Forest Dialysis Unit

Quality Report

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

B. Braun Avitum UK Limited operates Forest Dialysis Unit. The service has 12 dialysis stations for patients and operates two sessions daily. The service is open six days a week and operates 144 sessions in total for a maximum caseload of 48 patients. The service is a nurse led unit, which provides outpatient satellite dialysis to NHS funded patients.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 9 May 2017 and followed this up with an unannounced visit on 17 May 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's 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 of how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this unit was dialysis. Where our findings on dialysis – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the dialysis core service.

Services we do not rate

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

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

- Reported incidents were investigated but the process did not always ensure learning and action points were identified.
- The service did not have a sepsis policy/standard operating procedure to follow if patients displayed signs of sepsis.
- Medicines management did not always meet national recommendations. Intravenous fluid boluses were administered without prescription or other guidance.
- Staff did not check patients' identity prior to administering medicines or commencing haemodialysis treatment.
- There was a damaged headrest and damaged footrests on the dialysis chairs, which compromised effective cleaning and posed an infection control risk.
- Not all patients felt involved in their care and treatment.
- Governance processes were not effective to ensure a robust approach to managing quality and performance. There were no action plans from review meetings and these were not minuted.
- There was not an effective process to monitor risks and understanding of efficient risk management processes was not clear.
- Staff did not receive feedback from corporate operational management meeting or from meetings with the local NHS trust.

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

- The service had a good incident reporting culture.
- The service demonstrated good practices for effective infection control and prevention.
- The environment complied with national guidance for satellite dialysis units. The unit appeared visibly clean and tidy.
- All equipment was regularly serviced and maintained. Consumables were all in date and well managed.
- Nursing staff levels ensured safe and efficient patient treatment.

Summary of findings

- There was a good working relationship between the unit and the consultant nephrologist, who was responsible for patients' treatment. There was effective multidisciplinary working and a close working relationship with the local NHS trust.
- Staff completed contemporaneous documentation about care and treatment given to patients.
- Policies and procedures reflected current evidence-based guidance.
- The service monitored key performance indicators. These demonstrated the service performed similar to other dialysis centres.
- Staff treated patients with respect and compassion.
- Patients were complimentary about the care and treatment they received at the unit.
- The service met the needs of the local population and the needs of individuals attending for dialysis.
- There were no waiting lists for patients who wished to receive dialysis at the unit.
- There were processes to support patients who missed their dialysis.
- Staff felt valued and there was a positive culture. We observed team working and respect for others.

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 five requirement notices that affected Forest Dialysis Unit. Details are at the end of the report.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis Services		We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Background to Forest Dialysis Unit

B. Braun Avitum UK Limited operates Forest Dialysis Unit. The Forest Dialysis Unit is situated on the outskirts of Cinderford in a business park. The unit opened in September 2012 and provides haemodialysis to people who live in the Forest of Dean and local area on behalf of Gloucestershire Hospitals NHS Foundation Trust.

The unit did not support patients completing their dialysis at home or patients receiving peritoneal dialysis. A dialysis centre in a local NHS hospital supported these patients.

The service has had a registered manager in post since 2012. The service is registered to deliver the following registered activities: 'Diagnostics and screening procedures' and 'Treatment of disease, disorder or injury'.

We inspected Forest Dialysis unit on 9 May 2017 and 17 May 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Lisa Layton and one other CQC inspector. The inspection team was overseen by Catherine Campbell, inspection manager and Mary Cridge, Head of Hospital Inspection.

Information about Forest Dialysis Unit

Forest Dialysis Unit operates on an outpatient basis and can accommodate up to 12 patients at each session. The unit provides morning and afternoon sessions every day from Monday to Saturday. The service treated adults only with the majority of patients (65%) being over the age of 65 years.

During the inspection, we spoke with eight staff including the registered manager, registered nurses and senior managers. We spoke with six patients and two relatives. We also received 15 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed eight sets of patient records.

There had been no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service was inspected once before in July 2013, which found that the service met all standards of quality and safety it was inspected against.

In the reporting period from January 2016 to January 2017, the unit provided 3100 haemodialysis sessions. All session were provided for NHS-funded patients. The unit did not support patients who completed their dialysis at home or received peritoneal dialysis (dialysis where the peritoneum in a patient's abdomen is used as membrane). These patients were supported from dialysis centre in a nearby NHS hospital.

The unit employed a manager, six registered nurses, three care assistants and one receptionist.

Track record on safety:

- The unit reported no never events in the reporting period from January 2016 to January 2017.
- The unit reported 172 clinical incidents in the reporting period from January 2016 to January 2017.
- The unit reported no serious injuries in the reporting period from January 2016 to January 2017.

Summary of this inspection

- The unit reported no incidents of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA) or hospital acquired methicillin-sensitive Staphylococcus aureus (MSSA).
- The unit reported no incidents of hospital acquired Clostridium difficile or incidences of hospital acquired E-Coli.
- The unit had received one complaint in the reporting period from January 2016 to January 2017.

Services accredited by the following national bodies:

- Investors in People accreditation (2016).
- ISO 9001:2008 (accreditation given to organisations, which fulfil a set of quality management standards).

Services provided at the unit under service level agreement:

- The building is owned by a local NHS trust and leased to Avitum. The trust maintains the building and is responsible for: clinical and or non-clinical waste removal, maintenance of the building and grounds, maintenance of medical equipment, delivery of pathology and histology services;
- A third party company via a service level agreement carries out the maintenance and service of dialysis chairs.
- A third party company via a service level agreement carries out water treatment system maintenance.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We found the following issues that the service need to improve:

- Reported incidents were investigated but the process did not always ensure learning and action points were identified.
- The service did not have a sepsis policy/standard operating procedure to follow if patients displayed signs of sepsis. The service did not use a recognised early warning tool to alert staff to deterioration in their condition during dialysis.
- Staff did not check patients' identity before administering medicines or commencing haemodialysis.
- Medicines management did not always meet national recommendations when administering intravenous fluid boluses, which is categorised as a prescription only medication.
- Medicines (intravenous fluid and oxygen cylinders) were not stored safely and in accordance with national guidance.
- System did not provide assurance that actions had been completed to ensure the safe care and treatment of patients following quality assurance reviews.
- There was a damaged headrest and damaged footrests on the dialysis chairs, which compromised effective cleaning of the chairs and infection control.
- Patient records were not always stored safely and arrangements for disposal of confidential waste did not ensure patient confidentiality at all times.
- Staff did not receive dementia training.
- Staff did not have access to patients' medical notes held by the commissioning NHS trust and not all staff had access to the electronic database, where important information about patient prescriptions was stored.

We also found the following areas of good practice:

- The service had a good incident reporting culture.
- The service demonstrated good practices for effective infection control and prevention.
- The environment complied with national guidance for satellite dialysis units. The unit was clean and tidy.
- Staff adhered to recommended practices for infection control such as the use of personal protective equipment and the use of anti-septic non-touch techniques, when connecting patients to dialysis machines.

Summary of this inspection

- All equipment was regularly serviced and maintained. Consumables were all in date and well managed.
- Nursing staffing was of a level to ensure safe and efficient patient treatment.
- There was a good working relationship between the unit and the consultant nephrologist, who was responsible for patients' treatment.
- Staff completed contemporaneous documentation about care and treatment given to patients.
- The service had efficient contingency plans in the event of adverse conditions.

Are services effective?

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

We found the following areas of good practice:

- Policies and procedures reflected current evidence-based guidance.
- The service monitored key performance indicators. These demonstrated the service performed similarly to other dialysis centres.
- Patients had access to dietetic services and dietitians made visits regularly.
- There was effective multidisciplinary working and a close working relationship with the local NHS trust.
- There were effective processes to ensure consent was obtained.

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

- Staff were not aware of national guidance for patiens with chronic kidney disease when patients were nearing the end of their life.
- There was varied knowledge amongst nursing staff about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Are services caring?

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

We found the following areas of good practice:

- Staff treated patients with respect and compassion.
- Patients were complimentary about the care and treatment they received at the unit.
- There were processes to assess patients' emotional needs.
- Staff took care to maintain patient dignity and confidentiality as required.

Summary of this inspection

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

- Not all patients felt involved in their care and treatment.
- There was not a specific end of life care pathway in line with national guidance for patients towards the end of their life.

Are services responsive?

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

We found the following areas of good practice:

- The service met the needs of the local population and the needs of individuals attending for dialysis.
- The building met national guidance for satellite dialysis units.
- There was good provision for support to patients going on holiday and the unit welcomed patients from other parts of the country to receive dialysis while on holiday.
- There were no waiting lists for patients who wished to receive dialysis at the unit.
- There were processes to support patients who missed their dialysis.

Are services well-led?

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

We found the following areas where the service needs to make improvements:

- Governance processes were not effective to ensure a robust approach to managing quality and performance. There were no action plans from contract review meetings.
- There was not an effective process to monitor risks and managers' understanding of efficient risk management processes was not clear.
- Staff did not consistently receive feedback about learning from clinical incidents, from corporate operational management meetings or from meetings with the local NHS trust.
- Action plans to improve services were not always followed through.

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

- Leaders had the knowledge, skills and experience to manage the service.
- Staff felt valued and there was a positive culture. We observed team working and respect for others.
- All patients and staff were positive about the service

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

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

Incidents

- The unit had a good safety record. There was a clinical incident policy and system in place for reporting incidents. Staff knew and understood their responsibilities to report incidents and knew how to do so.
- There had been no never events at the unit between January 2016 and January 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The unit reported no serious incidents between January 2016 and January 2017. Serious incidents include acts or omissions in care that result in unexpected or avoidable death or unexpected or avoidable injury resulting in serious harm.
- Staff reported incidents on two different systems. Staff reported clinical incidents or adverse patient occurrences on a B. Braun electronic system. Incidents about the premises were reported on the NHS electronic incident reporting system. B. Braun held an oversight of all reported incidents. All adverse patient occurrences and other incidents were discussed in the bi-monthly contract reviews, which meant that the NHS trust were aware of all reported incidents.
- Incidents were investigated in accordance with the corporate standing operating procedure. The service reported 172 adverse patient occurrences on the B. Braun electronic incident reporting system between January 2016 and January 2017. Most of these were categorised as 'other cause', which included for example patients who wanted to shorten their time on dialysis. We looked at four incidents reported between January 2016 and March 2017. The incidents were investigated but the process did not ensure identified learning was shared with staff to prevent similar incidents in the future. For example, minutes of staff meetings did not include a discussion of incidents and any learning from these. However, there was some evidence that learning was shared when incidents happened in other dialysis units. For example, a change in practice had occurred when assessing dialysis access, also included asking patients about bleeding from the fistulas (a vascular access created in a vein used to remove and return blood during haemodialysis) in between dialysis sessions.
- Senior staff were aware of and could describe their responsibilities under the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Mandatory training

- Staff were up-to-date with mandatory training and updates as required by Braun. Staff completed mandatory training in the safety systems, processes and practices annually. Mandatory training included governance, health and safety, infection control,

equality and diversity, basic life support, hand hygiene, fire training and consent. The service had a contemporaneous training record for mandatory training and regular updates. There was no specific training or annual update on sepsis although staff told us this was included in their annual infection control update.

- Staff were up-to-date with mandatory training and updates as required by the NHS trust. The training matrix highlighted some staff had not yet completed their annual update for this year. We discussed this with the registered manager who explained that the e-learning modules were only released in the month they were due. All face-to-face training was booked for all staff to ensure compliance. Staff were given the equivalent to one working day every year to complete their mandatory updates, however, they told is this was not enough as most module took an hour to complete. Managers felt this was sufficient time to complete all required training.

Safeguarding

- The service had processes to ensure staff were trained to recognise vulnerable adults at risk of abuse and there was a 'Protection of vulnerable adults and safeguarding' policy to provide guidance. Staff were aware of signs of abuse and knew how to report concerns. They had completed mandatory e-learning updates in both child protection and adult safeguarding at level two, every three years. This training included information about female genital mutilation. Training records showed that all staff had completed the B. Braun mandatory yearly update in vulnerable adults and child protection. Staff were also required to complete the NHS trust's e-learning module. Seven members of staff out of 11 had completed their annual update. The remaining four members of staff were scheduled to complete the training in the month it was due.
- At the time of our inspection, staff at the unit had not needed to make a safeguarding referral. The unit did not treat children or meet children; however, staff had access to a policy for vulnerable children, which provided information about what to do if they had concerns about a child's welfare.
- B. Braun had a corporate safeguarding lead who could offer advice and support. Staff told us they would refer any concerns about patients to the NHS trust safeguarding lead.
- The service carried out disclosure and barring service (DBS) checks every three years, in line with their corporate standing operating procedures. DBS checks help employers to make safer recruitment decisions and prevent unsuitable people working with vulnerable people. We reviewed staff records and found that all staff had had a DBS check within the last three years.

Cleanliness, infection control and hygiene

- The unit appeared visibly clean and tidy. We checked for high and low level cleaning and dusting and found all areas to be visibly clean. There were hand-washing facilities for every two dialysis chairs in line with Health Building Note: 07-01. Environmental cleaning audits from January 2017 to April 2017 demonstrated 98%-99% compliance.
- Staff cleaned equipment thoroughly between patients. However, six chairs had damaged footrests and one chair had a damaged headrest. This meant efficient cleaning could not be assured and could therefore pose an infection control risk. This had been reported at corporate level and the unit was awaiting a decision about purchasing new replacement chairs. The chairs were still in use, as they did not have additional chairs.
- We noticed one piece of equipment (a hoist sling), which was cleaned after use but stored in the linen room on top of other new slings. The used sling was for single patient use but it was not stored in a separate bag. This did not comply with best practice for infection control
- The unit had four isolation rooms, which exceeded the national guidance. These rooms were used to maintain effective isolation processes or could be used if patients preferred to receive their treatment in a single room facility. Each room had en-suite toilet facilities with an emergency call bell and a hand basin for staff to wash their hands.
- Decontamination of medical devices, including dialysis machines was carried out efficiently. Staff cleaned the dialysis machines after each session in accordance with their corporate guidance. There was an internal decontamination schedule after each patient and once a week staff programmed the machines to carry out an extended internal cleaning and decontamination process. Each dialysis station was cleaned with an anti-bacterial solution after each dialysis session. Solutions were prepared and dated according to recommendations.

- The service reported six incidents of central venous exit site infection between June 2016 and January 2017. We asked staff about these and were told these all related to the same patient who demonstrated poor compliance with infection control measures. There had been no reported cases of methicillin-resistant Staphylococcus aureus (MRSA) or methicillin-sensitive Staphylococcus Aureus (MSSA) bacteraemia at the unit between January 2016 and January 2017.
- The service had effective processes for screening patients for blood borne viruses. All patients were screened every three months and patients who returned from holiday had to be screened when they got back. When patients returned from holiday or if they had been admitted to hospital, they received dialysis in a side room until screening showed they did not have any transmittable infections or viruses. There were standing operating procedures to guide staff in additional infection control measures if required.
- There were effective processes for infection control screening in accordance with the corporate standard operating procedure for infection control. There was an MRSA protocol with action cards to provide guidance for staff about screening. All patients were screened when commencing dialysis treatment at the unit and every three months thereafter. If patients had been on holiday or admitted to hospital, they received their dialysis treatment in one of the isolation rooms until screening processes showed they were clear of MRSA. All new patients were also screened for blood borne viruses and there was guidance for staff to follow if patients tested positive as carriers for these viruses. Patients had their own blood pressure cuff, which they wore for the duration of their dialysis treatment, and this was replaced every three months.
- Staff applied infection control measures efficiently when dealing with patients. The service had standard operating procedure for infection control to provide guidance. Staff had access to and wore appropriate personal protective equipment such as gloves, aprons and full-face shields. We observed staff wash their hands before and after patient contact. Staff asked relatives to leave the dialysis station, when patients were attached and disconnected from dialysis, to reduce the risk of accidental contact with bodily fluids (blood).
- We reviewed hand hygiene audits from January to March 2017and found staff were 93% - 100% compliant with hand washing procedures. We also reviewed audit results for compliance with anti-septic non-touch techniques for January to March 2017. Results showed 93% compliance. This was discussed in staff meetings and staff were reminded of good practice. The service did not display audit result for patients and visitors to see.
- All staff had completed the B. Braun hand hygiene e-learning modules for hand hygiene and aseptic non-touch technique. Training records showed that only three out of eleven staff had completed the annual mandatory e-learning update in infection control, as required by the NHS trust, at the time of our inspection. We discussed this with the registered manager who told us these modules were only released for staff to completed in the month they were due. All staff hand completed the B. Braun hand hygiene e-learning module.
- The service had effective water testing procedures in the water treatment plant area. Staff carried out checks in the morning and repeated before the afternoon sessions started. Records between January 2017 and May 2017 demonstrated 100% compliance. If the test results showed variances, staff called in engineers who attended within four hours. In the meantime, staff could change dialysis settings after discussion with the consultant. There was no evidence that water treatment systems caused delay or resulted in cancelled treatments for patients. Staff were trained to carry out bacterial water sampling procedure. The service had trained an additional three members of staff during April 2017 to ensure there was always a member of staff on duty who could carry out the checks in the water plant area.

Environment and equipment

- The unit was in a modern and spacious building on an industrial estate. The building was repurposed in 2012 and complied with national guidance (Health Building Note: 07-02, 2013) to deliver a satellite dialysis service.
- The building was spacious with ample parking facilities for patients attending for dialysis. Most patients used ambulance or taxi transport. Some patients were transported to and collected from the unit, by their spouse or other next of kin. There was secure entrance, which was monitored by CCTV. On arrival, patients and their relatives entered a spacious waiting area with chairs and a reception desk. Part of the waiting area was screened off for staff to weigh patients before

commencing dialysis treatment. There were two large unisex toilet facilities, which was suitable for patients with either left sided or right sided mobility difficulties. There were no changing facilities for patients as is recommended in the Department of Health: Health Building Note 07-01.

- The unit had emergency equipment in case of medical emergencies and in accordance with national guidance (Resuscitation Council, 2015). There was one resuscitation trolley, which was stored in the middle of the unit. There was a portable suction unit on the trolley and automated defibrillators that staff were trained to use. There was no piped oxygen in the building but there were oxygen cylinders for staff to use in emergencies. There was a tamper evident box with emergency medicines for anaphylaxis (a severe and potential life threatening allergic reaction). Records from January 2017 to May 2017 showed staff checked the equipment on the trolley daily.
- The service had effective processes to ensure all medical devices were regularly serviced and maintained. The unit held a log of all medical devices, which showed when regular service was required. Staff were aware of processes to report faulty equipment and we saw two pieces of equipment that were awaiting collection, as they were faulty. The equipment was taken out of use, clearly marked as faulty and stored away from the clinical area.
- There was an equipment replacement programme and processes to alert managers when equipment was due to be replaced. All dialysis machines were replaced every ten years in line with the Renal Association guidance. There were two spare dialysis machines in case any of the other machines developed a fault; these machines were ready for use if required.
- Storage facilities met national guidance as outline in the Department of Health: Health Building Note 07-01: Satellite dialysis unit. Storerooms were spacious, clean and tidy. There was separate access for the delivery of consumables and all doors to the outside were locked securely. Staff had access to the storerooms via a keypad lock.
- The service had effective process to deal with clinical waste. There were a sufficient number of waste bins, which staff emptied before they were overfilled. Staff used sharps boxes in line with policy and closed these between usages to avoid accidental needle stick injuries. There was a dirty utility area, which was clean and tidy. There was an outdoor access door so that staff could dispose of clinical waste safely. Staff separated clinical and non-clinical waste in line with national recommendations. The outside area where waste was stored was in a sealed off enclosure and the area was tidy.
- We checked expiry dates of consumables and found all were in date and there was efficient stock rotation processes. Staff monitored the temperature of the storerooms and records showed they were within the reference values given. Staff were aware of actions to take if the temperatures were outside of the reference range.
- Alarm guards on dialysis machines were set according to individual assessment of safe limits. Staff responded quickly when alarms sounded. Nurses reviewed pre-set alarms when patients commenced their dialysis treatment, to ensure the alarm limits were appropriate for the individual patient. When the machines alarmed, staff responded quickly and reviewed the causes for alarms sounding. For example, we observed one patient's machine alarming repeatedly for the same reason. Staff took actions to address common causes and when these did not work, they escalated it to the consultant nephrologist. They discussed the issues and agreed a plan of action. This was carried out promptly and the event was documented in the patient's care record.
- The dialysis area met Health Building Note: 07-01 guidance. There was sufficient space around dialysis chairs for two people and staff could access the chair from either side. The flooring was intact and easy to clean. Each station had a table for the patient to use and a nurse call system, which was within easy reach for all patients.
- The layout of the unit meant that not all stations were visible to nurses at all times as recommended in the Health Building Note: 07-01. The main unit was open plan with eight dialysis stations. Most of the stations were visible from the nurse's base but two of the dialysis chairs could not easily be seen. There were two mobile screens available to screen off a dialysis chair if required. However, they were not easily accessible and it was unclear if a chair could completely be screened off, to maintain patients' privacy in case of an emergency.

Medicine Management

- Medicines were not always administered under the direct instruction of a prescriber. It is a legal requirement for any medicines, including intravenous fluids, to be prescribed by an appropriate practitioner before being administered. Staff administered boluses of fluids intravenously if patients dropped their blood pressure during dialysis. These boluses were not prescribed or given as a patient group direction. The unit did not have standard operating procedures in place to guide staff what to do in the event of a patient a symptomatic drop in blood pressure during dialysis. The unit had an IV bolus policy, however this did not include the giving of intravenous fluids. This was not in line with national guidance (Standards for Medicines Management, Nursing and Midwifery Council, 2007, National Institute for Health and Care Excellence, CG 174, 2013).
- Staff did not formally check patients' identity before administering intravenous medicines. Staff told us this was because they knew the patients very well. If bank or agency staff worked on the unit, permanent staff would ensure the patients' identity was formally checked. The Nursing and Midwifery Council standard 2 (NMC, 2015) recommend staff check the 'five R's' (right patient, right time, right drug, right dose and right route) before administering intravenous medicines. However, NMC standard 8 (2015) state that the registered practitioner must be certain of the identity of the patient to whom the medicines is to be administered. There was a 'general medicines guidelines', which stated staff should ensure they were certain of patients' identity before administering medicines. It also included information about medicines management for staff, including temporary staff such as bank and agency.
- There were systems to ensure the consultant nephrologist reviewed patients' usual medicines monthly. Staff discussed each patient's treatment in a monthly meeting with the consultant nephrologist. The unit had a quality assurance (QA) folder where the named nurse added issues for discussion. If the named nurse was working on the day of the meeting, they would discuss their patient with the consultant nephrologist, or another nurse would do so on their behalf. Nurses signed the entry in the QA folder when staff had discussed the issues with the consultant nephrologist. However, we noticed staff had not signed 22 entries from January 2017 to 17 May 2017 including 14 entries made following the QA meeting on 12 May 2017. We asked staff about the missing signatures and they stated that actions had been carried out although staff had not always signed the record. We followed through two unsigned actions, which despite being left blank had been completed. However, the system did not provide assurance actions had been completed to ensure the safe care and treatment of patients.
- There were processes to ensure prescription of dialysis treatment. Prescriptions contained information about the haemodialysis filter to be used, length of treatment time and dry weight (weight after dialysis treatment).
- Staff took actions if patients showed signs of an infected line or fistula. Staff phoned the consultant nephrologist to obtain a verbal prescription for antibiotics. The prescription was also sent electronically and staff wrote it as a 'stat dose' on a paper prescription chart. The consultant signed the prescription (paper format) at the next opportunity. Nurses arranged for patient transfer to the nearby NHS hospital for further assessment if required. If sepsis was not suspected but the patient demonstrated signs of other medical problems, staff referred patients to their GP and telephoned the GP to tell them of their concerns.
- A registered nurse held the keys to the medicines cupboard. The registered nurses delegated the setup of individual patient's dialysis medicines and equipment to a trained and competent health care assistant. The registered nurse then checked and administered the medicines as prescribed and in line with legislation.
- Medicines were mostly stored safely. There was a clean utility room where medicines were stored in locked cupboards. There were also two fridges for medicines, which required storage at a cooler temperature. The fridges were locked and a registered nurse carried the keys. We checked some of the medicines and found that all were in date. Staff monitored the fridge temperatures and staff were aware of actions to take in case these fell outside of the reference values given. However, fluids for intravenous administration were stored on trolleys in the main dialysis area. This does not comply with safe practice for storage of intravenous fluids as outlined in the Safe and Secure Handling of Medicines guidance from the Royal Pharmaceutical Society (2005)
- Storage of oxygen cylinders did not meet national recommendations. Small oxygen cylinders were stored in an upright position on the floor. Empty cylinders were marked 'empty' on a piece of paper stored next to full cylinders. The Department of Health: Medical gases.

Health Technical Memorandum 02-01 (2006) recommend racking systems are used and that cylinders are stored in a designated area to avoid accidental damage or being knocked over.

- The unit had a service level agreement with the pharmacy department at nearby NHS hospital. Staff checked agreed stock levels once a week and ordered any medicines delivered from the pharmacy department. When the medicines order was delivered, staff checked these and them away into safe storage as soon as possible. There was evidence of stock rotation to ensure medicines did not go past their expiry date.

Records

- Individual patient dialysis records were written in a manner that kept patients safe. Staff completed paper records and entered information about dialysis sessions on a renal database. This information was shared with consultants at the nearby NHS hospital who was responsible for patients' dialysis treatment. This included information about patients' vital signs before, during and after dialysis, information about patients' weight and blood test results.
- Staff completed paper care records effectively and in line with their corporate operating procedure. We reviewed six patient records and found them all to be organised and legible. Each patient had a folder, which contained his or her dialysis records and their care and treatment pathways. The unit used a 90-day care pathway for new patients commencing dialysis at the unit. This pathway included information about infection screening, patient education programme and assessment of parameters at different points during the first 90 days of patient dialysis. Once the dialysis was well established, staff used a continuing care pathway which was re-assessed every three months and ensured on going care followed evidence-based guidance.
- Information was shared between the B. Braun electronic database and the local NHS hospital. A combination of paper and electronic patient records was used. This meant the consultants and dieticians working within the NHS trust and B. Braun staff had access to the current patient records at all times.
- Patient records were not always stored securely. During our inspection, we noticed that patient records were stored in an unlocked filing cupboard in an unlocked office where nurses did not have a view of when people entered the office. This meant that unauthorised people could gain access to confidential information about patients. We brought this to the attention of the nurses who took prompt action to lock both the filing cabinet and the office. We also noticed a sack of confidential waste stored in the main dialysis area. The waste was not marked as confidential nor was it stored securely where unauthorised people could not gain access. The unit had guidelines about patient confidentiality. However, this did not include guidance about confidential waste management.
- Staff carried out documentation audits once a quarter. The results demonstrated each nurse's thoroughness when completion patient records. We reviewed the results from audits carried out in quarter January 2017 and April 2017. The results varied from 91% to 95% of completeness of patient records.

Assessing and responding to patient risk

- The unit did not employ any medical staff, which meant there was no immediate access to medical staff in the event of a medical emergency. The unit had processes to follow which included calling an ambulance for emergency transfer to the local NHS hospital. Staff told us it had rarely happened, as patients receiving dialysis in the unit were stable patients with well-established dialysis.
- The unit did not have a sepsis policy or guidelines to follow. Staff phoned the consultant nephrologist, if patients showed signs of infections related to their vascular access. The consultant gave a verbal prescription for nurses to administer antibiotics. If sepsis was suspected, staff arranged for an ambulance transfer of the patient to a local NHS hospital, for further assessment and treatment.
- Staff monitored patients throughout their dialysis treatment. Prior to commencement of the treatment, staff assessed patients' general health, weight and blood pressure. Throughout the treatment, staff monitored patients' vital signs (blood pressure, pulse and temperature) every hour and when the treatment had finished. However, the unit did not use an early warning scoring system to alert staff to a patient who was deteriorating. Patients were encouraged to rest in the dialysis chair for a little while post dialysis to ensure there was no bleeding from the fistula and to ensure they did not feel unwell/light headed.
- The unit had a corporate operating procedure for staff to follow in the event of an urgent patient transfer was

required. This included information about who to contact regarding the transfer, organising transfer and ensured information was shared with patients' next of kin.

Staffing

- The unit had safe staffing levels in line with The Renal Workforce Planning Group (2002) and the Renal Association (2009) recommendations. Staff were contracted to work across all the Gloucester dialysis units but were rarely asked to travel to a different unit to cover. Actual staffing levels were equal to the planned levels of staff as some staff worked extra shifts to cover, which ensured the unit was staffed safely to care for and treat patients. The unit employed 5.9 full time equivalent nurses and three healthcare assistants. One member of staff had left the unit in the last 12 months. At the time of our inspection, there was one vacant post for a dialysis nurse and there were plans to fill the vacancy.
- There was always an experienced member of staff available to support junior or new member of staff. The working rota was created to ensure there was always a senior member of staff on duty. Senior staff from nearby dialysis units covered in the event of sickness or staff holiday.
- The unit was staffed with one qualified nurse to four patients in line with national guidance. As the unit did not work to full capacity, this meant that often the actual staffing was one registered nurse per three patients. There was also a healthcare assistant on duty on every shift. Staff worked long shifts from 7am to 6.30pm. We checked rotas between January 2017 and May 2017; these rotas demonstrated there was always three registered nurses on duty and that there was a senior nurse on duty every day. When the senior nurses were on holiday, another senior nurse from a nearby B. Braun dialysis centre came across to cover the unit.
- The unit had processes to cover for staff sickness. Between November 2016 and January 2017, there had been 13 % sickness. This is higher than the national average of 3 to 4%. Staff worked extra hours to cover shifts.
- The unit had used agency staff on five days during April and May 2017. The registered manager kept information sent to them by the agency, which confirmed their training, competence and disclosure, and barring checks. The unit used a basic general health and safety induction, which the agency nurse signed when completed. This included emergency procedures, fire equipment, layout of the building, basic renal information about dialysis prescriptions and how to operate essential equipment such as the dialysis chair.
- A consultant nephrologist visited the unit every week on alternate days and times to ensure they had an opportunity to see all patients. These meant patients were reviewed once a month by the consultant, or more often if there were concerns about patients' renal treatment. Staff had access to the consultant nephrologist at other times via the telephone. Although all patients were under the care of one consultant nephrologist, the team of consultants at a nearby NHS hospital offered support it they were not available. Staff told us it was easy to get hold of one of the consultants if they had concerns about patients.
- There were no technical staff at the unit. There was a service level agreement with B. Braun technical engineers for regular service and maintenance of equipment. This included call outs if technical problems arose with dialysis equipment.

Major incident awareness and training

- The unit had equipment for staff to use in the event of emergency. Staff received fire-training updates annually via e learning. However, only five out of eleven nurses had completed the update in 2017. There were fire extinguishers and fire exit displayed throughout the unit. We asked some patients if staff had told them how to disconnect themselves from the dialysis machine in the event of a fire. The patient records demonstrated that patients had been told how to do this and signed an agreement to acknowledge this. One patient we spoke with could not remember how to disconnect. Staff told us they knew which patients required assistance in the event of an emergency.
- There was a contingency plan specific to the unit. This plan provided guidance for staff to follow in the event of an incident such as loss of dialysis capacity due to water/plant, power or machine failure, fire with partial or full loss of building. Other incidents included adverse weather conditions, issues with specialist suppliers, breach of infection control protocols (blood borne virus and MRSA) and reduced staff resources due to sickness.

There was also a list with emergency phone numbers to contact including issue with machines and the water plant. The contingency plans involved contacting relevant staff at the NHS hospital nearby.

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

Evidence-based care and treatment

- Most treatment in the haemodialysis unit was managed in accordance with national guidance. There was a 90-day treatment plan followed by a continuing treatment pathway. These pathways were evidence-based on national guidance from the Renal Association haemodialysis guidelines (2009) and the National Institute for Health and Care Excellence (NICE), 2015): Renal replacement therapy for adults. There was a plethora of standing operating procedures to ensure evidence-based practice; this helped ensure treatment followed current guidance.
- Staff monitored and recorded patients' vascular access in line with NICE Quality Statement (QS72) statements 8 (2015):'Haemodialysis access – monitoring and maintaining vascular access'. The majority of patients (72% to 78%) between June 2016 and January 2017 had an arteriovenous fistula as their vascular access. This was less than and therefore worse than the Renal Association guidance (2015) of 80%.
- An arteriovenous fistula is a surgically created vein used to remove and return blood during haemodialysis. Patients were referred to a local NHS hospital for formation of vascular access. We saw individual care plans for those patients with arteriovenous fistulas that were difficult to cannulate. These care plans included schematic drawings and additional guidance from the vascular consultant performing the fistula. If patients' fistula were difficult to cannulate this task was undertaken by more experienced staff.
- Staff monitored patients receiving dialysis in line with Renal Association Haemodialysis Guidelines (2009). However, the unit did not meet guideline 1.3: 'Patients travel less than 30 minutes for dialysis treatment' as some patients travelled up to an hour for their treatment. Patients who attended the unit told us they chose to receive their dialysis treatment at this unit. They told us they were pleased with the location of the unit and did not mind travelling a little further for their treatment.
- Staff were not aware of any national guidance to inform care given to patients with advanced kidney disease, nearing the end of their life. Staff told us the consultant nephrologist initiated conversations with patients about their wishes about resuscitation. This decision was communicated to all staff. The unit did not have any policy or standard operating procedures for end of life care. This meant that we could not be assured practice followed recommendations outlined in the National Service Framework for Renal Services.

Patient Outcomes

- The unit collected data, which was submitted to the UK Renal Registry by the local NHS trust. The data from the unit was combined with the NHS Trust data and submitted as one data set. Due to the inclusion with the trust, the unit could not benchmark the effectiveness of its service to other dialysis providers. Staff collected data about ten haemodialysis key performance indicators. These included data about dialysis frequency, treatment time, blood pressure recordings and blood test results such as haemoglobin, phosphate and calcium levels. Performance indicators for the unit were similar to the country average for all key indicators. For example, dialysis frequency data showed that the average number of weekly treatments for patients were three times a week in seven out of eight months from June 2016 to January 2017 with three sessions per week being the recommended frequency.
- The unit had a calendar with details of when different performance reports should be completed and sent to the corporate operational manager for review. This included a monthly 'management plan' and a quarterly 'outcomes and explanation report'. The management plan held information about key performance indicators, which was reviewed against set target, as agreed with the local NHS trust. Data from January 2017 to April 2017 demonstrated the unit met all key performance indicators except the target in one measure.
- The service completed a number of monthly quality checks, which showed compliance with national standards. The monthly checks included monitoring of treatment time for each patient. Haemodialysis

treatment should total 12 hours week, which are typically three treatments per week. On average, 94% of patients received at least 12 hours dialysis a week. This exceeded their target of 87%. When treatment times were reduced, this was due to patients' choice although staff encouraged patients to complete their full treatment each time.

- The trust had set a group target of 80% of patients having an Albumin concentration of greater than 35 g/dl; however, for all four months staff reported albumin levels of 59%-60%. There was an opportunity for the registered manager to provide information about measures put into place to improve the results but the framework did not include additional information about albumin levels. The management plan also presented information in relation to other performance indicators such as infection control, water testing, mandatory staff training and information about staffing levels.
- The unit audited information relating to how long patients waited to commence their dialysis treatment from their scheduled appointment time. We reviewed data relating to quarter three of 2016 and found that all patients commenced dialysis treatment within the target timeframe. We noticed that some patients commenced dialysis ealier than their specific appointment time if they had arrived early.

Pain relief

- Staff offered the use of a local anaesthetic cream prior to cannulation of the fistula if patients found this process uncomfortable or painful. Patients were appreciative of how staff considered their comfort during dialysis.
- Staff did not administer regular analgesia to patients receiving dialysis. Patients attended on an 'outpatient' basis and took their own medication as prescribed. If patients complained about pain during treatment, nurses assessed possible reasons and consulted with the consultant nephrologist if required. Nurses could administer paracetamol if the nurses had completed the annual update delivered by the local NHS hospital in medicines management. However, if patients did not have a hospital drug chart, nurses were unable to give them paracetamol as this was given as an 'as required' medicine in line with the NHS trust policies. Staff told us they were rarely required to give any additional medicines such as paracetamol.

Nutrition and hydration

- Patients had access to a dietitian who reviewed patients regularly. The dietitian was from a local NHS trust and visited the unit every month on alternate days to ensure they saw all patients regularly. Patients received a face-to-face review once every three months. The dietitians wrote up their records and spoke with staff about any changes on the same day, before leaving the unit. The dietitian reviewed patients' monthly blood test results remotely and therefore monitored patients every month in-between face to face visits. If slight amendments were required to nutrition because of tests, these were actioned immediately. The dietitian emailed or telephoned the unit to ensure staff and patients were informed of any changes that were required.
- Results from a recent patient survey (2016) demonstrated that 14 patients of those that responded (26 patients) were satisfied with the information they received about diet and 12 patients felt they had sufficient information about fluid management. The registered manager told us this had been raised with the dietitian. They were not sure why the satisfaction result was lower than expected as records showed regular reviews. The registered manager had an action plan, which included a discussion with the NHS trust.
- Staff offered hot or cold drinks and a biscuit while the received dialysis treatment. The local NHS trust provided this. Patients also often brought in biscuits to share with other patients during the dialysis session. Many patients brought in their own lunch or snacks to eat during their treatment.

Competent staff

- The two senior dialysis nurses had a post registration qualification in renal nursing/management of patients with renal dysfunction. There was a comprehensive induction programme for new staff members with different competencies and knowledge to achieve within set periods. The induction programme also included medical devices training for the dialysis machines and infusion pumps used. These competencies included understanding of the principles of drugs used, such as anticoagulants. We reviewed the training records and noted that compliance with applicable 'once only' training was 100% for registered

nurses and 81% for healthcare support workers. However, some staff completed this training in 2012 and there was no evidence that these competencies had been reassessed since.

- Nurses received training and competence assessment for a needling technique referred to as wet needling, when connecting patients to dialysis machines. They followed clinical care pathways to ensure secure vascular access. If nurses took blood sample from the fistula, they used a technique referred to as 'dry' needling so not to dilute the blood sample.
- Six members of staff had completed additional training and competency assessment in bacterial water sampling and the use of Endosafe (a rapid microorganism test).
- There were arrangements for supporting and managing staff. All staff received an appraisal once every year as well as a mid-year review. Records were kept in personnel files and reminders of when these were due, were displayed on a noticeboard in the staff room. At the time of inspection, the displayed information showed that not all staff had had the planned midyear review or appraisal as planned, one nurse had not received their midyear review in April as planned.
- All staff received yearly face-to-face updates in basic life support training including anaphylaxis training. The two senior nurses also held an intermediate life support qualification, which they obtained March 2017. At the time of our inspection, records showed that three out of 11 staff members had had their yearly update in 2017 and all other staff were booked onto sessions throughout the year.

Multidisciplinary working

- There was efficient team working between staff. There was a team briefing each morning where the list of patients were discussed and any relevant information about equipment and resources were shared. This helped ensure safe working processes.
- There were processes to ensure effective multidisciplinary working. The consultant nephrologist from a nearby NHS trust had the overall responsibility for managing patients' care. Nurses played a vital role in ensuring care and treatment was carried out as prescribe and to communicate any changes to the consultant. Nurses told us their working relationship with the consultant nephrologist was good and that they were supportive. The consultant visited the unit regularly and communicated via telephone as required between visits.
- The unit communicated effectively with patients' GPs. Nurses told us they spoke with patients' GPs regularly about concerns that patients had and if they felt it was urgent. These concerns could be in relation to a new health complaint or referrals for support that was not related to dialysis, such as arranging occupational health referrals. Staff also informed the patients' GP if patients did not attend for their dialysis sessions. We saw letters that demonstrated regular communication from the consultant nephrologist to patients' GP, when there were changes to treatment or medication.
- Patients received regular reviews by a dietitian from a nearby NHS trust. If patients needed input from other allied health professionals this would be discussed with the nephrologist or with the patient's GP. This included support from a clinical psychologist but patients had to travel to the nearby NHS trust to receive this support, as the clinical psychologist did not visit the unit.
- There were effective working relationships with regional transplant centres. Patients waiting for a renal transplant received specialist care, including psychological support, from the regional centres. Once patients were accepted onto the renal transplant waiting list, staff obtained regular monthly or three monthly additional blood tests, which were sent directly to the renal centres.

Access to information

- Processes were followed to enable staff to have access to policies and good practice guidance. The registered manager and corporate senior staff shared responsibility for ensuring all policies were in date. Staff accessed polices via the organisations intranet. If these were required to be printed, all policies stated they were valid for a 24-hour period only. This promoted the use of the most current best practice standards by prompting staff to recheck the intranet for updates.
- Staff had access to patients' blood results. Patients had monthly blood tests to help inform treatment decisions. The named nurse was responsible for documenting these and for ensuring, the results were discussed with both the patient and the consultant nephrologist. Most staff had access to this information. We spoke with one nurse, who was unable to log into the computer system

that held the information, as they did not have a password. This did not compromise care as they could ask other nurses to check relevant information about patients for them. However, this was not good practice, which staff recognised this and that it was their responsibility to ensure they had access.

- Staff did not have access to patient's medical records as these were held by the NHS local hospital. However, nurses had electronic access to information about patients' dialysis prescriptions, blood results, dietitian review and GP letters. The consultant nephrologist visited the unit every week to review patients and spoke to staff about changes to treatment plans. The consultant reviewed blood test results remotely when these were available and communicated with nurses at the unit if they made changes to prescriptions. This ensured staff could print off a new treatment plan to take account of changes to dialysis treatment.
- Patients did not hold any medical records or information about their illness and treatment plans. We saw two examples of a red rubber bracelet worn by patients, to alert others (medical staff) not to use that arm for blood tests or to check blood pressure in the event of a medical emergency. This bracelet helped to maintain the patency of the fistula used to cannulate for dialysis treatment. Patients' did not carry any other documentation to help inform medical staff in emergencies.

Equality and human rights

- The unit had an operating procedure to ensure patients with protected characteristics were not discriminated against. The operating procedure provided guidance to staff about accessing for example translation services or written information in large-scale print or Braille.
- The unit was easy for patients with disabilities to access. All treatment areas were on the ground floor and were spacious to accommodate people in wheelchairs. Two toilets were specifically designed to provide easy access for patients with either a right-sided or a left-sided weakness. The toilet facilities also had an emergency call bell to summon assistance if required.
- Staff obtained information about patients' communication needs in line with the Accessible Standards (2016). This helped ensure that patients could access information in the right format and that staff were aware when patients had additional needs.
- The Equality Act 2010 places a legal duty on all service providers to take steps or 'make reasonable adjustments' in order to avoid putting a disabled person at a substantial disadvantage when compared to a person who is not disabled. An assessment of patients formed part of the initial assessment when they commenced treatment at the unit. Staff ensured patients' needs were met wherever possible for example by purchasing specific equipment or facilitating the dialysis treatment in a side/single room if required.
- The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS acute providers and independent acute providers that deliver £200,000 or more of NHS-funded care. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. Senior staff did not have any knowledge of the NHS Workforce Race Equality Standard (WRES) published in 2016.

Consent, Mental Capacity Act and Deprivation of Liberty

- Staff obtained consent and acted in accordance with patients' wishes. Staff obtained written consent from all patients when patients started treatment at the unit. Thereafter staff obtained verbal consent before treatment and care interactions were commenced. This consent was not document in patient records. Staff explained that there was also implied consent as patients attended for their treatment. This was in line with their corporate policy. If staff had any concerns about consent issues, they would refer this to the consultant nephrologist
- Staff acted in accordance with patients' wishes, which sometimes meant that patients' dialysis session was shortened. When this happened staff explained the potential consequences of shortening the dialysis session but took account of the patients' wished and disconnected them from the dialysis machine. Staff reported this as an adverse patient occurrence. This had happened between three and five times each month between January 2017 and April 2017.
- The consultant nephrologist explained how consent was obtained in patients with a learning disability. This involved an assessment of the patients' mental capacity

and understanding of the proposed treatment. They stated that patients with additional needs were rarely treated in satellite units due to the challenges these treatments may pose.

- Staff we spoke with understood processes to follow if a patient's ability to provide informed consent to care and treatment was in doubt. This included raising issues with senior staff and the patient's consultant prior to starting. The renal consultants explained what processes they had followed with a patient who had a learning disability. This involved an assessment of the patients' mental capacity and a multidisciplinary best interests meeting. This complied with the recommendations in the Mental Capacity Act (2005).

Are dialysis services caring?

Compassionate care

- Staff treated patients with compassion, kindness, dignity and respect. We observed staff interact with patients in a compassionate manner. Patients told us staff were caring and described their care as: "First Class", "Can't fault the service" and "They [nurses and doctor] saved my life".
- Staff sought the views of patients and their relatives to improve service provision. The service carried out annual patient satisfaction surveys. We reviewed the results from the B. Braun 2016 survey. The response rate was 62% and represented just over half of the patients attending the unit for dialysis (26 patients). The survey consisted of 24 questions and the score for overall satisfaction with care was 92% and 96% were very satisfied with the hygiene in the unit. However, the survey highlighted a number of patients were less satisfied with some areas of care and treatment including satisfaction with chairs and the temperature of the dialysis area. The unit did not participate in the NHS Friends and Family test, as the patients were consistently the same. There were a number of different options to provide feedback displayed in the waiting area.
- Staff took care to ensure patients' dignity was maintained at all times. Staff were aware of the importance to provide care for a diverse population and ensured patients' individual wishes and needs were met wherever possible.
- Staff maintained patient confidentiality. However, the majority of the dialysis stations were in an open bay but staff took care to speak with patients in a lowered tone to maintain confidentiality. The unit had consultation rooms where patients could speak with staff in private.
- Staff were mindful of maintaining privacy but their individual dialysis stations could not easily be screened off when care interactions took place. However, two consultation rooms could be used for clinical examinations although staff stated the rooms were rarely used. In the patient survey, all patients (26 patients) stated they were very satisfied or quite satisfied with privacy during treatment and clinical examinations.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in a manner that ensured patients understood the information they were given. Staff used a 90-day clinical pathway that included a patient education programme. Patients received information about the treatment, fluid management, diet, vascular access, medicines, how to adapt to dialysis and information about kidney transplant. We observed staff took time to explain for example blood results and checked the patients had understood the information by asking further questions.
- Patients felt informed about their care and treatment. They told us they had sufficient information to ensure they could make informed choices about their care and treatment. Patients stated the consultant and nursing staff took time to explain and discuss different aspects of their condition, treatment and care as required. However, the patient survey from 2016 showed only 42% (10 patients) felt involved in their care, 54% (14 patients) were satisfied with advice given on diet and only 46% (12 patients) felt they had sufficient information about fluid management. The registered manager had an action plan, which included a discussion with all staff to re-enforce information about diet and fluid management. They also discussed the feedback with the NHS trust in the regular contract review meetings.
- Patients generally attended their appointments on their own so we were unsure about how involved their relatives felt if this was appropriate. However, we spoke

with two relatives who both felt they knew what was happening about their spouse's treatment. If patients and their relatives wanted to speak with the consultant, staff could arrange this at a convenient time.
- A dietitian interacted positively with patients. They brought a chair along so they could sit down and talk with patients. These ensured patients did not feel hurried or rushed in their conversation with the dietitian.
- We observed appropriate use of 'banter' between staff and patients, which helped create a pleasant environment for all. All staff greeted patients when they arrived and said goodbye to them when they left after their treatment.

Emotional support

- Patients and their relatives felt supported by nurses and the consultant at the unit. The patient satisfaction survey showed that 88% (23 patients out of 26 patients) felt staff listened carefully to what they said.
- Each patient had a named nurse who was responsible for regular reviews of patient's treatment and care needs. Patients were not always aware of who their named nurse was and some patients seemed a little surprised, when we asked them about who their named nurse was. However, this did not have any negative impact on patient care, as all staff clearly knew all the patients.
- There were processes to ensure staff assessed patients' quality of life and emotional wellbeing. Patients received information about adapting to dialysis as part of the patient education programme when they started dialysis treatment. Staff asked patients if they felt low in mood as part of the continuing care pathway, which was reviewed every three months. Staff could refer patients to a clinical psychologist at a nearby NHS trust if required.
- Staff had access to the local NHS trust's end of life care pathway. The need to implement this was reviewed every three months as part of the continuing care pathway assessment. However, staff's knowledge of end of life care was varied and there was no evidence that end of life care was planned in accordance with national frameworks such as 'End of life care in advanced kidney disease – a framework for implementation'.

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

Service planning and delivery to meet the needs of local people

- Regular contract reviews were held to ensure the service met the needs of local people. These meetings were held every two months with the commissioning nearby local NHS trust. Prior to the inspection, we spoke with senior leaders in the NHS trust, who told us they felt B. Braun provided a good service, which met the needs of local people. Patients told us they were pleased with the facility and the location as this had shortened their transport time to and from the unit to their homes.
- The unit did not have a transport user group. We obtained feedback from surveys carried out by the Clinical Commissioning Group and Health Watch. The surveys showed there were mixed reviews of the effectiveness and responsiveness of the transport to and from dialysis sessions. These problems were mostly regarding transport to and from another nearby dialysis facility. These were ongoing problems but seemed to be largely attributable to when the usual driver was away.

Access and flow

- Service utilisation met the needs of the local population. The unit provided between 477 and 539 dialysis sessions per month between June 2016 and January 2017. This meant the utilisation was 83% to 88%. There were no waiting lists for patients who were referred for dialysis. Consultants at a nearby NHS trust accepted new referrals. Once the registered manager was informed of the patient, they contacted the patient to arrange the first available appointment and this included the arrangement of transport to and from the unit. The registered manager invited new patients to visit the unit before starting their treatment to ensure the location met their expectations.
- The dialysis service provided flexibility and choice for patients. Most patients attended the unit three days a week and had the choice of available morning or

afternoon sessions to suit their preference. One patient told us the unit had changed their morning slot for an afternoon slot as requested, otherwise they would have had to get up very early, which did not suit them.
- Patients did not have to wait long for their treatment to start form the scheduled time given. A patient satisfaction survey from 2016 demonstrated the most patients (70%) waited less than 15 minutes.
- If patients could not attend their regular appointment, staff invited them to attend at a different time for example the next day. If patients missed their dialysis appointment, staff telephoned the patient to check they were well and to arrange another appointment the following day. They also informed the consultant and the patient's GP. Staff reported missed appointments as an adverse patient occurrence on the B. Braun electronic incident reporting system.

Meeting people's individual needs

- The unit supported patients with arrangements for dialysis while on holiday and welcomed patients from other regions for dialysis sessions. There was a holiday coordinator based at the renal dialysis units in a nearby NHS trust. The co-ordinator liaised directly with patients, consultant nephrologists and co-ordinators to arrange dialysis for patients going on holiday that required dialysis at a different unit. They also arranged dialysis for patients on holiday nearby. We spoke with patients who had been on holiday both in this country and abroad whilst receiving dialysis.
- The unit accommodated patients' preferred times for dialysis wherever possible. One patient and their relative also told us about how staff had helped plan the days of dialysis so that the patient could attend an important family event.
- Staff took account of patients' individual needs when they received dialysis treatment. The dialysis stations each had a television and patients had their own individual headset. Each station had a table and staff offered hot and cold drinks and a biscuits while patients received dialysis. Staff encouraged patient to bring in their own food in as well as books, IPads or similar items to help them pass the time.
- Staff took care to ensure patients were comfortable whilst receiving dialysis. The unit had purchased overlay mattresses to place on top of dialysis chairs to ensure patient comfort.
- There were not many patients, who participated actively in their own care. Some patients had obtained access to 'Patient View', which allowed them to review their own blood test results on line. Staff told us patients did not express an interest in being actively involved with setting up dialysis. If patients considered a home dialysis option, staff would support them in learning how to set up and end treatment processes. However, there was a home dialysis specialist nurse based in another nearby dialysis unit so it was likely the patient would transfer to that unit for teaching and support.
- The unit was airy with natural light from windows. The temperature of the room could sometimes be difficult to adjust to all patients' preferences. Staff had purchased blankets for all patients as a Christmas present which they encouraged patients to bring for each treatment.

Learning from complaints and concerns

- Staff listened to patients' concerns about the delivery of care and treatment. Staff explained they had suggested a patient forum group but patients had shown little interest in this. The unit provided feedback to patients about the results of the patient satisfaction survey in 2016. In the feedback, staff also explained suggested actions to address particular issues of concern. For example, staff encouraged patients to tell them if they were cold while receiving dialysis. Staff told us they wanted to hear about how patients felt they could be more involved in their care as eleven patients (42%), who participated in the patient satisfaction survey, expressed they did not feel involved in their care.
- Staff followed a standard operating procedure, if patients had complaints or concerns about their care. Complaints were rare and the unit had only received one complaint in the last 12 months. This complaint related to transport issues. Patients knew how to make a complaint but all patients, we spoke with, said they were very pleased with the service.

Are dialysis services well-led?

Leadership and culture of service

- B. Braun had an organisational structure, which included a managing director who was supported by an operations manager and a clinical quality manager. This was in addition to financial, commercial and human resources divisions within the company. Each dialysis

unit had a registered manager, who was supported by the operations manager, the clinical quality manager and a practice development nurse. The operations manager was present during our inspection. They knew the unit well and it was evident that they visited the unit regularly.

- Leaders had the skills, knowledge and experience to manage the service. Two deputy managers/senior dialysis nurses supported the registered manager. The registered manager and the two senior dialysis nurses all held a post-registration course in renal nursing. The registered manager also managed three other dialysis units located within a nearby NHS hospital. They shared the week between the different locations and aimed to spend one whole day each week at the unit. All staff confirmed that they saw the registered manager regularly and could always contact them via telephone if they had any questions or concerns.
- All staff we spoke with told us they respected the registered manager. Senior nurses told us they felt well supported in managing the day-to-day running of the dialysis service. Registered nurses, healthcare assistants and the unit clerk felt well supported by the senior dialysis nurses. There was camaraderie amongst staff and a sense of team working. Throughout the inspection, we observed staff interact and help each other and share tasks in response to service needs. For example, all staff helped to get the dialysis stations ready between sessions. If two patients were ending their treatment at the same time, staff helped each other to ensure patients' needs were addressed.
- We observed effective communication between staff and that the senior dialysis nurse maintained a clear overview of service needs at all times. Although they also had designated patients, they had capacity to support staff with tasks or questions, which was beyond their competence, skills or experience.
- Staff told us they felt valued and all nurses stated they enjoyed working at the unit. For example, one nurse told us they travelled over an hour each way to work but that they enjoyed the work and the people so they did not mind travelling further.
- Staff were aware of the need to be open and honest with patients. Staff gave examples of conversations with patients about their care such as the consequences of missing dialysis treatment or shortening their planned duration of dialysis.
- Staff had effective working relationships with the commissioning key people in the local NHS trust. This was confirmed by feedback from the consultant nephrologist. Staff were friendly, knowledgeable and experience and had processes to support safe delivery of care.
- The organisation obtained an accreditation with 'Investors in People' in 2016 at level two (Silver Award). This accreditation is awarded to organisations who meet their standards for people management. The organisation was given a list of seven recommendations for continuous improvement. These included simplifying communication around organisational values and to work with employees to do so, clarity around what high performance looked like and encourage employees to engage and come up with new ideas.

Vision and strategy for this core service

- B. Braun's corporate vision was commitment to provide safe patient care and to engage with local communities. In addition, they wanted to reward and recognise good staff. The company had a strategic vision of how to achieve this. It focussed on four elements: clinical care, multidisciplinary working, the importance of additional support for patients and their families outside of the dialysis centre and to have robust governance processes.
- The company had a strategy to support positive staff experiences. This strategy focussed on four 'P's: prioritise people, practice effectively, preserve safety and to promote professionalism and trust. The corporate contract was reviewed and renewed every five years. Corporate managers oversaw the contracts and held the organisational overview of performances in different localities. The contract was next up for renewal in 2018.
- Staff were aware of their role and responsibilities in providing effective and safe care to all patients. Staff spoke positively about providing safe care in the local area but there was varied awareness about organisational or local vision and strategy amongst the staff.

Governance, risk management and quality measurement (medical care level only)

- There was a governance framework to support the delivery of the strategy and good quality care. Quality

assurance was monitored at corporate level through regular audits. The registered manager completed an operational report management plan every month, which was sent to the head office. The management plan was set up as a dashboard and held information, for example about: key performance indicators, adverse patient occurrences and staffing. There were monthly operational management meeting where these were discussed.

- There was a bimonthly contract review meeting with the local NHS trust who commissioned the dialysis service on behalf of NHS England. Relevant staff attended this meeting from the NHS hospital, the operations manager and the registered manager. B. Braun staff presented information about key performance indicators, adverse patient occurrences, monitoring of infection prevention and screening, maintenance issues (building and water quality testing), staffing, uptake of home dialysis and transport issues. The registered manager did not hold any minutes of these meetings and were not sure if minutes were taken. This meant that we were not assured that there was effective communication to identify opportunities for service improvement. We did not see any evidence of action points to improve service provision or evaluation of if these had been completed.
- There were not effective processes to feedback from quality meetings and contract reviews to all staff. There were monthly staff meetings, which were minuted. We asked to see the minutes of meeting for January to March 2017. The minutes demonstrated that there was a set agenda, which included 'quality management'. The minutes reflected staff were given updates and reminders about operational changes. However, the minutes did not demonstrate any discussion about patient safety, patient outcomes or adverse patient occurrences. This meant that we were not assured lessons were learnt and shared from incidents or when key performance indicators were not met. This was a missed opportunity to improve service delivery and ensure safe care and treatment.
- There were processes to ensure a systematic approach to auditing and monitoring. There was a list of dates for registered managers to submit reports to the corporate operations manager. These reports included the monthly management plan, information about treatment time and adequacy analysis, treatment start times, staff rotas and management of consumables. However, we were not clear how this information was used or how feedback was given to the registered manager and staff at the unit.
- There were not effective processes to manage risks. The registered manager had a list of local risks and there was a corporate document named 'health and safety risk register'. However, the corporate health and safety risk register was a list of risk assessments undertaken and did not specifically identify current local clinical and operational risks. The risk assessments were general risk assessments associated with, for example, fire or taking blood samples. The risks were 'RAG' rated (this meant risks were rated as red, amber or green, according to the level of risk they presented) but there were no dates of when these had been undertaken. The local risk register listed nine risks. However, there was no explanation of the risk posed, how the impact had been assessed or how any mitigating actions would lower risks. The risk registers did not identify who was responsible for actions and it was not evident when all actions to mitigate risks, had been completed.

Public and staff engagement

- Staff gathered the views of patients via the annual patient survey. There was also a box in the waiting area where patients or their relatives could submit their views about the service or suggest improvements to the unit. Staff told us they had suggested a patient forum but there had not been sufficient interest from patients and their relatives. Patients told us they always felt welcomed and respected. Staff were friendly, professional and listened if they had concerns, ideas or suggestions.
- Patients and their relatives we spoke with felt engaged and involved in decision-making. However, this was not reflected in the annual patient survey 2016. Staff identified an action to ask all patients and their relatives which aspects of their care they would like to be involved in. Staff were not aware of any feedback from this and of any changes to care and treatment was delivered, to ensure patient involvement.
- Staff told us they liked working at the unit and they were supported to attend regional events for their professional development. There was a corporate commitment to support all staff who wanted to undertake a post-registration course in renal qualifications. There were development opportunities

for healthcare assistant staff to undertake national vocational qualifications in renal competencies and gain a role as a dialysis support worker. This meant they would be trained to look after patients receiving dialysis including at commencement and end of treatment. There was one such opportunity for one person at the unit at the time of our inspection.

- Staff told us they felt enthusiastic about improving the dialysis experience of patients. Staff had listened to patients concerns about feeling cold during dialysis treatment. They had organised for all patients to receive a blanket as a Christmas present. Patients told us they appreciated this gesture.

Innovation, improvement and sustainability

- The registered manager had plans to introduce new initiatives to improve staff engagement. These involved a forum for staff to identify if any improvements could be made to patient outcomes. They were also planning to introduce a six-monthly 'buddy' system to encourage a questioning approach and an opportunity for competence and knowledge level assessment.
- The unit was in the process of introducing the dialysis support worker role. Once healthcare assistants had completed a national vocational set of competencies in relation to renal dialysis care, they could apply for vacant positions for dialysis support worker. This meant they would be trained to look after patients receiving dialysis, including commencement and ending of treatment.
- The unit had plans for a phased replacement of older haemodialysis machines to ensure these were replaced every ten years as recommended by the Renal Association guidelines and manufacturer's recommendations.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must replace damaged dialysis chairs to ensure efficient infection prevention.
- The service must ensure staff follow a written protocol, a patient group direction or a prescription when they administer intravenous fluids to patients displaying signs of symptomatic hypotension.
- The service must develop a sepsis policy/standing operating procedure to ensure potential sepsis is identified and treated in a timely manner.
- The services must review their risk management processes to ensure current risks are identified and acted upon.

Action the provider SHOULD take to improve

- The service should ensure that intravenous fluids are stored in locked cupboards to ensure they are not tampered with.
- The service should ensure a procedure is in place to correctly identify patients before administration of medicines or dialysis commences.
- The service should improve systems to confirm actions from the monthly quality assurance review have been carried out.
- The service should ensure oxygen cylinders are stored safely and in accordance with national guidance.
- The service should carry out a risk assessment with regards the safety of anticoagulant medicines, when these were temporary stored by individual dialysis stations.
- The service should review processes to ensure safe disposal of confidential waste.
- The service should improve processes to feedback information to staff about incident investigations, performance and general feedback from corporate management meetings and contract review meetings.
- The service should ensure all actions following the patient survey are carried out and evaluated.
- The registered manager should ensure they have knowledge of and evidence compliance with the Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2), which became mandatory in April 2015.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for service users. The registered person must ensure the risks of, a preventing, detecting and controlling the spread of, infections, including those that are health care related.** **How the regulation was not met:** • There were damaged footrests on six chairs and one chair had a damaged headrest. This compromised effective cleaning and could pose a risk for the spread of infections. **Regulation 12 (1)(2)(h)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for service users. The registered person must ensure the risks to the health and safety of service users receiving care and treatment are assessed.** **How the regulation was not met:** • The service did not have a sepsis policy or pathway to ensure patients with potential sepsis were identified and treated in a timely manner. Treating sepsis in patients receiving dialysis may differ from usual management intervention. **Regulation 12 (1)(2)(a)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for service users. The registered person must ensure the proper and safe management of medicines.** **How the regulation was not met:** • The service did not have relevant standard operating procedures, patient group directions or use patient prescriptions to ensure the safe administration of intravenous fluid boluses when patients demonstrated symptomatic hypotension during dialysis treatment. This was not in line with national guidance (Standards for Medicines Management, Nursing and Midwifery Council, 2007, National Institute for Health and Care Excellence, CG 174, 2013). **Regulation 12(2)(g)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good governance.** • The service did not demonstrate if actions from contract reviews were identified and actioned to improve the delivery of dialysis treatment. **Regulation 17(2)(a)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with requirements of this Part. The service did not have a risk register, which meant we could not be assured all current clinical and operational risks were assessed, monitored and actioned to mitigate risks. Regulation 17(2)(b)