiving care and treatment.
- The provider must ensure that all prescription charts are accurately completed in respect of each patient receiving care and treatment.
- The provider must ensure that all care plans are accurately completed in respect of each patient receiving care and treatment.
- The provider must take action to assess, monitor, and mitigate all risks in relation the unit. This should include assessing the need for call bells on the unit, to ensure that all patients are able to summon help in an emergency and the positioning of the nursing station on the unit.
- The provider must take action to replace the faulty dialysis machine media data ports.
- The service must take action to address the concerns raised by the patients receiving care and treatment on the unit. For example, patient comfort and waiting times.

### Action the provider **SHOULD** take to improve

- The provider should address the storage of privacy screens to ensure they are easily accessible to the staff should they be required.
- The provider should take action to ensure all competency files are fully completed and reviewed.
- Emergency equipment should be consistently checked daily in line with corporate policy.
- Fridge temperature checks should be consistently taken on a daily basis in line with corporate policy.
- The provider should have a system for managers to perform internal checks on a daily and weekly basis to ensure corporate policy and procedures are being followed.
- The provider should take action to provide staff with procedures and training with regards to the identification, process, and management of patients with sepsis.
- The provider should take action to address the need for staff to be able to access the referring trust systems.
- The provider should take action to ensure that monthly quality assurance meetings take place.
- The provider should take action to monitor and publish data with regards to the Workforce Race Equality Standard (WRES).

## 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 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 (1) (2) (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and decisions taken in relation to the care and treatment provided.</p> <p>How the regulation was not being met:</p> <p>Not all patient records, including care plans, observations and prescription charts were accurately completed in respect of each patient receiving care and treatment.</p> <p>Regulation 17 (1) (2) (b) assess, monitor and mitigate the risks relating to the health 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).</p> <p>How the regulation was not being met:</p> <p>Not all risk assessments specifically related to the unit had been completed to ensure the safety of patients receiving care and treatment.</p> <p>Regulation 17 (1) (2) (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.</p> <p>How the regulation was not being met:</p> <p>Following the patient survey in 2016, the needs of the patients had not been sufficiently addressed.</p>
Regulated activity	Regulation



This section is primarily information for the provider

## Requirement notices

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulation 15 (1) (e) All premises and equipment used by the service provider must be properly maintained.

How the regulation was not being met:

Several dialysis machines had media data port faults. These must be replaced to ensure that each machine functions effectively to minimise the risk of staff input errors.