

Diaverum Dialysis Clinic - Lings Bar

Quality Report

Lings Bar Hospital
Beckside
Gamston
Nottinghamshire
NG2 6PR
Tel: 0115 9814390
Website: www.diaverum.com

Date of inspection visit: 15 October 2019
Date of publication: 17/12/2019

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Requires improvement 

Overall summary

Diaverum Dialysis Clinic - Lings Bar Nottingham is operated by Diaverum UK Limited. The service facilities include 12 dialysis stations and an additional three siderooms for use for patients needing to be treated in isolation.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection of the service on 15 October 2019.

Summary of findings

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

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

Services we rate

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **Good** overall.

We found good practice in relation to dialysis services:

- The clinic was well staffed and consistently met the required nurse to patient staffing ratios.
- Staff had completed mandatory training and competencies and were suitably skilled for their roles.
- There were processes in place for safe medicines management.
- Patients were complimentary about the care they received at the clinic.
- There was a consistent approach to record keeping and records were stored securely.
- Staff were observed to closely follow infection prevention control procedures when performing invasive procedures. Dialysis machines were routinely cleaned between patients. There were robust systems in place to manage patients with blood borne diseases.
- There were clear governance systems in place for sharing relevant information between staff at all levels.

However, there were areas where the service needs to make improvements:

- We did not observe staff asking patients about their well-being prior to the start of dialysis sessions. This meant that there was a risk that staff were not fully aware of potential risks to patient's health and well-being prior to them commencing treatment.
- There was an infection control risk due to patients sharing a blood pressure machine and cuff, and a thermometer for taking observations prior to treatment sessions. The equipment was not cleaned between each patient use.
- We found that some equipment was out of date for testing. Although most of this out of date equipment belonged to the acute trust, it was used by Diaverum staff on occasion. There was some out of use / condemned equipment in the clinic which was not labelled 'do not use', therefore there was a risk that it was not clear to all staff that the equipment was not safe for patient use.
- Complaints information was not clearly displayed or widely available to patients- there were no complaints leaflets or posters available within the clinic.
- Some patients had long waits between arriving on transport at the clinic and starting their dialysis session. There could also be long waits for transport for patients to return home. This meant that patients often had to spend long periods out of the house in order to receive dialysis 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, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Midlands Region)

Summary of findings

Our judgements about each of the main services

Service

Dialysis services

Rating Summary of each main service

Good



- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service generally controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available six days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles

Summary of findings

and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

There were often long waits before and after treatment due to transport issues. It was not always easy for people to give feedback and raise concerns about care received as there were no complaints leaflets or posters available in the clinic. Leaders did not always follow effective governance processes to ensure that patient risks were identified and managed.

Summary of findings

Contents

Summary of this inspection

	Page
Background to Diaverum Dialysis Clinic - Lings Bar	7
Our inspection team	7
Information about Diaverum Dialysis Clinic - Lings Bar	7
The five questions we ask about services and what we found	9

Detailed findings from this inspection

Overview of ratings	13
Outstanding practice	39
Areas for improvement	39
Action we have told the provider to take	40

Good



Diaverum Dialysis Clinic - Lings Bar Nottingham

Services we looked at

Dialysis services

Summary of this inspection

Background to Diaverum Dialysis Clinic - Lings Bar

Diaverum Dialysis Clinic – Lings Bar Nottingham is operated by Diaverum UK Limited. The service is an independent single specialty provider of dialysis in Gamston, Nottinghamshire. The unit primarily serves the community of south Nottingham. It also provides haemodialysis for those patients from outside the area who may be on holiday.

The service has a registered manager in post, who at the time of the inspection, had recently been appointed and had registered with the CQC in July 2019.

We inspected this service on 15 October 2019 using our comprehensive inspection methodology. The inspection was unannounced (staff did not know we were coming).

The facility is based within Lings Bar Hospital. The service has 12 treatment stations and is open Monday to Saturday from 6.15 am to 6.15pm. Facilities include three side rooms for patients requiring treatment in isolation.

There is a service level agreement with a local NHS trust to provide haemodialysis (HD) to adults over the age of 18.

Most patients use hospital arranged transport, to and from the facility with a small number using their own transport. There are designated parking spaces for those who wish to drive, including two disabled parking bays.

Diaverum works closely with the referring Trust. It is a nurse led clinic with weekly visits from the consultant nephrologist and trust dietitian. There are monthly multidisciplinary team (MDT) meetings held with the consultant and clinic manager/senior staff nurse.

Staff within the clinic can access an NHS email account to ensure patient confidentiality. Staff also have access to electronic records and IT systems to collate blood and virology results.

Arrangements for emergency patient care i.e. cardiac arrest, are via a 999 call to the paramedic ambulance service. All staff have basic life support training and all required equipment was on site. Registered Nurses have ILS training as required from Trust.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in dialysis, with off-site support from an inspection manager. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Diaverum Dialysis Clinic - Lings Bar

The service provided dialysis treatment. This location is registered to provide the following regulated activity:

- Treatment of disease, disorder or injury.

During the inspection, we visited all clinical areas of the dialysis unit at the Lings Bar Nottingham clinic site. We spoke with nine staff including; the registered manager, nurses, assistants, admin staff and Diaverum UK managers. We spoke with eight patients and observed

four episodes of patient care delivery. During our inspection, we reviewed three sets of patient records and four prescription charts. We reviewed policies, training records and audit results.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. We have previously inspected this location on four occasions since its registration in May 2012.

Summary of this inspection

Findings from the last inspection included breaches of the following regulations:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

This resulted in three requirement notices being issued. Following our inspection, the service produced an action plan to address the requirements. During this inspection we identified that there was an ongoing breach of regulation 17.

Activity (July 2018 to June 2019):

The clinic provided a service to 46 patients at the time of the routine provider information request, which had dropped to 44 patients at the time of inspection. Most patients were aged over 65. During the activity reporting period 5,727 dialysis sessions had been provided by the clinic. All patients were NHS-funded.

Track record on safety (July 2018 to June 2019):

- No never events or serious injuries
- 105 incidents were reported from April 2019 to September 2019, with 66 of these being patient related incidents.
- One complaint was reported in the year prior to inspection.

Services provided at the service under service level agreement:

The provider had a service level agreement with the local NHS trust to provide dialysis services. The premises used by the clinic were owned by the NHS trust who had responsibility for all building and non-dialysis equipment maintenance and cleaning services. Staff at the clinic and all dialysis equipment was owned by Diaverum UK Limited.

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 have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Medical staff were provided by the local acute trust.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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

- The service generally controlled infection risk well. They kept equipment and the premises visibly clean. However, staff did not always use equipment and control measures to protect patients, themselves and others from infection.

Good



Summary of this inspection

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, some equipment at the clinic was found to be out of date for testing.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, staff were not observed to routinely ask about a patient's wellbeing before they commenced treatment, meaning they may not be fully aware of any risks to patient starting a dialysis session.

Are services effective?

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Dialysis services were available six days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

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

- Staff did not routinely assess and monitor patient's pain in the clinic.

Good



Summary of this inspection

Are services caring?

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Good



Are services responsive?

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. However, there were often long waits before and after treatment due to transport issues.

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

It was not always easy for people to give feedback and raise concerns about care received as there were no complaints leaflets or posters available in the clinic. However, the service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Good



Are services well-led?

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **Requires improvement** because:

Requires improvement



Summary of this inspection

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

All staff were committed to continually learning and improving services.

However:

Leaders did not always operate effective governance processes, throughout the service in order to identify and manage patient risk.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dialysis services	Good	Good	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Dialysis services

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Requires improvement 

Are dialysis services safe?

Good 

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Staff we spoke with told us that they had completed their mandatory training requirements. Many of the training modules were available as e-learning. Any face to face training sessions were delivered locally at clinic sites by the practice development nurse for the region.

The mandatory training was comprehensive and met the needs of patients and staff. The practice development nurse worked together with the clinic manager and individual staff to identify appropriate training needs and developed an annual education plan. The delivery of the plan was achieved by identifying priorities for module completion in each quarter. There were nine mandatory training modules that were required to be completed annually. These included modules such as infection prevention control, manual handling, fire safety, and hand hygiene. Some of the modules, such as medication management and aseptic non-touch technique competencies, were only applicable to registered nursing staff. Training data provided by the clinic showed an

overall compliance of 97.3% with annual mandatory training modules. In addition, all staff at the unit were trained in basic life support; registered nursing staff were trained to immediate life support level as this was part of the trust contract requirements. All other staff were trained in basic life support. Life support training was required to be updated annually and there was 92% compliance with this. There were additional mandatory training requirements that needed to be completed every three years in 18 modules including the mental capacity act, sharps management, pressure ulcers, falls, conflict resolution and arterio-venous fistula care (for relevant clinical staff). Training data provided by the clinic showed 100% compliance with triennial mandatory training requirements. There were three one-off mandatory training sessions that staff were required to complete which included code of conduct, national early warning score (NEWS) and sepsis awareness and Prevent training. We saw that there was 100% compliance with one-off training modules.

Clinical staff did not all routinely complete training on recognising and responding to patients with mental health needs, learning disabilities and dementia. However, a dementia module had been recently introduced into the mandatory training programme and there was 100% compliance by clinic staff with completion of this training module. In addition, there was a specific training module called 'the frail person' being introduced which trained staff in managing patients with more complex needs. All staff were required to complete training on the Mental Capacity Act (MCA), which was tailored to their job role. We saw that there was 100% compliance with this training module.

Dialysis services

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept a log of mandatory training compliance and had a process for monitoring compliance. The provider had a target for training compliance of 100%. The practice development nurse for the region reviewed all staff's training compliance on a monthly basis and highlighted any staff due to update any training modules to the clinic manager. The clinic manager then prompted staff to complete training on line or book onto a face to face training session. Conversations about any training compliance concerns were held between the clinic manager and individual staff member and documented. We were told that during these conversations, any reasons for poor compliance were explored and ways of supporting staff to achieve compliance were agreed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

All staff received training specific for their role on how to recognise and report abuse. All clinical staff were required to be trained to level two in safeguarding adults and children, with the clinic manager being trained to level three for both adults and children's safeguarding. During our last inspection in 2017 we found that staff had not received any children's safeguarding training. However, during this inspection we saw that all staff were up to date with their safeguarding training and there was 100% compliance with safeguarding adults and children's training modules. There was a named safeguarding lead for the organisation overall who provided support to all clinics within the Diaverum UK group.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding adults policy which detailed staff roles and responsibilities in relation to safeguarding concerns, which all staff had access to on the internet. In the reception area we saw information on display which provided advice and contact numbers for

contacting the local safeguarding teams. There was a standing agenda item on the clinic team meeting agenda for discussion of any safeguarding concerns that had been raised.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. They kept equipment and the premises visibly clean. However, staff did not always use equipment and control measures to protect patients, themselves and others from infection.

There was a corporate infection prevention control policy used across all Diaverum clinics in the UK. Staff were supported by an infection prevention control (IPC) lead from Diaverum UK.

All clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. The waiting area was carpeted which the clinic manager had raised as a concern to the senior management team. Clinical treatment did not happen in this area but if there was an unexpected blood spillage, staff had access to special cleaning granules and the domestic staff could be called to clean the area immediately. The clinic manager told us they hoped to get the carpet replaced in the near future. We saw that the dialysis chairs were in good condition and that any that were not fit for purpose had been removed from use and condemned. However, there were no signs on the condemned chairs to advise staff not to use them. We raised this with the clinic manager during our inspection who was arranging for notices to be placed on all out of use equipment and have it removed from the unit.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that staff cleaned the dialysis chairs thoroughly after each patient's use, with anti-bacterial wipes. Dialysis machines were also wiped clean between patients and a 'clean' sign was placed on the machine once this was completed. There was a process for disinfecting the dialysis machines between each patient and at the end of each day. The machines had a built in system to prompt staff to perform a citric acid clean after each use and record completion of the disinfection process. The process took around 40 minutes and the machines were programmed to prevent further use until the disinfection process had been completed. In addition, each machine

Dialysis services

had a further bleach disinfection clean on a Saturday afternoon after the clinic was closed for the rest of the weekend. Separate machines were used for any patients with blood borne diseases such as hepatitis C. These machines were identified with a red sign and red tape to ensure they were kept separate. There was a separate bleach disinfection point that was used for cleaning machines that had been used on patients being treated in isolation rooms. All machines, including the spare machines not in use, had the two disinfection processes completed to ensure that they were always ready for use if they were needed.

Environmental cleaning records were up to date and demonstrated that all areas were cleaned regularly. There was a cleaning schedule in place which listed daily, weekly and periodic cleaning tasks on a checklist for completion. We requested scores from cleaning audits from July 2019 to September 2019 and saw that the average cleanliness score for the unit was 94%.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff washing their hands and using hand gel before and after patient contact. There was easy access to hand wash sinks which had sensor taps and each patient station had a hand gel pump. There were hand hygiene posters displayed above the sinks. Staff were all bare below the elbow. All staff were observed for a hand hygiene audit each month. The clinic manager told us that there was 100% compliance with hand hygiene audit standards within the service. There were PPE dispensers containing gloves and aprons readily available throughout the unit. We saw staff using PPE appropriately. In addition, each staff member had an individual face visor which was named and for their exclusive use. We saw that these were worn when patients were connected to or removed from a dialysis machine to ensure protection of staff member's facial area and associated mucous membranes (eyes, nose, mouth) from splashes, sprays, and spatter of body fluids.

Each patient had an individual treatment box which contained a tourniquet, tape and the machine card which stored data about individuals treatment. This meant that there was less risk of any cross contamination as patient's weren't sharing basic equipment. The boxes were cleaned at the end of each session. However, all patients attending the clinic shared a blood pressure machine and

thermometer which they were asked to use prior to treatment whilst they were in the waiting area. We noted that this was not cleaned between patient use. We raised this with the clinic manager who told us that the blood pressure monitor cuff was used over patient's clothing and the thermometer was not in direct contact with the patient's skin. However, they accepted that as patients were touching the equipment and it was not cleaned after each use, this could create an infection control risk. The manager planned to review this practice following our inspection findings.

All dialysis tubing which connected patients to the machines was single use and was disposed of in clinical waste bags after use. We observed staff using an aseptic non-touch technique (ANTT) when inserting needles into the patient's vascular access point in order to connect them to the dialysis machine. The ANTT method ensures that microbial contamination is prevented by ensuring that sterile body sites are not touched either directly or indirectly by healthcare professionals. Staff were required to have an annual competence assessment of their ANTT methods. We asked for records of these competences and saw that 100% of all staff required to complete this annual competency were compliant with the requirement.

There was routine two-monthly methicillin-susceptible staphylococcus aureus (MSSA) swab testing from the nose of each patient in line with trust protocol. Any positive results were highlighted to the renal consultant and haemodialysis lead specialist nurse at the acute trust who provided the required medication prescription for that patient. During the previous 12 months there had been no reported cases of MSSA. All patients were also screened for blood borne diseases such as Hepatitis B and C, three-monthly, and for human immunodeficiency virus (HIV) annually, in line with trust guidance. There had been no cases of healthcare acquired infections in the service during the previous 12 months. Any patients returning from holiday having received dialysis away from home, had all blood screening tests before and after their holiday, including screening for carbapenemaseproducing enterobacteriaceae (CPE) until three negative test results had been received. CPE are bacteria that normally live harmlessly in the bowel but can cause an infection if they get into the blood stream. The bacteria are resistant to certain types of antibiotics making infections more difficult to treat.

Dialysis services

There were three side rooms available to treat patients in isolation to prevent the spread of infection. Any patients with hepatitis B or C or HIV or those who had received dialysis away from base were treated in side rooms using designated dialysis machines. The side rooms were also available to treat patients who had infectious illness such as diarrhoea and vomiting.

Patients were offered the opportunity to receive the flu vaccination whilst attending the clinic and we saw that there was information displayed about this.

There was a water treatment room on site which provided purified, filtered water for use during dialysis treatment sessions. The quality of water used during dialysis has to be closely monitored in order to meet standards set by the Renal Association. The standards ensured that water used was free from infection. The service had a procedure for monitoring the water treatment system to enable them to meet the required standards. The procedure included a daily check of salt levels, chlorine levels and the water pressure which were done by a registered nurse and recorded in a folder. We saw that the log of checks had been consistently completed for the previous year. The procedure detailed contact information for service contacts in the event of fault or for support and advice. Emergency out of hours contact details were also provided. In addition to the daily testing, weekly water samples were sent for testing and the results were reviewed by the clinic manager and reported to the quality monitoring team at the acute trust in line with contractual requirements. This meant that there was close monitoring of the water quality used for dialysis to ensure it was free from infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, some equipment at the clinic was found to be out of date for testing.

The dialysis clinic was located in the grounds of a local NHS hospital and there was a service level agreement between Diaverum UK and the hospital. The maintenance of the premises and non-dialysis equipment was the responsibility of the NHS trust, whilst the dialysis specific equipment belonged to, and was the responsibility of Diaverum UK. There was secure

controlled access to the clinic by swipe card for staff and buzzer entry for patients and visitors. The clinic was located on the ground floor and there was level access for wheelchair users. There was a designated car park for sole use of the clinic, although we saw that other members of the public often used the designated parking spaces. Many of the patients arrived on transport but for those that drove, they told us that the car park was often busy, and they were not always able to find a parking space. Patients explained this was a particular problem on clinic days. One patient told us that when they had needed to park further away, the ambulance transport staff and the consultant had moved their car nearer for them whilst they were having treatment. There was a waiting area in the reception where patients sat after arriving and whilst waiting for their treatment session. The reception area was manned by the ward clerk most of the time. There was sufficient seating available as well as a range of information leaflets and a television to occupy patients whilst they waited.

The service had enough suitable equipment to help them to safely care for patients. In the clinical treatment area there were 12 dialysis stations separated into two bays of six. The nurse's station was central to the unit and ensured all patients in the bays could be observed by the nursing staff. Each dialysis station was bright and spacious and contained a treatment chair which could be reclined and fully adjusted to ensure patient's comfort. Stations were close enough to allow some patient interaction if patients wanted to speak with each other but provided sufficient distance between neighbouring dialysis stations to prevent the risk of cross infection and offer a degree of privacy. This was in line with Health Building Note 07-01- Satellite dialysis unit. There were no privacy curtains to separate the stations, but staff could provide privacy screens if patients requested them or there was a need for privacy such as in the event of an emergency. In addition, there were three isolation rooms available for patient use which were visible from the nurse's station. There was a further side room that was not in use as it was deemed to be too far away from the nurse's station for patients to be visible for monitoring by staff. All patients had access to individual television screens and free WIFI for internet access.

Patients could reach call bells and request assistance if necessary. However, staff were very visible on the unit

Dialysis services

and made regular checks on patients, therefore, we did not observe the call bells being used frequently. During our last inspection in 2017 the call bell system was out of order but this had been fixed.

Staff responded quickly and appropriately to alarm guards on dialysis machines and did not simply override the alarm but investigated the cause of the alarm and took appropriate action where necessary.

There was a treatment room and two consulting rooms which were used by the consultant and dietitian. We saw that these rooms contained handwash sinks and wipeable plinths as well as some basic equipment. There were some items of equipment in these rooms, that were out of date for testing, such as a set of chair weighing scales which were last tested in April 2016 and the plinth which was last tested in January 2012. We raised this with the clinic manager who told us that the equipment belonged to the local trust and was very rarely used by Diaverum staff. Although staff rarely used this equipment, there was no process in place to work with the local trust to identify when equipment in the consulting and treatment rooms was due for testing. Following our inspection, we saw that the clinic manager had arranged a date in November 2019 for the equipment belonging to the NHS trust to be tested to ensure it was in date and fit for use.

In the dialysis treatment area there was a locked clean utility room for storage of dressings, medication and other clinical items. We found all items we checked to be within their expiry date.

In addition, there was an equipment store room containing blood pressure monitors, an ECG machine, centrifuge and fridge for blood samples and a hoist. We found all of these equipment items to be within their due date for testing. There was a technical area room which was used for storage of spare dialysis machines and contained a locked cupboard for storage of hazardous substances in line with control of substances hazardous to health (COSHH) requirements. We found two 5kg bottles of a disinfectant and descaling agent for haemodialysis machines on top of the COSHH cupboard which should have been locked away. We raised this with staff who immediately removed the bottles and told us that the bottles had not been in the cupboard due to an overstocking issue, meaning all stock could not fit in the

cupboard. Following our inspection, we saw that a risk assessment had been completed and actions to be taken to mitigate the risk in the event of any future overstocking were clearly documented.

There was a main storage room which contained larger amounts of clinical supplies such as tape, needles and syringes. The room was locked by use of a digital door handle lock which only staff had the code to. The stock levels were monitored by the healthcare assistant on a daily basis as stock for treatment sessions was collected from the store room twice a day. We saw that there were four full five-litre bottles of citric acid used for disinfecting the dialysis machines, stored in this room which should be stored in the COSHH cupboard. This was raised with the clinic manager who removed these bottles immediately. Fluid solutions and bicarbonate of soda for use during dialysis were also stored in this room. Since these items were temperature sensitive, the temperature of the room needed to be monitored and recorded on a daily basis. We saw that there was a temperature log for this room which had been fully completed over the previous six months with no dates of the temperature being outside of the recommended range.

There was an emergency resuscitation trolley located in the dialysis treatment area. Daily checks of the equipment on the top of the trolley were completed. This included checks of the oxygen cylinder, pulse oximeter, suction and defibrillator units. The trolley was sealed with a numbered tamper proof security tag which was removed once a month to enable staff to check the contents of the trolley. The trolley contained an anaphylaxis kit, airways, and intravenous fluids alongside a checklist detailing all items. When staff performed the monthly check, they used the checklist to identify that all items were present in the trolley and checked the expiry dates of all items. We saw that all daily and monthly checks had been completed which was evidenced by documenting the checks on a log. We did a random check of items on the trolley and found that all items we checked were within their expiry date. Staff told us that the anaphylaxis box which contained the emergency drugs was replaced by pharmacy when it reached its expiry date. We saw that the emergency drugs were kept in a sealed box which had a clear expiry date written on it and that the box was in date. During the monthly checks

Dialysis services

of the resuscitation trolley, staff also performed checks of the two emergency evacuation kits kept on the unit. These kits contained equipment for use if patients needed to evacuate the building in an emergency.

Staff ensured specialist equipment was fit for use. All the dialysis machines were on a rolling replacement programme and had a planned preventative maintenance programme. Renal Association guidance states that dialysis machines should be replaced every seven to ten years or after completing between 25,000 and 40,000 hours of haemodialysis usage. The clinic manager kept a record of when machines had been installed, their age and their hours of usage. We saw that all dialysis machines in use at the time of our inspection had been replaced within the last 18 months. The hours of usage were automatically recorded and the data was able to be downloaded through an electronic system. The maximum hours of usage for any of the dialysis machines in use at the time of our inspection was 7,675 hours. There was a service contract in place for the dialysis machines and there were service records for each machine indicating when it had last been serviced. These records showed that all planned preventive maintenance on the machines was up to date. Managers told us that when machines broke down they were able to get repairs carried out quickly. There were four spare dialysis machines available in addition to the 12 used during dialysis sessions, so there were always replacement machines available in the event of a machine breakdown. When new machines were installed a representative from the supplying company came to the clinic to ensure all staff were trained in the use of the machines. When any other new medical devices equipment was bought by the clinic, managers told us that they asked company representatives to deliver a training session to some staff. A train the trainer approach was then used to ensure all staff were trained in the safe use of all medical devices.

During our inspection there was an outstanding problem with a switch in the water treatment plant which was awaiting replacement. Although the part to replace the switch had been received it had not been replaced as staff were waiting for an engineer to attend. The manager told us that although an engineer visit had previously been arranged, the staff member who was due to enable access to the building for the engineer had forgotten to attend the clinic to let him in. This had been reported as an incident and managers had spoken with staff to

ensure this didn't happen again. Staff were waiting on another date for the engineer to visit to be arranged. At the time of our inspection this meant that there were outstanding maintenance works in the water treatment plant. However, staff told us this had not impacted on their ability to continue to deliver the service to patients.

Staff disposed of clinical waste safely. We saw that clinical equipment such as used gloves and aprons and used dialysis lines was disposed of in orange clinical waste bags which were disposed of separately in line with the local trust's policy. Black bags were in use for domestic waste and there were additional clear bags for all recyclable waste. Due to all the packaging associated with dialysis products, most of which were single use products, there were high volumes of recyclable waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, staff were not observed to routinely ask about a patient's wellbeing before they commenced each treatment session, meaning they may not be fully aware of any risks to a patient starting a dialysis session.

There were procedures in place to assess and manage patients with blood borne diseases. All patients were screened for blood borne diseases such as Hepatitis B and C, three-monthly, and for human immunodeficiency virus (HIV) annually, in line with trust guidance. Patients with diseases such as hepatitis C were treated in side rooms using separate dialysis machines. These machines were identified with a red sign and red tape to ensure they were kept separate. In addition, any patients returning from receiving dialysis away from base, whilst on holiday, were treated in an isolation room for three months, using the same machine for each treatment, in order to reduce the risk of cross infection.

Staff completed risk assessments for each patient when they were first commenced dialysis treatment at the unit and updated them when necessary using recognised risk assessment tools. All patients were risk assessed when they first started treatment at the clinic which included moving and handling risk assessments, falls risk assessment, and venous needle dislodgement risk assessment. In addition, all patients received diabetic

Dialysis services

foot checks and had a tissue viability care plan completed. Risks assessments were repeated at least monthly on all patients for venous needle dislodgement, falls, pressure ulcers and manual handling. In addition, their venous access point (fistula or catheter) was reviewed monthly for flow and any signs of infection. We reviewed three sets of patient records and saw that all risk assessments had been completed and reviewed appropriately. On arrival for each dialysis treatment session all patients took their own blood pressure, temperature and weight and the information was entered into the electronic records system by the nursing staff. Observations including blood pressure, temperature and heart rate were repeated on a regular basis throughout the dialysis treatment session. The frequency of observations was determined according to the patient's observation readings taken prior to treatment on the day and staff's clinical judgement of their presenting condition. All patients had observations taken hourly as a minimum. Results were recorded automatically by the machine and added into the electronic records system by the named nurse. The frequency of observations would be increased if the findings were of concern. Managers told us that prior to each treatment session all patients were asked about their general wellbeing, mood, diet and appetite, and any shortness of breath or falls. This was in order to establish if patients were well enough to receive their dialysis treatment and to identify if any referral on to other healthcare professionals was required. Managers explained that the electronic record system attached to the machines prompted these questions and prevented staff progressing treatment until answers had been added into the system. However, when we observed patients starting their dialysis session we did not observe this practise and we were unclear if staff had recorded that these questions had been asked in order to progress the treatment, without having asked them. After our inspection the clinic manager told us that staff would engage in an open conversation with the patients assessing how they have been since their last dialysis. They told us that the list of questions prompted by the machine were not asked specifically but all nurses connecting a patient to a dialysis machine were aware of the need to ascertain wellbeing information prior to commencing treatment. Therefore, we were not reassured that patient wellbeing was fully established before treatment was commenced.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients were monitored throughout their treatment session and if any of their observations were deteriorating the national early warning score (NEWS) was used to monitor them and escalate concerns if required. Staff had been trained in the use of NEWS and sepsis recognition and management. Training was required to be completed as a one-off only session but managers told us that if new information was released, update training would be provided. There was an arrangement in place for patients to be transferred to the local acute trust in the event of deterioration or other emergency such as cardiac arrest.

Staff knew about and dealt with any specific risk issues. For example, staff told us about the process for managing patients with a prolonged bleeding risk following haemodialysis and were aware of the policy around this.

There were processes in place to manage any patients with challenging behaviour. If a patient had a challenging behaviour staff told us they would try to de-escalate the situation following the clinical guidelines 'patients who are agitated and/or aggressive/violent and the emergency control of acutely behavioural disturbed adult patient'. Staff told us about a patient with worsening dementia who had become less compliant with treatment. They had involved their partner in the treatment sessions to encourage them to attend and were using mental capacity and deprivation of liberty safeguards policy to inform their approach to care. Staff also told us about how they had transferred a patient with learning disabilities to an earlier slot so that their sister could attend the session and support them to be compliant during the treatment.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff told us that patients had access to clinical psychology by referral. Staff would identify patients in need of psychological support by talking to them and being aware of noticing changes such as a drop in mood. If any changes were noted, the consultant would be contacted and a referral would be sent to the renal psychologist by email. The psychologist aimed to reply within three working days of receiving the referral.

Dialysis services

and then sent a questionnaire to patient and following return of this would book an appointment with the patient directly. Appointments were delivered at the local acute trust.

Staff shared key information to keep patients safe when handling over their care to others. We saw patient treatment schedules which were produced by the nurse in charge at the beginning of each day and were kept on the nurse's station desk where all staff could easily see them. These included details of each patient's name and appointment time as well as any mobility, vision, hearing or communication impairments. Staff RAG rated this information to identify a personal emergency evacuation plan for each patient for use in the event of the need to leave the building in an emergency.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of all grades to keep patients safe. There were sufficient staff in post to cover service provision for up to 48 patients although there were only 44 patients on active treatment at the time of our inspection. There was a maximum of 12 patients receiving dialysis treatment at any one time. National guidance and the trust contract required a staffing ratio of one nurse to four patients (1:4) to ensure safe provision of care. On the day we inspected the service there were 11 patients attending for the morning treatment session and eight patients attending for the afternoon session. There were four staff on shift; three registered nurses and a dialysis assistant. All staff were working a 12- hour shift which covered the morning and afternoon dialysis sessions. The clinic manager was working clinically to provide cover as one of the healthcare assistants was off sick. The manager advised us that there were usually four staff on shift which included a minimum of two registered nurses supported by two additional staff, either healthcare assistants or dialysis assistants. We were told that dialysis assistants counted in the numbers for registered nursing staff since they were competency trained to a level meaning they could perform most

nursing duties. Dialysis assistants could connect patients to the dialysis machines in order to commence treatment and disconnect them from the machine when treatment sessions were complete. They performed all registered dialysis nursing duties with the exception of administering medication, which was not within the scope of their role. We asked to see staffing rotas for the previous three months and saw that there were always at least two registered nursing staff and a dialysis assistant on shift which met the requirement of a 1:4 nurse staffing to patient ratio. The staffing rotas showed that the number of nurses and healthcare assistants on all shifts matched the planned numbers required to meet the nurse to patient ratio.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Staffing establishment was determined using a headcount calculator model and there was a policy and procedure for calculating staff headcounts and whole time equivalent staff numbers. Clinic managers were trained in rostering and the headcount calculator tool to support them to maintain safe staffing levels.

The service had no nursing staff vacancies at the time of inspection. Managers reported that the service was fully staffed at the time of inspection. Data provided prior to the inspection had showed that there were some staffing vacancies, but since the twilight dialysis sessions had been withdrawn, there was a full staffing establishment.

The service had high turnover rates for nursing staff. Two out of two (100%) healthcare assistants and three out of five (60%) dialysis nurses, had left the service in the previous 12 months. The same amount of new staff had joined the service as had left the service during this period.

The service had low sickness rates for registered nurses (0%) in the three months prior to inspection. There were higher sickness rates (9%) for healthcare assistants and dialysis assistants in the three months prior to inspection.

The service used bank staff to meet any shortfall in staffing levels on staff rotas. During the three months prior to inspection, the service used bank dialysis nurse staff to cover 50 shifts. No healthcare assistant or dialysis assistant shifts were covered by bank staff. Managers limited their use of bank staff to staff that were familiar

Dialysis services

with the service. Managers told us that Diaverum UK had its own internal group of experienced dialysis nurses who could be easily accessed to cover shifts and ensure appropriate staffing levels were met for each shift. Managers made sure all bank and agency staff had a full induction and understood the service. Evidence of induction training was kept by the clinic manager. Induction included emergency procedures, equipment training, awareness of policies such as information governance and access to electronic records. All bank staff were required to have a minimum of one year's dialysis experience to work in the clinic.

During the three months prior to inspection, the service reported that zero shifts were covered by agency nurses or health care assistants.

Medical staffing

The service had access to enough medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Medical staff were provided by the local acute trust.

There was a named consultant nephrologist who was employed by, and based at, the local NHS trust and provided cover for dialysis patients. The consultant visited the service weekly to conduct clinics for planned patients, new patients and consultations with any patients with concerns. All dialysis patients were reviewed in the clinic at least six-monthly, or more frequently if necessary. Managers told us that there was no clinic cover provided if the consultant was unavailable, however, advice was always available by telephone or email from other consultant staff or an on-call registrar. The consultant was contactable outside of clinics by email and mobile phone and the contact details were available to all staff. The consultant also attended monthly multidisciplinary meetings with the senior nurses to review care plans, monthly blood results and dialysis prescriptions.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient records were comprehensive and all staff could access them easily. Records were available in paper and

electronic formats. Diaverum had its own electronic records system which all staff had access to. In addition, staff entered patient information into the trust's electronic patient record system. All Diaverum staff had honorary contracts with the referring trust to enable them to access their electronic records system. This system contained the most detail relating to patient care and was visible to the multidisciplinary team. During our last inspection staff told us that the provider and trust electronic systems did not communicate with each other, meaning staff had to duplicate information entry into two different systems. At that time, we were told that there were developments to facilitate information sharing between the two systems, but during this inspection, we found that this was not yet in place.

We reviewed three sets of medical records during our inspection and saw that they were complete and up to date. Staff updated patient's records after each dialysis treatment session.

There was a medical records policy which detailed the required contents of patient's medical records. Managers told us that 20% of patient records were audited at random on a monthly basis. We saw evidence of these audits for the previous three months and noted that there was generally good compliance with record keeping standards set out in the audit.

Paper records were stored securely in a locked trolley which was kept at the nurses station. Each patient on treatment had a paper file stored in the trolley which provided key information for individual's dialysis treatment sessions. This included copies of their dialysis prescription and treatment record, medications lists, consent to treatment forms and clinic letters.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines management was governed by a corporate Diaverum UK medication handling, storage and disposal policy. Staff were trained on the safe administration of medicines including intravenous

Dialysis services

medicines. Registered nurses were required to complete annual medicines management training. We saw that 100% of all substantive staff were up to date with their medicines management training.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. A review of all patient's medication and dialysis prescriptions was done at the monthly multidisciplinary team meeting held between the consultant and the nursing staff.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. All medicines were stored in a locked cupboard or locked fridge in the locked clean utility room. There was a small range of medication stored in the clinic which included medicines for pain relief, some antibiotics, a drug for managing hypoglycaemic (low blood sugar) episodes and a clot busting drug. Another drug to stimulate red blood cell production was stored in the fridge as it was temperature sensitive. We randomly checked the dates on the medications stored in the cupboard and fridge and found that they were all in date. Staff told us that if any medicines were found to be out of date, pharmacy were contacted to arrange for them to be destroyed and replaced. We were told that there was a monthly medications audit of all medications. We asked for these audits results and saw that audits had been completed each month for the previous six months and there was a record that all stock was in date and quantities of stock matched logs. We saw that room and fridge temperatures were routinely recorded. Most recorded temperatures during the previous six months were within range with the exception of three dates in July 2019 when the room temperature had been high due to hot weather conditions. This had been recognised and escalated and placed on the clinic's risk register. Planned action was to put a portable air conditioning unit in the store room by next summer.

There were no controlled drugs stored or administered at the clinic.

Staff followed current national practice to check patients had the correct medicines. There was a nominated renal pharmacist at the trust who supported consultants to appropriately prescribe medicines to dialysis patients. Most medicines were prescribed by the consultant or non-medical prescriber nurse specialist based at the

local acute trust. We saw that prescriptions for erythropoietin and iron were kept in a separate folder as they were administered intravenously during the dialysis treatment sessions. We reviewed four of these prescriptions and saw that they had all been signed and dated by the prescriber and the dose and frequency of the medicine was documented. Staff had consistently recorded when the medicine had been administered. Audit of dialysis prescription delivery, which included prescription and administration of erythropoietin and iron, was completed on 10% of patient records at random each month. We saw audit results for prescription delivery for the previous three months and found that there was generally good compliance with the audit standards. All other prescriptions for medication were kept in the patient's paper record files. We saw that when any patients had medicines administered, this was completed by staff wearing a red 'do not disturb' tabard in order that they weren't distracted with the aim of reducing any medication errors. Staff at the dialysis clinic did not prescribe medicines. However, there were some patient specific written directions for administration of some medications by competent registered nurses to facilitate haemodialysis. Consultants were able to set up these directives for specific patients to receive a list of set medicines. We saw that patient specific directives in use had been signed and dated by the consultant in charge of their care. The clinic manager told us that the documents were reviewed and rewritten every six months by the renal consultant.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any safety alerts relating to medicines were highlighted by the practice development nurse or area manager to the clinic manager who ensured that information was cascaded to staff at the clinic either in team meetings or by email.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went

Dialysis services

wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff we spoke with knew what incidents to report and how to report them. Staff we spoke with were able to give examples of what they would report as an incident and told us they had access to an electronic incident reporting system.

Staff reported all incidents that they should report. There was an incident reporting and follow up of clinical incidents policy which identified staff responsibilities and provided guidance on how and when staff should report incidents. The service reported 105 incidents from April to September 2019. There were 66 patient incidents, two staff / visitor incidents, six products related incidents and 31 facilities/ equipment /external services related incidents reported. The highest number of patient incidents were related to patients voluntarily shortening their treatment session, or not attending their session through choice (rather than illness). The highest number of facilities / equipment / external services related incidents were due to external service issues such as food or laundry services.

Incidents were a standing agenda item at monthly clinic team meetings. At the meeting managers fed back any learning and actions from incidents to staff. One example of learning implemented following an incident was the introduction of taped marks on the floor for placement of the dialysis chairs to ensure there was enough room for them to be fully reclined in the event of an emergency. This was introduced following the need to recline a chair quickly when a patient became unwell which resulted in damage to the water and electric supply in the wall behind as the chair was too close to the wall to fully recline. As a result, each dialysis station now had taped marks on the floor for placement of the chair to avoid it hitting the wall behind if it was fully reclined.

Staff reported serious incidents clearly and in line with the organisation's policy. The provider did not report any serious incidents in the previous year.

There was a further policy for the reporting of serious medical incidents as well as procedures for response to major incidents such as the loss of essential utilities (IT and power), the loss of workforce and the loss of water

supply. There were business continuity plans at the clinic for staff to follow in the event of such an incident. These included relocation of patients to other Diaverum satellite dialysis units or to the local NHS hospital dialysis unit. Since the clinic was located in an NHS hospital building there was also a lockdown plan to ensure the safety and security of all staff, patients, visitors, property and assets in the event of a major incident.

The service had no never events in the 12 months prior to inspection.

Staff understood the duty of candour. The duty of candour is a legal responsibility of providers to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Managers told us that Diaverum fostered a culture of openness and honesty if things went wrong and that they would immediately inform patients, extend an apology and carry out an investigation. All staff were trained in the duty of candour requirements so they knew when the trigger had been reached and what steps should be followed. Staff we spoke with confirmed this. Although no duty of candour notifications had been required during the previous 12 months, managers confirmed that they had a process in place to identify and submit duty of candour notifications and a policy which detailed the process needing to be followed if necessary.

Managers debriefed and supported staff after any serious incident. As part of the debriefing process, learning outcomes and improvement plans were communicated to all staff through team meetings or by email.

Managers investigated incidents thoroughly. If a serious incident occurred in the clinic, such as a medication error, air embolus or water treatment plant failure, the process was for an immediate review to ensure patient safety was secured, followed by a root cause analysis which included the development of an action plan which was communicated to any staff member or patient involved.

Dialysis services

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

Good 

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **good**.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. All policies and procedures were based on national guidance, standards and legislation set out by the renal association haemodialysis guidelines, National Institute for Health and Care Excellence (NICE) QS72 and the national service framework for renal services 2004. Managers told us that all policies and procedures were available on the intranet which all staff had access to, and they were reviewed a minimum of three-yearly. We reviewed four policies / procedures and saw that three were in date for review. Managers told us that all policies were corporate rather than clinic specific and there was an ongoing process of policy review at the time of our inspection. When policies were updated, this was highlighted to the clinic manager who discussed it with the team and staff were then required to read the updated policy and sign to say they had done so.

NICE QS72 statement 8 states that adults receiving haemodialysis should have their vascular access monitored and maintained using systematic assessment. Managers told us that each patient had their vascular access assessed prior to each treatment and this data was audited on a monthly basis. We reviewed this data and saw that there was consistent documentation that a pre-dialysis assessment of each patient's vascular access was completed prior to the start of each treatment session. Staff reviewed patient's vascular access for any signs of infection and completed monthly transonic flow monitoring on all arteriovenous fistulas to ensure blood

flow through the fistula was sufficient for effective dialysis. There were targets set out at corporate level to increase the use of arteriovenous fistulas for vascular access and reduce the use of catheters in order to minimise the risk of infection. Renal association guidance recommends no more than 20% of patients dialysed through a catheter and Diaverum had set a target of no more than 23% of patients using a catheter to dialyse. Clinic data for September 2019 showed that 88% of patients were dialysing through a fistula and only 12% were using a catheter for vascular access; this was better than the recommended percentage.

The clinic supported patients to dialyse away from base, when they were on holiday for example. There was a senior nurse who supported dialysis away from home for clinic patients to access dialysis at other units and for patients on holiday to access dialysis at this clinic. They coordinated the gathering of information and updated blood results and communicated with patients and clinic managers to arrange dialysis appointment slots.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had something to eat and drink during dialysis sessions. All patients were offered a choice of sandwich which was prepared in house by catering staff at the hospital and had access to hydration.

Specialist support from staff such as dieticians was available. The dietitian from the local trust visited the clinic once a week during the consultant clinics but was also available to visit patients on other days as required. They were able to provide specialist dietary support and advice to patients. There were information leaflets available in the reception and waiting area relating to diet and fluid intake and dietitian support.

Pain relief

Staff did not routinely assess and monitor patient's pain at the clinic.

Staff told us that they assessed patients for any pain using a scale of one to ten but did not use a recognised tool. However, we did not witness any patients being asked about pain levels and we did not see any

Dialysis services

documentation in the care records of this. Therefore, we were not reassured that patients pain was routinely monitored. We did not, however, see any patients in pain during our inspection.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in data submission to the UK renal registry through the local acute trust. The clinic provided a pre-defined set of data to the trust on a monthly basis which was fed into the trust database and submitted as combined data to the registry. The registry provides independent analysis of renal replacement therapy and acts as a source of comparative data for benchmarking services. However, since the clinic submitted combined data through the local trust, they were not able to benchmark their own service against other providers.

The service performed well in national clinical outcome audits and managers use the results to improve services further. The renal association recommends that patients receiving dialysis three times a week and should achieve blood results that indicated dialysis was effective. The clinic monitored patients' blood levels monthly to identify how well they were dialysing. The blood results were reported through the electronic system and reviewed by the consultant. Results showed that during the previous year, there between 91% and 98% of patients receiving treatment at the clinic achieved effective dialysis based on national guidelines. A range of other clinical performance measures were also collected and reported internally within the Diaverum UK group through a dashboard system. Clinic managers and area managers were able to monitor performance through this dashboard and benchmark their performance against other Diaverum clinics. Performance measures collected included the number of patients with a fistula, haemoglobin levels, urea clearance rates and blood flow rates. An overall score was calculated from this data which was an arbitrary score, where the higher the score the better the performance. There was a target achievement score of 2540 for each clinic for the year 2019. From January to September 2019, the Lings Bar clinic scored between 901 and 907 each quarter, which

meant that they had achieved a score of 2,712 within the first three quarters of the year and had therefore exceeded the Diaverum UK annual target before the year end.

Managers carried out a comprehensive audit programme. Each Diaverum clinic had an unannounced annual clinical audit led by a practice development nurse and the nurse director for the organisation. The audit covered uniform compliance, infection prevention control, fistula care, medicines, and the water treatment systems. Each clinic was scored as an overall percentage for compliance and was rated as either compliant or non-compliant. There were 17 mandatory criteria which clinics to meet in order to be compliant. The Lings Bar clinic was last audited in November 2018 and was given a score of 96.1% and rated as compliant. There were a range of other operational audits which were completed monthly by each clinic and reported to the local trust during contract meetings. These included records audits, infection prevention control audits, medicines audits and shifts not meeting the one to four nurse to patient ratio. In addition, the clinic monitored performance against key performance indicators such as number of appointments, number of sessions missed or cut short and treatments commenced within 30 minutes of a patients appointment time. We saw the latest performance data and found that the Lings Bar clinic performance was good compared to the other clinics in the Diaverum UK group. In quarter three of 2019, clinical performance measure data provided showed that Nottingham was the highest performing clinic in the Diaverum UK group. Managers told us that the strong working relationship between the clinic and the local NHS trust contributed to the clinic's high performance.

Managers used information from the audits and dashboard data to improve care and treatment. Any low compliance areas found during the audit process were reviewed by the clinic manager and area manager so that they could agree actions needing to be taken. There was an action plan template used to record these actions which documented actions to be taken, the named responsible person for the actions, due date and completion date. Actions included reminding staff at team meetings of hand hygiene requirements and procedures for administering anticoagulation medicines and cleaning venous access ports as well as carrying out additional ad hoc staff hand hygiene audits.

Dialysis services

Managers shared and made sure staff understood information from the audits. The monthly meetings held between clinic managers and staff included a standing agenda item to discuss quality which covered audit results and performance information.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All registered nursing staff employed at the clinic were experienced dialysis nurses. Nursing staff were supported by dialysis assistants and healthcare assistants who completed specific competency training to enable them to perform designated tasks. For example, the dialysis assistant completed additional training to develop skills such as being able to insert fistula needles and set patients up and take them off the dialysis machines. Practice development nurses for each region provided face to face training sessions for staff and developed an annual education plan with staff to deliver identified training needs.

Managers gave all new staff a full induction tailored to their role before they started work. One member of staff who had recently started working at the unit told us that they had received very good teaching and had completed both basic and competency-based dialysis specific training since starting in post. They described a process of having a competency log in a folder that was signed off when competencies were completed. Staff had a period of around two months after starting working in the clinic when they were supernumerary in order to give them time to complete all the required training.

Link nurse roles were in place at the clinic for infection control, renal access, shared care and transplants. The link nurses attended additional training and supported other staff at the clinic to provide effective patient management.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge and made sure staff received any specialist training for their role. There was clinical competency training in addition to key mandatory

training sessions that staff were required to update. For example, all staff were required to have an annual aseptic non-touch technique competency update and assessment. In addition, all staff had to complete a range of dialysis specific training including arterio-venous access and blood borne virus training. The renal nurse specialist from the local acute trust provided additional renal specific training updates annually, such as central venous catheter management training.

Managers supported staff to develop through yearly, constructive appraisals of their work. There was an appraisal window which was set from November to February each year when all staff received an annual appraisal. Managers described this as a two-way process where staff self-appraised their own performance and the supervisor appraised their performance, and the appraisals were reviewed and discussed at an appraisal meeting. Previous learning objectives were reviewed and targets were set for new objectives which were achieved through learning plans which were agreed during the appraisal meeting. Through the appraisal process, staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Data from the provider showed that 100% of staff who had been in post during the previous appraisal window had received an appraisal with their line manager within the last year. One staff member explained that they had been supported to access an external course in renal care to enhance their specialist knowledge and skills.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The clinic manager had a monthly one to one meeting with the area manager, either face to face or by telephone. Meetings followed a set template and were documented. Managers told us that all nursing staff had informal supervision meetings with the clinic manager every eight weeks but that these were not documented unless specific concerns were raised that required ongoing actions. In addition, the clinic manager had shadowed shifts with all members of staff to get an understanding of how they worked and what their job role entailed. The process supported staff to deliver effective care and treatment.

Managers identified poor staff performance promptly and supported staff to improve. The clinic manager would

Dialysis services

meet with any staff member who failed to meet standards of care and competence for safe care and would put a performance management plan in place to support the member of staff. Regular meetings were held to monitor progress and development and human resources would be involved in supporting any performance management plans.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Regular team meetings were held by the clinic manager for all staff. We saw minutes of these meetings and noted that they were held regularly and followed a set agenda which covered health and safety, risks, quality, performance, training, staffing, organisational updates and patient feedback. Minutes were circulated to all staff in the team by email.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Nursing staff worked together with the consultant from the local acute trust to deliver safe and effective care to patients. The consultant visited the clinic weekly and was able to review four or five patients during these visits. All patients attending the clinic were reviewed by the consultant a minimum of six-monthly but could be seen more regularly if required. There was no visiting cover available for the consultant clinics in the absence of the renal consultant, but there was an agreement in place for other renal consultants to be available for advice and support by telephone or email. There was daily communication between nurses at the clinic and the renal consultant by email and patient information was shared through staff at the clinic having access to the hospital's record system. There was access to the renal nurse specialist for advice, support and training throughout the year, and they visited the clinic weekly. A dedicated dietitian from the trust visited the clinic on a weekly basis to see patients during the consultant clinic. Staff told us they were able to visit on other days to see patients who did not attend for dialysis on the day of the consultant clinic. A podiatrist from the trust visited the clinic monthly to provide foot care for patients with illnesses such as diabetes. There was access to physiotherapy and clinical psychology services by referral; patients had to travel to the acute trust for these appointments.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Monthly multidisciplinary meetings were held between nurses and the consultant to review and discuss all patients on the clinic's caseload. However, other members of the multidisciplinary team such as the dietitian did not attend these meetings.

Seven-day services

Dialysis services were available six days a week to support timely patient care. There were two dialysis sessions each day from Monday to Saturday. The morning sessions ran from 7am and were completed before the afternoon sessions began at 1pm. The clinic did use to offer a third 'twilight' session in the evenings three times a week, but this had been stopped due to low numbers of patients wanting to access these sessions and difficulties staffing the sessions. All patients affected had been consulted with about the withdrawal of the twilight appointment slots and had been offered alternative appointment slots.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support. We saw a wide range of information posters displayed and leaflets made available to patients in the clinic waiting area and reception. These included information on topics such as fistula care, slips, trips and falls, dialysis away from home, mindfulness and diet and fluid management. There was information available about applying for grants, going on holiday whilst on dialysis and pregnancy. This meant that patients were supported to manage their own health, care and wellbeing and were encouraged to maximise their independence. However, leaflets were only provided in the English language, although staff told us that some information was able to be requested in other languages. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

All patients were provided with a patient handbook when they first started treatment at the clinic. This provided

Dialysis services

information on the dialysis treatment procedure and advice on living with dialysis and remaining healthy. In addition, there was contact information for kidney patient support groups and helplines.

There was a named holiday coordinator at the clinic who supported patients who wished to travel and helped them to plan dialysis sessions away from their usual base. Patients were encouraged to travel where possible, in keeping with the clinic's ethos of promoting an active lifestyle.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. All clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards during their induction and updated this three-yearly. Data provided showed that 100% of staff were up to date with this training. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to describe instances when they had needed to adapt their approach to care when there were concerns about a patient's ability to consent to treatment. There was an informed consent for treatment policy which provided guidance for staff to follow. Staff explained how they had involved relatives in patient's care by encouraging them to attend the clinic with the patient in order to support them.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The informed consent policy set out the process for obtaining written consent to dialysis at the start of treatment at the clinic. Staff made sure patients consented to treatment based on all the information available. The policy set out that patients should be provided with information prior to their first treatment, which included explanation of the risks and benefits of treatment and of any available

alternative treatment, in order that they could make an informed decision about receiving dialysis treatment. Patients were also requested to provide consent for blood sampling and data sharing. All consent forms were updated annually. Day to day consent for treatment was on an implied consent basis.

Staff clearly recorded consent in the patients' records. We reviewed three sets of patient records and saw that these all included a record of the patient's written consent to treatment.

Are dialysis services caring?

Good 

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **good**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. All dialysis stations contained fully adjustable chairs which patients could adjust to ensure their comfort during treatment sessions. There were separate sex toilet facilities available. Patients mostly received treatment in open shared bays although side rooms were available. The side rooms were generally used for patients requiring treatment in isolation but patients could request treatment in a side room if one was available. Staff recognised when patients may require additional privacy and dignity, for example, one patient told us they received their treatment in a side room because they had bowel problems and that by nurses offering them the side room meant this meant that their privacy and dignity during treatment was respected. There was sufficient space between treatment stations to ensure patient's privacy was maintained. Treatment screens were available to provide further privacy in the event of the need for any emergency treatment. Each treatment station had a television screen available for individual use. Patients also had access to free Wi-Fi during their dialysis sessions.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and

Dialysis services

those close to them in a respectful and considerate way. We observed that staff were friendly and engaging with patients and spoke to them throughout their treatment to put them at ease and help them to relax.

There was a staff photograph board in the reception area which gave each staff member's full name and role. In the dialysis treatment area there was a staff information board indicating which staff were on duty that day with a named nurse in charge. Each patient had a named nurse who took them on and off of the dialysis machine and monitored them during the treatment session.

Patients said staff treated them well and with kindness. All patients we spoke with told us they were happy with the care provided by staff. One patient described staff as being 'lovely and respectful' and another told us 'staff treat me as I want to be treated'.

Staff followed policy to keep patient care and treatment confidential. We saw that staff kept care records confidential and had personal conversations so that details could not be overheard by other patients attending the clinic.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were aware of religious festivals and made sure to recognise them by putting up displays or decorations to mark the event. Patients told us how staff celebrated their birthday by providing a card and cake and singing 'Happy Birthday' if they had to attend for dialysis on their birthday.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Where staff identified a patient requiring additional emotional support they could refer patients to the renal psychologist based at the local trust. Staff would identify patients in need of psychological support by talking to them and noticing changes such as a drop in mood. If any changes were noted, the consultant would be contacted, and a referral would be sent to the renal psychologist by email.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff recognised that the dialysis experience was an unwelcome experience for some patients and offered to play games and activities in order to help patients pass the time and make them feel more at ease during their treatment sessions. Staff recognised when patients with complex conditions needed additional support and encouraged relatives to attend with any patients experiencing anxiety or distress during treatment. There were special arrangements in place to facilitate private discussions and consultations with patients to ensure that privacy, dignity and confidentiality was respected at all times. There were consulting rooms and side rooms where that could be accessed as required. There was information about patient support groups provided in the patient handbook and in leaflets available in the reception area. Staff told us they would contact the patient's GP or social care if they felt they needed additional support in the community.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients were actively involved in making decisions about their ongoing care. Shared care was promoted at the clinic following appropriate patient education. Patients were encouraged to take their own blood pressure and temperature and wash their access arm prior to each dialysis session. They also were asked to weigh themselves pre and post dialysis. Some patients were taught how to prepare and prime the dialysis machine before treatment sessions, following training and a competency sign off. Priming the machine meant to remove air from the blood lines and the dialyser as well as any remaining sterilising agents before the patient was connected to the machine. There was a self-care haemodialysis policy which set out guidance for the process. There were 14 key elements to shared care and Diavium policy was for patients to be encouraged to participate in at least five of these in order to empower them and provide ownership of their care. The clinic

Dialysis services

manager had completed a training course on supporting patient self-care in haemodialysis in September 2019. At the time of our inspection there were no patients who self-cannulated their vascular access point, but the clinic manager told us that they could support patients to complete this element of their treatment themselves if they wanted to.

Staff supported patients to make informed decisions about their care. All patients were reviewed at least six-monthly by the renal consultant and at this appointment had opportunity to discuss their treatment regime and make decisions about their future care. For example, patient's blood results and medications were reviewed with them and they were involved in any decisions about changes to treatment that may be suggested by the consultant. At each dialysis treatment session, they had a named nurse with whom they were able to discuss any concerns about their treatment.

Staff supported patients to make advanced decisions about their care. Patients that wanted to make advanced decisions about their care were referred to the consultant who would work with the patient to take appropriate actions in order for the patient to make the best informed decision. Staff could also refer the patient directly to the palliative care team who would become involved in providing the most appropriate palliative care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient satisfaction surveys were carried out twice a year in order to identify any areas for improvement. Action plans were developed and were made available to all staff and patients in line with the patient engagement and experience policy. We asked for results of the latest satisfaction survey and saw that the clinic had an overall score of 91.3% in June 2019, which was the second highest score throughout all the UK Diaverum clinics. There was a 71.7% response rate for the feedback questionnaire. The main negative issues raised by patients related to waiting times as a result of the transport delay which had a negative impact on the patients' dialysis experience. Staff monitored transport times and raised any concerns at operations and transport meetings. We saw that there was an action plan to record all occasions when transport was late and to take the log to the next meeting with the transport provider for discussion.

We saw a 'comments tree' in reception where patients could attach messages of thanks for staff. We saw comments stating that 'the nurses are all awesome' and 'nurses do it with skill and love'.

Are dialysis services responsive to people's needs?

(for example, to feedback?)

Good 

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, transport services did not always meet patient's needs in line with national quality standards.

Managers planned and organised services, so they met the changing needs of the local population. The clinic had a contract with the local NHS trust renal unit and worked closely with the trust to understand the needs of renal service users and plan services accordingly. The NHS trust worked with local commissioners to define the scope and specification of the service which were detailed in the service contract which the clinic delivered services against. The clinic had regular contract meetings with the local NHS trust to monitor performance and quality outcomes. Patients were able to access dialysis treatment at different sites in the area and depending on availability of sessions, were able to express their preference for which site they attended. The clinic worked with the local acute trust and other Diaverum clinics in the area to ensure patients could access dialysis treatment at their preferred clinic whenever possible.

The Lings Bar clinic facilities and premises were appropriate for the services being delivered. The clinic was situated on the ground floor in the grounds of an NHS hospital and had level access for wheelchair users. There were single sex disabled toilet facilities at the clinic.

Dialysis services

Parking was available at the Lings Bar clinic in designated spaces, including disabled parking bays adjacent to the clinic entrance. Patients told us that there were some days when parking was difficult, and the clinic manager explained that visitors to the main hospital sometimes used the designated parking spaces for the clinic. Staff at the clinic were seen to challenge people who parked in the spaces when they were not attending the clinic, in order to maximise the available spaces for visitors to the dialysis clinic. Transport was available for patients who required it using ambulance or car transport. There had been some concerns with one of the transport providers which had resulted in a planned change to a new provider from December 2019. Since the transport collected several patients at a time, this meant that some patients had a long journey time. Some patients on transport were brought in over an hour before their treatment time and some were not collected until some time after their treatment finished. This meant that patients often had long waits before and after their treatment slot. The clinic manager told us that transport was one of patients' main reasons for raising concerns. The National Institute for Health and Care Excellence (NICE) quality standard (QS72) states that adults using transport services to attend for dialysis are collected from home within 30 minutes of their allotted time and collected to return home within 30 minutes of finishing dialysis. The service did not routinely collect data to monitor patient wait times due to transport services, although observations during inspection and comments from patients we spoke with, suggested that transport services were not meeting this standard. The service had started keeping a log of occasions when patients had excess wait times before or after treatment sessions and these were reported as incidents and discussed at transport contract meetings. There was no transport service user group at the clinic. The clinic manager told us that this was since there was a lack of interest from patients in forming such a group.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was a training programme for all staff which included a module on the frail person and a module on dementia. Staff we spoke with recognised the more complex needs of patients with dementia and learning disability and described to us how they provided additional support to meet their individual needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For example, for patients with hearing loss patients staff described how they would write down any messages that they needed to convey if patients were unable to understand them through lip reading. Also, sight loss patients would be escorted to and from their dialysis station, and everything would be placed on the bedside table in front of them in a specific order, so patients could more easily access items they may need during the dialysis session.

The service had information leaflets available in English, but they were not available in other languages spoken by patients in the local community. However, managers made sure staff, patients, and carers could get help from interpreters through language line when needed.

Patients were offered flexibility in the scheduling of treatment sessions in order to facilitate work, religious practises and social needs. Patients were encouraged to work with nursing staff to identify individual care needs relating to their co-morbidities, cultural and emotional needs in order to plan holistic care.

There was a holiday coordinator at the clinic who supported patients with dialysis arrangements so they could go on holiday or receive dialysis away from their usual base.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. However, patients often had long waits before and after treatment due to transport issues.

Dialysis services

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The clinic manager told us that there was currently no waiting list to access dialysis treatment at the clinic as they were not at the full capacity of 48 patients on the caseload. Utilisation of capacity averaged 77% from April to June 2019. Capacity discussions took place during contract meetings with the NHS trust and options for increasing clinic capacity had been explored, including the addition of new stations to the existing premises, the development of new facilities and the addition of new treatment slots. At the time of inspection there were no plans to increase capacity as it was meeting the demands of the local population.

Managers and staff worked to make sure patients did not stay longer than they needed to. All patients attending the clinic had appointment times for their treatment slot and the clinic monitored the % of patients who started their treatment within 30 minutes of their appointment time. We saw that for those patients who arrived on time for their appointment, between 98% and 99% of patients from January to September 2019 started their dialysis treatment within 30 minutes of their scheduled appointment time. However, we heard from patients and staff that there could be lengthy waits in the clinic due to transport bringing them in early or collecting them late.

Managers worked to keep the number of cancelled appointments to a minimum. During the previous year, the clinic had not cancelled any planned dialysis sessions for non-clinical reasons. If patients had their appointments cancelled, managers told us this would be due to an emergency or unexpected event such as machine breakdown or power failure. The clinic had sufficient spare dialysis machines to accommodate machine breakdowns and managers were able to make alternative arrangements for dialysis at another clinic in the event of an emergency.

Managers monitored and took action to minimise missed appointments. Any patients who did not attend for appointments were contacted by the clinic manager to identify the reason for non-attendance. Nurses spoke with these patients to ensure they understood the risks of not attending for treatment and contacted their

consultant to make them aware in case the patient became unwell and presented at hospital. Incident reports were completed for each occasion when a patient did not attend for treatment.

The number of patients leaving the clinic before they had fully completed their dialysis session was low. This data was reported to the local NHS trust as one of the clinic's key performance indicators. We saw that from January to September 2019, 18 patients had chosen to cut their treatment sessions short and no patients had their treatment sessions cut short due to staffing reasons. If any patients requested to cut their treatment short by more than 15 minutes they would be asked to sign a disclaimer to ensure they understood the risk of not completing a full dialysis session.

Staff supported patients when they were referred or transferred between services. It was the responsibility of the referring consultant to identify patients suitable for dialysis and to arrange for them to have appropriate venous access in place before starting dialysis treatment at the clinic. New patients came to visit the clinic prior to starting their first treatment in order to familiarise themselves with the clinic environment and meet the staff. Patients were provided with an information handbook about the clinic and the dialysis process. Information about their dialysis treatment was communicated between the clinic and the renal consultant through the use of a shared electronic records system. Consultant review clinic letters were copied to the patient's GP.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received as there were no complaints leaflets or posters available in the clinic. However, the service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers did not always know how to complain or raise concerns. Although there was information provided about the complaints process in the information handbook given to patients on their first appointment at the clinic, the service did not clearly display information about how to raise a concern in patient areas. There was a copy of the Diaverum complaints policy in the patient waiting area, but no

Dialysis services

detail displayed about how to raise a complaint or a concern. Managers told us that complaint information was provided in the patient handbook, but we were not assured that all patients had easy access to this information as they may have lost the handbook after being given it several months ago.

There was a complaints policy and procedure. Staff understood the policy on complaints and knew how to handle them. Staff were encouraged to have open and transparent conversations with any patient who raised a concern in order to try and resolve them as quickly as possible. There was a formal process for managing written complaints which was detailed in the complaints policy, which included an escalation system to senior managers if appropriate. We saw that for all complaints raised, an investigation report was completed which logged the date and method of receipt of the complaint and the complainant's details. The complaint was reviewed by the clinic manager who categorised it as minor, moderate, serious or very serious. The clinic manager investigated the complaint and identified any themes, learning or actions required. They wrote a response letter to the patient which provided a summary of the investigation and an apology if appropriate.

Although there were verbal concerns raised to staff regarding car parking or transport, for example, there were very few written complaints received by the service, with only one being reported in the 12 months prior to inspection. We saw that there was a log kept by the clinic manager of any complaints which detailed any actions required and their due date and when they had been completed.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw that complaints were a standing agenda item at staff meetings and area manager meetings to ensure that any learning identified was shared widely with staff.

There were 45 compliments received by the service in the 12 months prior to inspection. There was a comments tree in the reception area of the clinic where patients could leave feedback.

Are dialysis services well-led?

Requires improvement 

We have not previously rated this service and cannot therefore compare ratings with the last inspection. We rated it as **requires improvement**.

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The clinic manager had the skills knowledge and experience required for the role. They were an experienced renal nurse who had been in post since July 2019 and had previously worked in senior roles in the NHS. They had been a matron and a clinical nurse specialist. The clinic manager reported to the area manager and was further supported by a practice development nurse for the area. There was a senior management team which supported the area teams and included a nurse director, operational director, medical director, and quality and compliance manager. Managers worked together well across the Diaverum UK group. The clinic manager had monthly meetings with the area manager and there were bimonthly area meetings between the clinic managers in the region, area manager and area practice development nurse. In addition, the clinic managers from all regions and the senior management team met twice a year for two-day shared learning forums.

The clinic manager often worked clinically on the unit and staff reported they were readily available and approachable for advice and support. Staff described that the clinic manager had 'an open-door policy'. The area manager and practice development nurse told us that they visited the clinic regularly and staff confirmed this. The senior management team (quality compliance manager and nurse director) aimed to visit all clinic sites once a quarter.

We saw that all staff, including the clinic manager, had annual appraisals to set objectives and development plans for the year ahead. All staff who had been in post

Dialysis services

during the previous appraisal window (November 2018 to February 2019) had completed an appraisal with their line manager. There were four new starter staff who had not been in post during the previous appraisal window who would receive their first appraisal during the next appraisal window which would run from November 2019 to February 2020.

Managers told us that Diaverum UK were very responsive to the improvements required following the last Care Quality Commission inspection. We saw that actions identified during the last inspection in 2017, that the provider must take had all been addressed following the implementation of action plans to achieve the requirements. For example, all staff now regularly completed children's safeguarding training and all staff routinely received training on new medical devices. In addition, some recommendations of actions that should be taken, such as the use of a personal emergency evacuation plan had been implemented.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a vision and strategy for the whole of the Diaverum group which put quality and service at the heart of care. The organisation's mission statement was 'to improve quality of life for renal patients.' We saw that the mission, vision and values were displayed in the clinic reception area. Staff we spoke with were able to tell us that the Diaverum values were 'competent', 'passionate' and 'inspiring'. Managers told us that the appraisal system was a values-based process.

Managers told us that strategic priorities had been defined for the five-year period ahead and were communicated to all managers and leaders. There were five strategic priorities across the Diaverum UK group which were:

- Drive continuous improvement to patient outcomes
- Be recognised as a great place to work; attract, engage and retain the best renal workforce in the UK

- Grow our business through selective participation in tenders
- Offer more services to our patients to improve quality of life
- Relentless focus on operational efficiency to minimise waste

Managers told us that progress and clinic activities were monitored against the strategic priorities through the use of patient feedback, human resources data, and clinical performance measures. All this information was available to all managers in an electronic organisational dashboard.

The strategic priorities had been used to inform a new mission statement which was developed in consultation with staff globally. The mission was to deliver 'Life enhancing renal care for body, mind and soul, with passion and inspiration. Empowering patients, their friends and family, because everyone deserves a fulfilling life.'

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We observed respectful and supportive working relationships at the clinic during our inspection. Staff described it as a 'lovely place to work'. Managers told us that any behaviour which was not consistent with the organisations values was not tolerated and that staff would be met with on a one to one basis to discuss any concerns and put agreed improvement action plans in place.

There was a rewards system for staff known as the 'Extra Mile awards'. Patients or staff could nominate any staff member to recognise their contributions to service excellence. Nominations were discussed by the senior management team and were awarded once a quarter.

Dialysis services

Staff receiving the award would be personally presented, by a member of the senior management team, with a certificate, flowers and a gift voucher to acknowledge their contribution.

There was a culture of openness and honesty and a focus on safe patient care. Staff said that they felt able to report incidents and concerns without fear of retribution. We saw that incidents were discussed at team meetings and learning was shared and actions for improvement were taken as a result of any concerns raised.

Governance

Leaders did not always operate effective governance processes throughout the service in order to identify and manage patient risk. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were structures, processes and systems in place to deliver good quality sustainable services. The organisation had a clinical governance policy which had the purpose of monitoring and evaluating the quality of care, identifying improvement areas and developing action plans for quality improvements. The policy aimed to establish a standardised process to clinical governance across all Diaverum clinics in the UK. The policy set out key governance actions required with responsible people, timeframes and the reporting structure identified. For example, clinic managers had oversight of water treatment monitoring and several regular audits and they were required to report these to the clinical operations manager monthly or three-monthly. However, we found that although there were systems and processes set out, they were not always effective. There was a lack of oversight of risk to patients in several areas. This included a failure to identify an infection prevention control risk through patients sharing a blood pressure machine and thermometer in the waiting area, and the equipment not being cleaned in between each patient use. There was also a failure to assess patient's wellbeing and fitness for treatment at the start of each dialysis session. In addition, there was a lack of oversight of the safety of all available equipment being fit for use. There was no process to ensure equipment belonging to the local acute trust was

regularly safety tested or that condemned equipment was labelled as 'do not use'. We were not assured that all Diaverum UK governance processes in place were effectively followed by clinic staff.

Staff were clear about their roles and there were clear lines of accountability throughout the clinic and the organisation as a whole.

There was a system to share information between the clinics and senior management team through regular meetings held at all levels. All meetings followed a set agenda and were minuted and the minutes were circulated to all appropriate staff by email.

The organisation held regional monthly clinical governance meetings to review performance and any risks at any of the clinics in the area. There was a performance dashboard accessible by all managers which enabled monitoring of quality. The dashboard was used as a means for improvement when any performance concerns were identified. Regular contract meetings were held between the clinic and the NHS Trust to ensure that key performance indicators were being met.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, not all risks were identified and escalated in order to identify actions to reduce their impact.

There were clear systems and processes for escalation of any performance issues. Performance data was routinely collected and reported to both Diaverum UK Limited and the NHS trust. There were a range of clinical performance measures collected and reported, including numbers of patients dialysing through fistula access, haemoglobin levels and blood flow rates. Diaverum UK Limited set an overall target performance score to be achieved which was a combined score for all measures. Scores were reported and monitored through the electronic dashboard. In addition, there was a systematic programme of clinical and internal audit to monitor quality and operational processes. Operational audit results and key performance indicator data was reported to the trust on a monthly basis to evidence performance

Dialysis services

against the contract. There were good working relationships between the clinic and the NHS trust. The key performance indicators were discussed at quarterly contract meetings held between clinic staff and the trust. These were attended by the renal consultant and matron and lead specialist renal nurse from the trust and the clinic manager, area manager and practice development nurse from Diaverum UK Limited. Performance was described as generally good. Data for September 2019 showed that there was 100% compliance with contractual key performance indicator targets. Performance indicators included a range of outcomes such as availability of equipment, number of treatments delivered, number of missed sessions, patient satisfaction, staffing ratios, staff training and appraisal rates, numbers of incidents and complaints and records and medicines audit results.

The clinic had a system for identifying, recording and managing risk. Any concerns that were identified as potential risks were reviewed and scored by the clinic manager using a risk assessment template and added to the clinic's risk register. The risk register was reviewed monthly by the area manager and the clinic manager as part of the clinic's governance processes and the clinic manager's one to one process. Any risks that scored higher than 15 were escalated and added to the corporate risk register. We saw that the clinic had four active risks on their risk register which were all rated as six or less on a five by five risk matrix where the maximum score was 25. The risks related to staffing, facilities and equipment and all had action plans in place that were in progress. However, we did not see the risks that we had identified relating to infection prevention control, equipment and patient risk assessment listed on the clinic's risk register.

There were business continuity plans and incident response procedures for staff to follow in the event of unexpected circumstances such as the loss of facilities, power, staffing, or water or in the event of a major incident.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance,

make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There was a performance dashboard which all managers had access to and the information was routinely discussed in team meetings. Information in the dashboard was used to monitor performance and identify any areas for improvement.

Information technology systems were used to capture data. For example, the dialysis machines had a treatment guidance system device attached to them which enabled patient monitoring data, gathered during dialysis sessions, to be entered directly into the patients electronic record system. Staff entered data gathered from the dialysis machine during treatment sessions into the treatment guidance system and then this system automatically uploaded the information into the patients electronic care record. This system meant that patient outcome data was able to be viewed in patient records in real time and could be used for reviewing patients care and reporting of patient outcomes.

There were shared electronic care records between the clinic and the NHS trust. The clinic staff had access to the trust electronic record system and entered patient data into the record after each treatment session. Staff had to duplicate information from their own electronic records system as the two systems could not communicate with each other.

There were effective arrangements for the clinic to submit data for entry on to the national Renal Registry. The registry enabled benchmarking of similar services against each other. Monthly blood results for each patient, which indicated how effectively they were dialysing, were reported onto the trust electronic records system for review by the consultant. The consultant then sent this data on for reporting to the Renal Registry. The clinic's register entries were combined with the NHS Trust entries on the Renal Registry. This meant that the clinic could not benchmark its own specific performance.

Engagement

Dialysis services

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers told us that they actively encouraged stakeholders, such as dialysis patients, to feedback on their experience. Feedback methods included bi-annual patient surveys, direct access for patients to senior managers, suggestion boxes and feedback cards and engagement with national British Kidney Patient Association advocates. One example of an improvement made following patient feedback was the introduction of a quarterly newsletter for patients and staff.

Staff surveys were carried out on a yearly basis and action plans were developed based on the results. For example, we saw that there had been two completed actions based on the previous year's staff survey, to reduce the overtime burden on permanent staff through recruitment and the use of bank staff, and to provide all staff with a salary increase. The latest staff survey results from December 2018 showed an average staff satisfaction score at the Lings Bar clinic of 3.8 out of five.

There was regular communication of information from managers to all staff at the clinic. The area manager and practice development nurse sent out corporate

communications by email. The senior management team provided updates through the organisation's newsletter which also included information about the global activity of the organisation.

Although the service did not directly engage with commissioners, they did regularly engage with the NHS Trust who they had a service contract with. This meant that there was regular review that the service was meeting required targets and meeting local patient's needs.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

There were twice yearly meetings with all clinic managers to share knowledge, review best practice and develop specific skills. This demonstrated a commitment for continuous learning and improvement.

All clinics had an annual unannounced audit led by the nurse director and practice development nurse and any areas of low compliance were reviewed by the clinic manager and area manager and improvement action plans were agreed. Audit data showed that the Lings Bar clinic was consistently one of the highest performing clinics in the Diaverum UK group and that for the last quarter (quarter three in 2019), it was the highest performing of the Diaverum UK clinics.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The service must ensure they follow governance processes in order to effectively identify and manage patient risks in relation to infection prevention control, risk assessment and suitability of equipment for use. (Regulation 17 (1) (2) a,b)

Action the provider **SHOULD** take to improve

- The service should ensure that there is a consistent method of assessing and documenting patient's pain.

- The service should ensure that complaints information is clearly displayed and widely available to patients throughout the clinic.
- The service should continue to work with local transport providers to minimise the wait times for patients between arriving on transport at the clinic and starting their dialysis session and when waiting to return home after treatment sessions.

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> <ol style="list-style-type: none">1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to:<ol style="list-style-type: none">a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;