Diaverum Dialysis Clinic - Lings Bar

Quality Report

Lings Bar Hospital
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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

Summary of findings

Letter from the Chief Inspector of Hospitals

Diaverum Dialysis Clinic – Lings Bar is operated by Diaverum UK Limited. The service has 12 treatment stations and is open Monday, Wednesday and Friday 6.15am to 11pm and Tuesday, Thursday and Saturday 7.30am to 6.30pm. Facilities include three side rooms and designated parking including two disabled parking bays.

There is a service level agreement with Nottingham University Hospitals NHS Trust to provide haemodialysis (HD) to adults over the age of 18. Haemodialysis is a type of renal replacement therapy offered to patients with chronic kidney disease and is the most common form of renal replacement therapy.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 27 June 2017, along with an unannounced visit to the clinic on 5 July 2017.

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

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

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:

- Staff had not received training in safeguarding children and young people in line with intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff that have any contact with children, young people and/or parents/carers should be trained to level two.
- Staff had not received training on the use of specific medical devices; weighing scales, intravenous volumetric pumps, blood pressure monitors, vascular access monitor and the electrocardiography (ECG) machine.
- Effective arrangements were not in place for identifying, recording and managing risks. Concerns identified by the inspection team had not been identified on the risk register. We raised our concerns with the clinic manager who was not aware of the risks or concerns we had identified
- Not all staff understood the requirements of the duty of candour regulation.
- Some provider policies had no review date specified. We could not be assured therefore that policies reflected evidence based guidance and that the content has been reviewed in line with current national guidance.
- At the time of our inspection the patient call bell system was out of order.
- The registered manager at the time of our inspection could not tell us if there was a replacement programme for dialysis machines.
- The 'medication preparation and administration' policy was not specific to the UK regulations and good practice guidance and did not include reference documents to assist staff in safe medicines preparation and administration.
- The service did not have specific processes in place to manage challenging behaviours for example, acute confusion, delirium or worsening dementia.
- The provider did not have a policy in the clinic for the positive identification of patients.
- We did not see personal emergency evacuation plan's (PEEP) in place for individual patient's. A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency.
- Pain assessments were not undertaken at this clinic.

Summary of findings

- Staff morale was 'low' and the team appeared 'fragile'. Concerns were raised around the leadership of the clinic and we were formally notified before our inspection that the registered manager would no longer be in post from 11 August 2017.
- Not all staff felt they were supported or encouraged to develop in their role. Results from the February 2017 staff survey and more recent peer review suggested staff felt there were limited opportunities for further training.
- Not all action plans had a 'due date' as well as a completion date in order to monitor that actions were addressed in a timely manner. Following our inspection we received a copy of the action plan developed as a result of the recent staff survey. We saw where actions had been identified for all concerns raised. However, as of 1 July 2017 none of the actions had a 'due date'.
- The provider did not collect data to monitor transport services against the National Institute for Health and Care Excellence (NICE) quality standard (QS72): adults using transport services to attend for dialysis are collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis.
- The service did not audit the time patients were taken off dialysis.
- The provider did not have an active 'patient user group' who met to share their views to positively influence change.
- A Workforce Race Equality Standard (WRES) report was not produced at this location.

However, we found the following areas of good practice:

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and incidents had been reported appropriately.
- Performance showed a good track record in safety, patient outcomes and access to treatment.
- Despite the high turnover of staff, consideration had been given to mandatory training and dialysis specific training. Where additional support had been required to support the clinic team we saw a robust plan in place.
- Systems and processes in infection prevention and control, medical records and safeguarding vulnerable adults were given sufficient priority and patients were protected from avoidable harm and abuse.
- Patient's care and treatment was planned and delivered and clinical outcomes monitored in line with evidence-based guidance, standards, best practice and legislation. This included the management of a patient's pain, nutrition and hydration needs and individual physical health needs.
- There was effective multidisciplinary working between clinic staff and the referring NHS trust.
- Feedback from patients was consistently positive about the nursing staff delivering day to day care and the service had only received one formal complaint in the 12 months preceding our inspection.
- A range of haemodialysis sessions were available taking into consideration the working, cultural and family responsibility needs of the patients currently receiving treatment at the clinic.

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.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis Services		Diaverum Dialysis Clinic – Lings Bar is operated by Diaverum UK Limited. The service has 12 treatment stations and provides haemodialysis services six days a week. At the time of inspection these services were commissioned by a local NHS trust. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 27 June 2017 along with an unannounced visit to the service on 05 July 2017. 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. Patients' were not always protected from avoidable harm and abuse; the provider did not have a specific policy referring to the positive identification of patients and staff had not received training in safeguarding children. However, staffing levels and skill mix were planned, implemented and reviewed to protect patients from avoidable harm. Current staffing concerns had been addressed appropriately with a robust action plan in place. Performance showed a good track record in safety; there was an open culture in which staff were open and transparent when raising incidents and near misses and changing risks to patients were identified and responded to appropriately. However, not all staff demonstrated to us they understood the requirements of the duty of candour regulation. Patients received effective care and treatment that met their needs; patient's care and treatment was planned and delivered and clinical outcomes monitored in line with evidence-based guidance, standards, best practice and legislation, outcomes for patients were largely positive, and met United Kingdom (UK) Renal Association guidelines. There was effective multidisciplinary working between clinic staff and the referring NHS trust. However, we were not assured all provider policies reflected evidence based guidance or that the content

Summary of findings

had been reviewed in line with current national guidance. Not all staff felt they were supported or encouraged to develop in their role and staff had not received training in some medical devices.
Patients were supported, treated with dignity and respect and were fully involved in their care. Feedback from patients was consistently positive about the nursing staff delivering day to day care. However, feedback from patients was mixed in regard to aspects of the care they received.
Patients' needs were mostly met through the way services were organised and delivered and patients could access dialysis treatment at the right time. However, a number of patients raised concerns regarding the waiting time for patient transport after the end of haemodialysis.
The leadership, governance and culture did not always support the delivery of high quality patient-centred care; effective arrangements were not in place for identifying, recording and managing risks, staff morale was 'low' and the team appeared 'fragile'. Feedback from patients and staff was mixed with recurring negative reference to the leadership of the unit.

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Background to Diaverum Dialysis Clinic - Lings Bar

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

This location is registered to provide the following regulated activity:

- Treatment of disease, disorder or injury

We have inspected this location on three occasions since registration in May 2012. There are no active compliance actions, requirement notices or enforcement associated with this service.

The registered (clinic) manager at the time of our inspection had been in post since August 2014. However, we were formally notified before our inspection that the registered manager would no longer be in post from 11 August 2017. In the interim, a member of staff, with previous experience as a clinic manager and also an area manager, was to commence in post for a two-month period on 10 July 2017 whilst recruitment for a permanent clinic manager was underway, this was to be extended if required.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 27 June 2017, along with an unannounced visit to the service on 5 July 2017.

Our inspection team

Our inspection team was led by Michelle Dunna, Inspector from the Care Quality Commission.

The team included one other CQC inspector, a specialist advisor with expertise in renal dialysis services and an expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them, for example as a carer.

Information about Diaverum Dialysis Clinic - Lings Bar

During the inspection we spoke with 11 staff including; registered nurses, dialysis assistants, health care assistants, reception staff, medical staff and senior managers, we also spoke with 14 patients. During our inspection, we reviewed four sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected three times, and the most recent inspection took place in March 2015 which found that the service was meeting all standards of quality and safety it was inspected against at that time.

The current establishment for Diaverum Dialysis Clinic – Lings Bar was one clinic manager (registered manager), one deputy clinic manager, 4.7 whole time equivalent (WTE) registered nurses, two dialysis support workers and three health care assistants (HCAs). Administration was supported by one full time receptionist. At the time of our inspection there were three (WTE) registered nurse posts vacant.

Staff training and development was supported by one practice development nurse, based regionally.

Activity

- The service currently has 49 patients receiving care on a regular basis. All patients treated are over 18 years of age.
- In the reporting period July 2016 to June 2017 there were 7,289 dialysis treatments recorded at this clinic; all were NHS-funded.

Track record on safety

Summary of this inspection

- In the reporting period July 2016 to June 2017 there were no never events.
- In the reporting period January 2017 to June 2017 there were 93 clinical incidents.
- In the reporting period July 2016 to June 2017 there was one serious incident.
- In the reporting period July 2016 to June 2017 there had been no incidence of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- In the reporting period July 2016 to June 2017 there had been one incidence of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- In the reporting period July 2016 to June 2017 there had been no incidence of hospital acquired Clostridium difficile (c.diff).
- In the reporting period July 2016 to June 2017 there had been one formal complaint.

Services provided at the hospital under service level agreement:

- Clinical and non-clinical waste removal.
- Maintenance of medical equipment.
- Dietetics.
- Patient transport.
- Housekeeping.

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 areas of good practice:

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Lessons were learned and communicated throughout the team to support improvements in services.
- Systems and processes in infection prevention and control, medical records, safeguarding vulnerable adults and disruption to services were given sufficient priority and patients were protected from avoidable harm and abuse.
- Performance showed a good track record in safety.
- Staffing levels and skill mix were planned, implemented and reviewed to protect patients from avoidable harm. Current staffing concerns had been addressed appropriately with a robust action plan in place.
- Staff recognised and responded appropriately to the deteriorating patient.

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

- Not all staff demonstrated to us they understood the requirements of the duty of candour regulation.
- Staff had not received training in all safety systems. For example, staff had not received training in safeguarding children.
- The provider did not have a specific policy referring to the positive identification of patients.

Are services effective?

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

We found the following areas of good practice:

- Patient's care and treatment was planned and delivered and clinical outcomes monitored in line with evidence-based guidance, standards, best practice and legislation. This included the management of a patient's nutrition and hydration needs and individual physical health needs.
- There was effective multidisciplinary working between clinic staff and the referring NHS trust and staff were able to access all the information they needed to assess, plan and deliver care.

Summary of this inspection

- Information about patient's care and treatment, and their outcomes, was routinely collected and monitored. Outcomes were largely positive, and met United Kingdom (UK) Renal Association guidelines.
- Staff were qualified and had the skills they needed to carry out their roles effectively.
- Staff were knowledgeable about protecting the rights of patients and demonstrated regard to the MHA Code of Practice, consent to care and treatment and the Mental Capacity Act.

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

- Staff had not received training in some medical devices.
- Pain assessments were not undertaken at this clinic.
- We were not assured all provider policies reflected evidence based guidance or that the content had been reviewed in line with current national guidance. Three policies we reviewed did not have a review date specified and one policy was not specific to the UK regulations and good practice guidance to assist staff in safe medicines preparation and administration.
- Not all staff felt they were supported or encouraged to develop in their role. Results from the February 2017 staff survey and more recent peer review suggested staff felt there were limited opportunities for further training.

Are services caring?

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

We found the following areas of good practice:

- Feedback from patients was consistently positive about the nursing staff delivering day to day care.
- Patients were treated with dignity, respect and kindness and supported to make decisions regarding their care and treatment.
- Patients were allocated a named nurse who met regularly with their patient in order to ensure they understood their care, treatment and condition.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this.
- Patients had access to a renal social worker or renal psychologist through the referring NHS trust and, on a day to day basis, were supported emotionally by the clinic nursing team.

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

Summary of this inspection

- Feedback from patients was mixed in regard to aspects of the care they received. Some patients raised concerns regarding the leadership of the clinic, transport delays and delays either starting or finishing their treatment.

Are services responsive?

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

We found the following areas of good practice:

- A complaints policy and procedure was in place and patients knew how to complain. The service had only received one formal complaint in the 12 months preceding our inspection.
- A range of haemodialysis sessions were available taking into consideration the working, cultural and family responsibility needs of the patients currently receiving treatment at the clinic.
- Facilities and premises were appropriate for the service being delivered.
- Services were planned so that patients could participate in their own care and were supported by the patient's named nurse.
- Access to treatment was timely and there had been no planned dialysis sessions cancelled for a non-clinical reason in the 12 months preceding this inspection.

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

- The provider did not collect data to monitor transport services against the National Institute for Health and Care Excellence (NICE) quality standard (QS72): adults using transport services to attend for dialysis are collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis.
- The provider did not have an active 'patient user group'.
- The service did not monitor the waiting time for patient transport after the end of haemodialysis. Patient feedback cited transport delays.

Are services well-led?

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

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

- There was a clear statement of vision and values. However, concerns identified during this inspection suggested the vision and values were not driven by safety and quality.

Summary of this inspection

- Effective arrangements were not in place for identifying, recording and managing risks. Concerns identified by the inspection team had not been identified on the risk register nor did the clinic manager have an awareness of our findings.
- Some provider policies had no review date specified. We could not be assured therefore that policies reflected evidence based guidance and that the content has been reviewed in line with current national guidance.
- Staff morale was 'low' and the team appeared 'fragile'. Concerns were raised regarding the leadership of the clinic and we were formally notified before our inspection that the registered manager at the time of our inspection would no longer be in post from 11 August 2017.
- Feedback from patients and staff was mixed with recurring negative reference to the leadership of the clinic. During the inspection we noted there had been a high turnover of staff in the last year. A recent peer review carried out by clinic managers from other locations within the organisation also identified concerns around the leadership skills of the clinic.
- Feedback from senior managers, including the clinic manager, suggested a 'disconnect' between the level of support the clinic manager felt they had received and the level of support the organisation felt they had provided.
- Renal Association guidelines suggest that machines should be replaced between seven and ten years of service or after completing between 25,000 and 40,000 hours of use for haemodialysis, depending upon an assessment of machine condition. During this inspection we were not made aware of the replacement programme for these machines.
- A Workforce Race Equality Standard (WRES) report was not produced for this service.

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

- The clinic actively engaged with staff and patients as part of their continuous quality improvement. Processes were in place to foster engagement.
- Staff were focused on continually improving the quality of care delivered through a comprehensive programme of audit.

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 service had an incident reporting policy and procedure in place to guide staff in the process of reporting incidents. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Staff reported incidents using an electronic reporting system. Between January 2017 and June 2017, the clinic reported 93 incidents through the incident reporting system. Examples of incidents raised included; shortened treatment time, water power failure, conflict between patients and staff, medication error, transport, machine malfunction, transfer to an emergency department and increased dialysis time.
- During our inspection we saw where recent incidents had been reported appropriately. For example, a failure with the patient call bell system, a deteriorating patient and shortened dialysis treatment times.
- Learning from incidents was shared with the clinic staff through staff meetings and email and with the referring NHS trust through monthly performance reports and bi-monthly contract meetings.
- During the period July 2016 to June 2017 there had been one serious incident requiring investigation, as defined by the NHS Commission Board Serious Incident Framework 2013. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
- Following this serious incident we saw a root cause analysis investigation had taken place and actions had been identified as a result of the investigation. The incident had also been discussed at the referring NHS trust's morbidity and mortality review meeting. As a result of this incident, training for staff on caring for the deteriorating patient including those patients identified with sepsis had commenced.
- There had been no incidence of a 'never event' in the last 12 months prior to this inspection. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There had been no notifiable safety incidents that met the requirements of the duty of candour regulation in the 12 months preceding this inspection. 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.
- Were an incident to occur that met the requirements of the duty of candour regulation, an organisational policy and procedure was available to staff providing guidance on the process to follow. All staff had been trained and made aware of duty of candour and what steps to follow when requirements had been reached. The online incident reporting system generated an alert when a serious incident occurred in the clinic to prompt staff to consider duty of candour.

- During this inspection we spoke with three staff specifically about duty of candour. Two out of three staff demonstrated to us they understood the requirements of the duty of candour regulation.

Mandatory training

- Annual mandatory training courses were delivered as part of refresher training and development and included 'face to face' and 'e-learning' modules. Staff training files included a contemporaneous training record. This included details of training undertaken including; induction, fire safety, medicine management, safeguarding, data protection, basic life support, hand hygiene, water testing, manual handling, PREVENT, anaphylaxis and integrated management system.
- At the time of this inspection, with the exception of basic life support (71%), all staff had completed this training. At the time of this inspection the remaining two staff did not have dates to complete their basic life support (BLS) training. We were not aware of the provider's target for the completion of mandatory training.
- Annual dialysis refresher training included for example; electrolyte imbalance, symptomatic dialysis-related hypotension and/or accidental venous needle/line disconnection.
- Training in sepsis screening and application of a sepsis protocol had commenced in May 2017 and was included as part of the 'National Early Warning Score' (NEWS) training. As of June 2017, six out of ten staff had completed this training and we saw plans in place to train the remaining four staff.

Safeguarding

- The clinic lead for adult safeguarding was the clinic manager who was trained to level three. Additional support was provided by the director of nursing who was trained to safeguarding level four.
- Staff were trained to recognise adults at risk and were supported with an effective safeguarding adults policy in place. Staff we spoke with demonstrated they understood their responsibilities and adhered to safeguarding policies and procedures.
- Staff new to the organisation undertook safeguarding of vulnerable adults (SOVA) training as part of their induction. Existing staff received SOVA training as part of the mandatory education process every two years.
- At the time of this inspection all staff had received safeguarding adults, level two training.
- The clinic did not treat patients who were under the age of 18. However, children were permitted to visit the clinic. Staff had not received training in safeguarding children and young people. This did not meet intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two.

Cleanliness, infection control and hygiene

- Diaverum UK Limited had infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice in for example, Meticillin-resistant Staphylococcus aureus (MRSA) / Meticillin-susceptible Staphylococcus aureus (MSSA) screening, blood borne viruses such as hepatitis B, hepatitis C and human immunodeficiency virus (HIV), aseptic non touch technique (ANTT) and the appropriate use of isolation rooms.
- During this inspection we observed most areas of the clinic to be visibly clean; however, on the evening of our unannounced inspection the floor in the clinical area was visibly dirty with evidence of dried liquids that had been spilt that day. We raised this with the clinic manager who told us this would be addressed the following morning. External contractors visited the clinic, six days a week, at the beginning of the day to perform cleaning duties.
- External contractors carried out a monthly environmental audit of the clinic, based on national cleaning standards. Results for March 2017 to June 2017 showed an overall compliance score of 93%. We saw action plans in place where national cleaning standards had not been met in addition to evidence where results had been shared with the clinic's nursing team.

- In the event of the need for a deep clean of a room post dialysing a patient with an infection, staff had to perform these. During the unannounced visit staff had been required to perform three deep cleans throughout the day.
- Staff performed disinfection of medical devices, including dialysis machines between each patient and at the end of each day. These followed manufacturer's and IPC guidance for routine disinfection. We observed staff cleaning equipment and machines during this inspection. We reviewed all dialysis machines in use during this inspection, and saw where appropriate disinfection of the machines had taken place on all machines. Three spare dialysis machines were stored clean and ready for use. Notices attached to the machines stated machines were clean and ready for use.
- All the patients we spoke with were positive about the cleanliness of the unit and the actions of the nursing staff with regards to infection prevention and control. Patients told us, "staff are always washing their hands", "the unit is always very clean" and "I've seen times when a machine leaks they {the staff} clean it up swiftly."
- We saw systems in place to prevent and protect patients from a healthcare-associated infection as a result of cross infection. Upon arrival to the dialysis clinic patients had access to a box containing medical tape and a tourniquet for their individual use. Policies and procedures were in place to assess patients as carriers of MRSA and/or blood borne viruses (BBV) such as hepatitis B and C. These included routine testing of susceptible patients in line with best practice guidelines, screening patients three-monthly for BBV, screening arrangements for those patients returning from holiday in 'high risk of infection' regions and appropriate use of isolation rooms and dedicated dialysis machines.
- The clinic had three side-rooms designated for isolation use. MRSA positive patients were dialysed in the side room with appropriate isolation precautions in place to prevent the spread of infection to other patients. Hepatitis B virus (HBV) positive patients were dialysed in isolation on a designated dialysis machine. Patients who had dialysed 'away from base' in a region with a high prevalence of Carbapenem-resistant Enterobacteriaceae (CRE) were also dialysed in isolation until three negative swabs had been received. CRE are bacteria that live in the bowel and that cannot be treated by certain antibiotics, known as carbapenem antibiotics.
- Between January 2016 and December 2016 there were no cases of clostridium difficile (c. difficile), no cases of MRSA and one case of MSSA. Clostridium difficile (c. difficile) is an infective bacteria that causes diarrhoea and can make patients very ill. MRSA is a bacterium responsible for several difficult-to-treat infections. MSSA differs from MRSA due to the degree of antibiotic resistance.
- The clinic had an IPC lead who was responsible for supporting staff, ensuring annual IPC competency assessments and training were carried out and undertaking IPC audits. IPC audits were carried out three-monthly. Results for the six months preceding this inspection demonstrated 98% compliance. Where areas of non-compliance had been identified we saw actions had been appropriately identified. Actions included for example, raising awareness of the '5 moments for hand hygiene' and reinforcing the requirement to use face shields. Results were shared as part of the clinic's performance report to the referring NHS trust.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Results for the reporting period January 2017 to June 2017 showed an average compliance rate of 94%. Hand hygiene results were communicated to staff through their staff meetings and through email. Minutes we reviewed from meetings confirmed this had taken place. Results were also communicated monthly to the referring NHS trust.
- Throughout the clinic all staff were observed to be compliant with best practice regarding hand hygiene and staff were noted to be bare below the elbow.
- There was access to hand washing facilities and a supply of personal protective equipment (PPE), which

included gloves, aprons and face shields. During this inspection we observed all staff to be using PPE appropriately. This included, but was not limited to, the use of face shields during the initiation and termination of haemodialysis.

- All staff were trained and competent in aseptic non touch technique (ANTT). Staff training folders demonstrated where an annual re-assessment of ANTT had been carried out in addition to annual refresher training in IPC and hand hygiene. During this inspection we observed all staff following ANTT practice appropriately. ANTT is a method designed to prevent contamination by applying strict rules and practices.
- The clinic had a large water treatment room, maintained and serviced by an external company. All water testing for the unit was carried out in line with the recommendations by the UK Renal Association and European standards for the maintenance of water quality for haemodialysis and haemodiafiltration. On a daily and monthly basis, nursing staff monitored the water supply in accordance with local guidelines and the requirements of the referring NHS trust. Records we reviewed indicated where this had taken place. Between January 2016 and December 2016, all samples were within the acceptable range.

Environment and equipment

- The layout of the clinic was compatible with health and building notification (HBN07-01) guidance. Access was good, parking plentiful with a secure entry point. A nurse's station allowed visibility of all patients during dialysis and privacy curtains were available when required. We observed there was sufficient space around dialysis chairs however, patients could, if they wished, speak with each other during dialysis in line with HBN recommendations.
- During dialysis all patient chairs permitted access to call bells. However, at the time of our inspection the call bell system was out of order. Senior staff told us this had been reported and information received following our inspection demonstrated where the area manager was focussed on resolving this issue. Patients we spoke with were not concerned about the call bells not working. They told us nurses were always close by should they need anything. We observed nursing staff completing hourly checks of patient's as part of their routine dialysis monitoring.
- Dialysis sets were single use and CE marked (this demonstrates legal conformity to European standards). The clinic receptionist kept, and we saw, a record of all batch numbers of all the dialysis set components used.
- There was a system in place to ensure that repairs to equipment were carried out if machines and other equipment broke down and that repairs were completed quickly so that patients did not experience delays to treatment. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. During our inspection we checked the service dates for all 15 dialysis machines, with the exception of one machine (serial number 2995) all machines were within their service date. We raised the out of date service (15 April 2017) with the clinic manager as the machine was in patient use. At our unannounced inspection the clinic manager told us an external company had been contacted to service the machine, we were not told a date when the service would be carried out and the machine remained in use despite the availability of a spare machine within the clinic. Information received following our inspection confirmed a service had been undertaken on 14 July 2017.
- The clinic was located within the grounds of an NHS trust community hospital. A service level agreement was in place with the hospital for the day to day maintenance of non-dialysis equipment and the environment. Failures in equipment and medical devices were reported through the hospital technical support team. Staff told us there were usually no problems or delays in getting repairs completed. However on the first day of our inspection the patient call bell system was out of order. We were told this had been the case for approximately two weeks. On our unannounced visit to the clinic the call bell system remained out of order. We raised this with the clinic manager who told us, and showed us, a quote to replace the current system had been submitted to the provider's financial manager.

- Patient weigh scales were available in the clinic and we saw where they had been appropriately service tested. Staff told us, in the event the weigh scales developed a fault or were unfit for use, a replacement set was available in the clinic and the fault would be reported.
- We checked the resuscitation equipment in the clinic. The resuscitation equipment appeared visibly clean. Single-use items were sealed and in date and emergency equipment had been serviced. Records indicated resuscitation equipment had been checked daily by staff and was safe and ready for use in an emergency.
- Water testing was completed weekly and monthly, by staff who had been assessed as competent, to ensure that water used during dialysis was free from contaminants. This was in line with guidance on monitoring the quality of treated water and dialysis fluid. We saw the record log that recorded the testing and the results. Staff were aware of the processes for obtaining samples and actions to take if results showed some contaminants.
- We observed staff following cleaning, decalcification and disinfection procedures specific to the type of machine(s) used in the clinic according to manufacturer's instructions and provider policies and procedures.
- We observed all staff had regard for alarm guards on the dialysis machines. Alarms were addressed appropriately and not overridden inappropriately by staff or patients. This meant significant risks such as the detection of dislodged needles could be identified at the earliest opportunity thus avoiding the risk of significant blood loss or cardiac arrest.
- Renal Association guidelines suggest that machines should be replaced between seven and ten years of service or after completing between 25,000 and 40,000 hours of use for haemodialysis, depending upon an assessment of machine condition. All 15 dialysis machines in use in the clinic had completed less than 25,000 hours of use. The clinic manager was not aware of the age of or, replacement programme for these machines.

Medicine Management

- Pharmacy support was provided by the referring NHS trust's pharmacy department. The lead for the safe and secure handling of medicines at this location was the clinic manager (who was the registered manager).
- Medicines, including intravenous fluids, were stored securely. No controlled drugs were stored and/or administered as part of the services provided at this clinic. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. Medicines requiring refrigerated storage and/or storage within a designated room were stored at the correct temperatures, in line with the manufacturers' recommendations, to ensure they would be fit for use. We reviewed fridge and room temperature records and saw where staff had signed daily to indicate temperatures had been checked and were within the required range. We spoke with staff who told us that where temperatures were not within the required range this would be escalated to the nurse in charge.
- Dialysis prescriptions were completed by the referring NHS trust's renal consultant or renal nurse practitioner and hand delivered to the clinic. All non-dialysis related medication was prescribed and dispensed by the patient's general practitioner (GP). Any changes in medications were made in consultation with the renal consultant. These were communicated to GPs via electronic records. Staff within the unit did not prescribe medications. Where a faxed prescription was used, the original was hand delivered to the clinic within 24 hours and we saw evidence of this in patient notes.
- Staff were trained on the safe administration of medicines including intravenous medicines. We reviewed staff competency files and saw all staff had received this training.
- The provider had a 'medication preparation and administration' policy to ensure staff safely prepared and administered medication in relation to the patient's haemodialysis treatment. However, the policy was not fit for purpose. This policy was not specific to the UK regulations and good practice guidance and lacked scope and detail. The policy did not specify a review by date or detail any reference documents to assist staff in safe medicines

preparation and administration. However, during our inspection we observed staff administering medicines in line with the Nursing and Midwifery Council (NMC) standards for medicines management. All staff appropriately checked the identification of the patient before administering medicines. This included; checking the patient's photo in the medical record and confirming the patient's name, date of birth and any allergies with the patient.

- Patient group directions (PGDs) were used during dialysis treatment for established renal failure (ERF) patients by registered nurses who had been assessed as competent to administer for example, low molecular weight heparin andtrisodium citrate (used to stop blood clots forming in the tubes of the dialysis machine). PGDs allow some registered health professionals (such as nurses) to give specified medicines to a predetermined group of patients without them seeing a doctor. We saw, in staff training files, where staff had been assessed as competent.
- Patient specific written directions (PSDs) for drug administration to ERF patients included sodium chloride 0.9%. Sodium chloride injection 0.9% was used to flush fistula needles prior to the commencement of haemodialysis and/or to maintain blood pressure throughout haemodialysis.
- Protocols and directions for PGDs and PSDs were stored within the patient's paper records and included a start date, consultant signature and date of signing. We saw completed records in the patient records we reviewed.
- The medicines procedure was checked against the prescription chart at the end of completion of dialysis treatment and documented on the patient's dialysis record sheet. We reviewed four dialysis record sheets and saw where the medicines procedure had been consistently documented.
- Drug prescriptions were audited monthly as part of the patient documentation audit. Results were reported at the monthly contract review meeting with the referring NHS trust. Results for the reporting period January 2017 to June 2017 showed a compliance rate of 97%.

Records

- Patient's individual care records were written and managed in a way that protected patients from avoidable harm. We reviewed four patient care records during this inspection and saw records were accurate, complete, legible and up to date. Records were stored securely in a locked room when not in use.
- Individual patient care records included for example, a patient referral/admission document, a consent form, patient specific risk assessments, a copy of the monthly blood results, multidisciplinary review notes, evidence of a dietetic review and any NHS clinic letters. We reviewed four patient care records during our inspection and saw where an evaluation of care, including risk assessments had taken place following each treatment.
- Recommended use of concentrates, water specification treatment systems, chemical and microbiological contaminants, type and use of dialysis membranes and frequency of dialysis were indicated by the consultant nephrologist from the referring NHS trust. These were documented on the patient's dialysis prescription, stored within the patient's care record.
- The clinic used a combination of paper and electronic records. In addition, staff had access to the referring NHS trust's electronic patient care records. However, at the time of our inspection the trust's electronic system did not communicate with the provider's electronic database. This meant staff had to input patient data twice to ensure the referring trust had access to the patient records at all times. Staff described this process as "time-consuming" but did tell us developments were in place to facilitate the sharing of data between the two electronic databases. We were not given a timeframe for when this would happen.
- Consultant nephrologists from the referring NHS trust accessed patient records and blood results through their own electronic database. Staff at the clinic updated records at the end of each dialysis treatment. We observed this process during our inspection.
- 'Shared-care' competency checklists were available to support patients that for example, self-needled and we saw where these had been reviewed monthly by the patient's named nurse.

Assessing and responding to patient risk

- Risk assessments were carried out for patients and risk management plans developed in line with national guidance. For example, we saw evidence of risk assessments for falls, pressure ulcers, malnutrition, diabetes and venous needle dislodgement (VND). Risks were managed positively and updated appropriately where a change in the patient's condition had arisen.
- The clinic did not currently use a nationally recognised early warning scoring system to monitor deterioration in the patient's condition. Observations, including temperature, blood pressure and heart rate were recorded on the patient's daily dialysis record sheet at the start, during (hourly) and at the end of dialysis. The patient's weight was recorded at the start and end of treatment.
- At the time of our inspection the clinic staff were in the process of receiving training on the national early warning scoring system and sepsis management and treatment. Nursing staff followed the referring NHS trust's sepsis policy and procedure and we saw guidance on both visibly displayed throughout the clinic.
- During the first day of our inspection we observed staff responding appropriately to two patients where their physical health was deteriorating. This included for example, increasing the frequency of observations, liaising with the referring NHS trust and arranging the emergency transfer of one patient to a nearby acute NHS trust.
- Procedures were in place to assess patients with blood borne virus (BBV) conditions such as for example, hepatitis B and C. These included routine testing of susceptible patients in line with best practice guidelines, screening patients three-monthly for BBV and screening arrangements for those patients returning from holiday in 'high risk of infection' regions. All patients new to the clinic were tested for hepatitis B surface antigen (HBsAg) and antibodies to hepatitis B surface antigen (anti-HBs).
- Specific processes were not in place to manage challenging behaviours for example, acute confusion, delirium or worsening dementia. However, staff we spoke with appeared knowledgeable about the level of care needed to support these patients and gave examples of encouraging carers to attend with the patient, avoiding the use of side-rooms to ensure high visibility of the patient and providing enhanced observation.
- During our inspection we noted a patient, at the end of their dialysis treatment, who had complex health needs. The patient had been placed in a side room for their dialysis treatment. We were not assured this patient had been cared for in an appropriate place and had been protected from avoidable harm. The patient call bell system was not in use and we did not see a risk assessment in place to guide staff should this patient have required assistance. We raised this immediately with the registered manager who told us they would remind staff to consider the appropriate placing of patients before commencing their dialysis treatment. Information received following our inspection told us the 'interim' clinic manager had reviewed the allocation of all patients and had moved some patients to ensure vulnerable patients were nursed in the main bays and in view of the nurse station.
- Staff recorded an assessment of the patient pre and post dialysis within the patient's paper care records. This included the start and finish time of treatment, a summary of the patient during treatment and a final evaluation of the patient following treatment. In addition, staff would enter the same information on the patient's electronic care records for both the location and the referring NHS trust.
- We did not see a policy in the clinic for the positive identification of patients. Information received following our inspection confirmed the provider did not have a specific policy referring to the identification of patients. Staff were expected to refer to the Nursing and Midwifery Council (NMC) standards for medicines management. However, a photo of the patient was present in all the patient care records we reviewed and we observed staff taking appropriate action to positively identify the patient prior to the start of treatment. This included, checking the photo and asking the patient to confirm their name and date of birth.
- Patients did not receive blood transfusions at this unit. Where a blood transfusion was required this would be carried out at the referring NHS trust.

- Nursing staff followed the referring NHS trust's transfer policy for patient transfers to the trust; this included a 'patient transfer sheet' used to document important information regarding the patient's physical health. The checklist included for example, blood borne virus status, cognitive state, relevant risk assessments and reason for transfer.
- The arrangements for emergency patient care for example, cardiac events, was directly via the local ambulance trust. Staff in the clinic had appropriate basic life support training and all necessary emergency equipment was available on site.
- Peritoneal dialysis was not carried out at this clinic. Peritoneal dialysis (PD) is a type of dialysis that uses the inside lining in a person's stomach as the membrane through which fluid and dissolved substances are exchanged with the blood.

Staffing

- A roster management policy and duty roster procedure was in place and underpinned the organisational 'workforce planning framework'. This enabled the clinic to effectively maintain safe staffing levels and ensured there were sufficient numbers of suitably qualified, skilled staff to carry out daily tasks. The policy and procedure outlined how the headcount (actual number of staff on duty) and full time equivalent (FTE) numbers were to be calculated and managed at clinic level.
- The clinic manager was trained in rostering and used the headcount guidance tool to support with maintaining safe numbers. Business continuity plans were in place to guide the clinic manager when responding to changing circumstances. For example, sickness, absenteeism and workforce changes. Agency and bank nurses were used when required to maintain safe staffing levels.
- Without exception, every member of staff we spoke with, including the clinic manager, raised concerns regarding the staffing levels in the clinic. Concerns included the high use of agency, staffing skill mix, short-term secondments of staff from other units and a high turnover of staff. Turnover of staff refers to the numbers of staff leaving the organisation. Information sent to us following this inspection showed, between January 2017 and May 2017, the staff turnover at this clinic was consistently higher than the average turnover for the organisation as a whole. Two members of nursing staff told us they felt the high staff turnover was as a result of poor leadership within the clinic.
- The organisation had taken the appropriate steps to ensure that there were sufficient numbers of suitably qualified, skilled staff to carry out daily tasks. The referring NHS trust's contract recommendations were a 1:4 nurse to patient ratio in order to ensure that the patients' health and social welfare needs were safely met. We reviewed staffing rotas for the period 1 March 2017 to the date of this inspection. There was no time where the nurse to patient ratio was less than one nurse to four patients.
- The current establishment for Diaverum Dialysis Clinic – Lings Bar was one clinic manager, one deputy clinic manager, 4.7 whole time equivalent (WTE) registered nurses, two dialysis support workers and three health care assistants (HCAs). Administration was supported by one full time receptionist.At the time of our inspection there were two staff new in post and three (WTE) registered nurse posts vacant (including a deputy clinic manager post).
- The organisation had an internal bank of staff made up of experienced dialysis nurses. Staff shortfalls were covered by overtime within the clinic, overtime by staff from other clinics within the organisation, from the bank or, in exceptional circumstances, external agency.
- For the reporting period 1 January 2017 to 30 June 2017, the number of hours covered by external agency and/or bank staff was 1,714 hours. Overtime shifts covered by staff in the clinic equated to 128 hours.
- There were arrangements in place for using bank and agency staff in order to ensure appropriate staffing numbers at all times. All bank and agency staff, including staff from other clinics, completed a 'temporary staffing checklist' prior to commencing their first shift. Completed checklists were contained within a 'bank and agency induction folder'. Checklists included for example, proof of professional registration, mandatory training and an orientation of the clinic. During our inspection we saw checklists had been completed appropriately. Pre-employment

checks were carried out by the human resource (HR) department and requests were made to the nursing agency to provide proof of qualifications, a disclosure and barring service (DBS) check, basic life support (BLS) training, manual handling training and a minimum of one year renal experience and/or renal qualification.

- During this inspection we did not observe patient care to be compromised or unsafe as a result of the current staffing levels. Staffing levels were reported monthly to the referring NHS trust as part of the clinic's performance report. We reviewed the performance report for January 2017 to June 2017. At no time had the clinic not had a nurse to patient ratio of 1:4 as specified by the trust. During the same reporting period nine treatment times out of a total of 570, which equates to 1.6% of treatments, had been shortened in February 2017 as a direct result of staffing levels.
- Five patients raised concerns about staffing and felt the clinic was 'short staffed.' This appeared largely to affect the time it took for patients to be taken off dialysis. The service did not audit the time patients were taken off dialysis.
- The clinic manager had entered a risk regarding staffing on the clinic's risk register in April 2017 and we saw the completed template for this risk. However a risk register document dated May 2017 did not show this risk. We discussed this with a senior manager within the organisation who told us the risk had not been completed with the detail that the organisation would expect to see. For example, the detail of the risk was not descriptive and there were no mitigating actions suggested to reduce the risk. The clinic manager had been asked to update the risk. In the interim, a staffing action plan had been put in place to support the clinic.
- In May 2017 staffing at this clinic had been added as a 'major' risk to the organisation's risk register. A review of this risk register demonstrated where actions had been put in place to minimise the risk of avoidable harm to patients as a result of staffing levels. Actions included for example, regular communication with the referring NHS trust, the secondment of a deputy clinic manager and senior staff nurse from other locations within the organisation, additional support from the regional practice development nurse and a recruitment plan in place.
- There was appropriate provision in place for medical cover of the dialysis patients. This was provided by the consultant nephrologist based at the referring NHS trust. The clinic staff were able to access the referring consultant nephrologist by telephone, bleep and email. In the event the consultant was not available the staff were able to discuss patient concerns with an on-call renal consultant.

Major incident awareness and training

- The organisation had a business continuity policy which outlined guidelines and whatmeasures were to be put in place in the event of any unforeseen and/or unplanned business disruptions. In addition, the clinic had a tailored business continuity plan (BCP) which was kept at clinic level. This was easily accessible to all staff and included guidance on for example, power supply failure, water supply failure, loss of heating, staffing shortages and water treatment plant failure. The week before the first day of our inspection the clinic had experienced a water failure incident resulting in patients being transferred to the referring NHS trust for their dialysis treatment. We discussed this with staff who demonstrated actions had been appropriately carried out in line with the clinic's business continuity plans.
- In addition to the BCP there was an internal alert system which once activated sent immediate notification to the senior management team. This communication was done via email. The referring NHS trust was also notified of the events and contingency plans were agreed. Once the situation had been resolved, an investigation into the cause of the event was done along with improvement plans where the contingency/recovery procedure was found to be inadequate.
- Appropriate emergency equipment was available on the premises and staff demonstrated to us that they knew how to use the equipment. Training on the use of emergency equipment for example, the automated

external defibrillator (AED) was carried out as part of basic life support training. An AED is a portable device that checks the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm.

- During our review of patients care records we did not see evidence of personal emergency evacuation plan's (PEEP). A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency.
- On 27 June 2017 the Chief Executive of the Care Quality Commission wrote to care homes, hospices and independent hospitals, as well as their membership bodies, asking that they review their fire safety processes in their registered premises to ensure they were up to date and were being applied consistently in practice. Following this inspection we asked the clinic manager what action had been taken in response to this request. We were told an assessment of this location would be carried out by the NHS trust within which this location was based. We were not assured however, the clinic manager would follow this up with the trust.

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

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.

Evidence-based care and treatment

- Services, care and treatment were delivered and clinical outcomes monitored in line with and against the UK Renal Association Standards, National Institute for Health and Care Excellence (NICE) and the referring NHS trust's requirements. The Renal Association is the professional body for United Kingdom (UK) nephrologists (renal physicians or kidney doctors) and renal scientists in the UK.
- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. An audit was carried out annually to assess clinical practice in line with local and national guidance. A total of 26 indicators were measured and included for example, set up and priming pre-treatment, patient assessment, dialysis prescription, medication, cannulation techniques and connection process. Results from the September 2016 audit were largely positive with 19 out 26 indicators achieving a score of greater than 90% and the overall audit score achieving 94% compliance. We saw a total of 15 actions had been identified following this audit with one action incomplete at the time of our inspection.
- All staff used a 'wet-needling' approach when cannulating an arteriovenous fistula (AVF), this approach was also used for obtaining blood samples. Staff followed the referring NHS trust guidelines (guidelines for performing dialysis in established renal failure) when performing these procedures. In the 'wet-needling' technique the needle is purged of air and saline is used to flush the needle. When taking blood samples, in order to avoid contamination of the sample due to saline, once cannulated, the needle was flushed 10 times with the patient's blood using a 'pull back/flush' technique.
- Measures were in place for the continued assessment of a patient's vascular access. For example, monthly transonic flow monitoring was carried out on all arteriovenous fistulas (AVF). An AVF is an abnormal connection or passageway between an artery and a vein. Transonic flow monitoring measures blood flow through the fistula. Monitoring results were reported to the vascular access nurse specialist at the referring NHS trust through individual electronic patient care records.
- All staff monitored patient's vascular access as part of their pre-dialysis assessment and following treatment. We saw an assessment of the patient's vascular access included in all four patient care records we reviewed. This followed NICE Quality standard [QS72]: Renal replacement therapy services for adults. Where there were concerns identified regarding the patient's vascular access, the referring consultant nephrologist was contacted for advice.
- Timely creation of fistula access was the responsibility of the referring NHS trust's consultant nephrologist. At

the time of our inspection 83% (40 out of 48) of patients had an AVF with a further three patients in the process of having an AVF created. This was similar to Renal Association guidance of 85%.

- The clinic offered support to those patients who were dialysing 'away from base' for example, those patients requiring dialysis whilst on holiday. The clinic manager and organisation's holiday coordinator ensured that relevant information was gathered and reviewed in a timely manner. This included for example, a transfer letter from the referring consultant and NHS trust, bloods results, methicillin-resistant Staphylococcus aureus (MRSA) status, dialysis and medication prescriptions and arrangements for transport.

Pain relief

- Pain assessments were not undertaken at this clinic. Individual patients managed their own pain and were responsible for supplying any required analgesia.

Nutrition and hydration

- Nutritional assessments were visible in all four patient records we reviewed. Where required we saw care plans in place and appropriately reviewed.
- Patients had access to food and hydration while undergoing treatment. During our inspection we observed staff offering food and drinks. Staff told us this was offered once during a patient's dialysis session.
- The clinic was supported by a renal dietician from the referring NHS trust who attended and reviewed all patients monthly to assess and support nutritional intake and calcium phosphate management.

Patient outcomes

- The unit participated in the UK Renal Registry through the referring NHS trust. The UK Renal Registry is a resource for the development of patient care in renal disease. It provides a focus for the collection and analysis of standardised data relating to the incidence, clinical management and outcome of renal disease. Due to the inclusion with other units, the unit was not able to benchmark the effectiveness of the service against other providers.
- The two methods generally used to assess dialysis adequacy are urea reduction ratio (URR) and Kt/V. Renal Association (RA) guidelines recommend a patient's average URR should exceed 65% and a patient's average Kt/V should be at least 1.2. Monthly blood sampling was carried out and results were checked by the nursing staff. For June 2016 to May 2017, an average of 84% of patients achieved a URR of greater than 65%. For December 2016 to May 2017, 66% of patients achieved a Kt/V of ≥ 1.4.
- RA guidelinesrecommend that pre-dialysis haemoglobin concentration should be maintained within the range 10.5-12.5g/dl. For the reporting period December 2016 to May 2017, 64% of patients had a pre-dialysis haemoglobin concentration within this range. Haemoglobin is the iron-containing protein in red blood cells that transports oxygen in the body. Haemoglobin is used as a measure of anaemia management.
- Patient blood results were reviewed monthly by the referring NHS trust and discussed during the bi-monthly contract meetings held at the trust. Minutes we reviewed from meetings held with the referring trust demonstrated where discussions had taken place regarding the clinic's results and actions had been put in place where appropriate. We saw evidence which suggested the NHS trust had considered the performance results for this service in relation to for example, dialysis adequacy, alongside the demographics of the population the clinic served.
- Clinical performance measures (CPM) related to dialysis adequacy, nutrition, anaemia management and mineral and bone disorder had been set by the provider as a measure of the performance of individual units in relation to haemodialysis. For the reporting period October 2016 to December 2016 the clinic performed better than most other locations within the organisation and achieved an overall score of 86%.
- Renal Association (RA) guidelines recommend that the duration of thrice weekly haemodialysis in adult patients with minimal residual renal function should not be reduced below four hours without careful consideration. For the reporting period 20 February 2017 to 28 June 2017 a total of 24 individual patient treatments were shortened by between 25 and 60 minutes. Of these, 11 treatment were shortened at the

patient's request and eight were shortened due to nursing staff shortages. For the same reporting period 249 patients had been treated at this clinic and 3,034 treatments delivered in total.

- For the reporting period January 2017 to June 2017, the proportion of patient non-attendances for haemodialysis sessions was two out of 3,631 treatments.
- Actions plans were developed following audits and discussed at clinic meetings and performance meetings with the referring NHS trust to improve patient outcomes. For example, as a result of clotting issues during dialysis staff were reminded to check machine pressures as part of their hourly checks and where patients had requested to shorten their dialysis treatment time staff were asked to explain the benefits of receiving the full amount of dialysis to the patient.

Competent staff

- Staff training had not been carried out on the use of specific medical devices. We did not see evidence of staff training in the use of for example, weighing scales, intravenous volumetric pumps, blood pressure monitors, vascular access monitor and the electrocardiography (ECG) machine. At the time of our inspection the clinic manger told us staff had not received training in the use of these devices. However, all staff had received training and had been competency assessed in the use of the dialysis machines.
- All new starters attended an induction programme and had a supernumerary period where they worked under supervision of their mentor. The induction programme covered a wide range of mandatory training. For example, basic life support, fire safety, data protection, medicines management (registered nurses only), aseptic non touch technique and hand hygiene. In addition, staff completed dialysis specific competencies relevant to their role.
- All staff were required to complete a basic dialysis competency programme. This was made up of four modules and included for example, training in procedures such as catheter dressing, vascular access techniques and safe injection practices. In addition to training in the management of intravenous cannulae, staff also trained for tunnelled and temporary central lines, arteriovenous fistulas (AV) and grafts. Evidence of training and competency assessments were contained within each staff member's training file. Our review of three staff files confirmed this had taken place.
- However, not all staff felt they were supported or encouraged to develop in their role. Results from the February 2017 staff survey and more recent peer review suggested staff felt there were limited opportunities for further training.
- Staff received basic life support training annually as a minimum. At the time of this inspection 71% of staff were up to date with basic life support training.
- At the time of this inspection all staff had received up-to-date training on manual handling and fire safety.
- Sepsis training had recently been introduced at this location. Between May 2017 and the first day of our inspection six out of ten staff had completed this training and we saw where there were plans in place to train the remaining four staff.
- Appropriate training, development plans and competency assessments were in place. All staff were given an orientation and individual training plans developed. Staff training competency folders were supported by online learning modules.
- The renal nurse specialist from the referring NHS trust attended at least once a month to update staff with training and to communicate any new procedures.
- Staff training and development was supported by a practice development nurse who worked regionally across the Midlands area.
- Arrangements were in place for supporting and managing staff. This included one-to-one meetings, appraisals, coaching and mentoring, performance management, clinical supervision and revalidation. In the 12 months preceding our inspection all eligible staff had received an appraisal.
- Validation of professional registration with the Nursing and Midwifery Council (NMC) was monitored by the

organisation's human resource (HR) department and the clinic manager. Reminders were sent to all staff alerting them when their NMC registration was due for renewal.

- Understanding of the principles of drugs used, such as low molecular weight heparin, intravenous iron and erythropoiesis (red blood cell) stimulating agents were included in module two of the basic dialysis programme. Our review of staff files showed all eligible staff had completed this training. Annual on-going competency-based assessments to ensure staff were kept up to date were in place.
- Link nurses were identified in the clinic. For example, for falls, pressure ulcers, nutrition and Infection prevention and control (IPC). Link nurses were responsible for providing a monthly update to the nursing team through email or the team meetings. We saw where an update had been provided by the falls link nurse in June 2017 informing staff of those patients 'at-risk' of falls.
- At this location one nurse had completed an accredited advanced renal course.

Multidisciplinary working

- Communication with the patient's general practitioner (GP) and any other service outside the trust network was carried out by the consultant nephrologist.
- The clinic followed the referring NHS trust's escalation policy for a patient with sepsis who required immediate review. This included close monitoring of the patient's observations and oxygen levels, requesting emergency ambulance for immediate transfer to the trust's emergency department and discussing the patient with the referring trust's renal unit.
- Diaverum dialysis clinic – Lings Bar was a 'nurse-led' dialysis unit. Overall responsibility for the patients care lay with the patient's consultant nephrologist at the referring NHS trust.
- The clinic worked closely with the referring NHS trust. It was a nurse led clinic with weekly visits by the consultant nephrologists and monthly multidisciplinary (MDT) meetings with the consultants, clinic manager and dietician. The wider MDT included a psychologist, community team and the vascular access team. Staff within the clinic had direct access to the trust's electronic data base allowing for ease of access to all relevant patient information and referrals. Daily communication with the trust was through NHS emails.

Access to information

- Staff accessed standard operating procedures, policies and protocols in paper format in the clinic, through the provider integrated management system (IMS) and through the referring NHS trust's intranet. All staff were aware of how/where to access policies.
- We reviewed ten paper policies in the clinic; all had a review date that had expired with the oldest date being October 2015. We raised this immediately with the clinic manager. Information received following our inspection showed seven out of ten policies sent to us were in date with a review date specified.
- However, three policies sent to us had no review date specified; policy number 3008 'Medication preparation and administration' had a last review date of 16 December 2015. Policy number 3002.01 'Standard HD Medications Ordering, Storage and Disposal' had a last review date of 16 April 2014. Policy number 3006.01 'Administration of Intradialytic Parenteral Nutrition (IDPN)' had a last review date of 13 March 2014. We could not be assured therefore that these policies reflected evidence based guidance or that the content had been reviewed in line with current national guidance.
- All patient records were available in both electronic and paper format. The organisation had an international renal information management system. The referring NHS trust had their own electronic patient record (EPR) system. All staff who delivered patient care had a confidentiality agreement in place with the referring trust. This allowed staff access to the EPR system. EPR provided access to all patient information and was visible to the multidisciplinary team. This system allowed all staff involved in the delivery of patient care to have access to view blood results and clinic letters and to follow up and monitor the progress of the patient.
- Paper/manual records were available in the clinic as a patient file and contained all information relevant to deliver effective, safe patient care.

- Changes made at multidisciplinary (MDT) meetings were communicated by letter to the patient's GP. Letters received into the clinic from outside agencies were forwarded to the referring NHS trust's consultant secretary to be entered onto the trust's electronic patient record system.
- In the event of an emergency and where a decision about changes to care and/or prescription needed to be made with immediate effect, the on call registrar was contacted as per the referring NHS trust's protocol and escalation pathway.
- All communication, referrals and changes to care were visible to all staff via the trust's EPR system.

Consent, Mental Capacity Act and Deprivation of Liberty

- Staff demonstrated to us a good understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. Mental Capacity Act awareness training was a mandatory training requirement for all staff. At the time of this inspection all staff had completed this training.
- A consent policy written in line with national guidance was available to all staff. We reviewed four patient care records and saw all patient records included a consent to treatment record. We observed staff obtaining verbal consent from the patients during the course of their treatment.
- During the time of this inspection there were no patients who lacked capacity to make decisions in relation to consenting to treatment. Where a patient lacked the mental capacity to give consent, guidance was available to staff through the provider consent policy. In addition to this staff told us they would encourage a patient to be accompanied by a family member or carer for support. If required the unit had access to an external interpreting and/or translation service for those patients whose understanding was limited due to a language barrier.
- Staff told us of one patient receiving treatment at this clinic who had 'fluctuating' capacity. In this instance the relative would be contacted and encouraged to attend the clinic with the patient for support and staff would follow the provider policy on consent for guidance.
- Staff were knowledgeable about protecting the rights of patients and staff demonstrated to us their regard to the Mental Health Act (MHA) Code of Practice.
- Medical advance planning and end of life care decisions were made jointly with the patient and the referring consultant nephrologist. Staff told us where advance decisions were in place this would be communicated to the clinic.

Are dialysis services caring?

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.

Compassionate care

- Patient satisfaction was formally measured through a six-monthly patient satisfaction survey. Results from the October 2016 patient satisfaction survey showed an overall patient satisfaction score of 88%. This score was worse than the clinic's previous score of 92% in March 2016 and similar to patient satisfaction scores received at other clinics within the organisation.
- Patient privacy and dignity was maintained at all times. Patients received treatment in shared bays. Privacy screens were available in the event of an emergency to maintain the patient's dignity during any emergency treatment or when required to maintain privacy at any other time. We observed the use of privacy screens during this inspection.
- We observed there was provision for patient comfort. For example, single sex toilet facilities, dialysis chairs and pressure relieving aids. Staff told us they were also able to accommodate a hospital bed when required.
- During this inspection we observed all staff treating patients with dignity, kindness, compassion, courtesy and respect. Staff introduced themselves prior to the start of a patient's treatment, interacted with patients and were inclusive of patients during general conversation.

- Staff demonstrated an understanding and respect of patient's personal, cultural, social and religious needs and we observed staff take these needs into account when delivering care. For example, celebrating important events with patients and encouraging a relative to attend with a patient whose first language was not English.
- During this inspection we spoke with 14 patients about various aspects of the care they received at this clinic. Without exception feedback was consistently positive about the nursing staff delivering day to day care. However, four patients raised concerns regarding the leadership of the clinic describing it as, "chaotic" and "obstructive." Feedback regarding other aspects of care at the clinic was mixed. Four patients raised concerns regarding transport and three patients raised concerns regarding delays either starting or finishing their treatment.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understood their care, treatment and condition. All patients were allocated a named nurse who was responsible for agreeing and sharing with patients their care plan. The named nurse met with their individual patients at least once a month. During this meeting they discussed for example, routine blood results, consultant multidisciplinary meeting outcomes, current medications, the patient's dry weight and blood pressure control, the patient's current care plan and any holiday plans. All the patients we spoke with were aware of their named nurse and confirmed to us regular discussions took place.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. This included for example, access to interpreting and translation services. During this inspection we observed staff interacting positively with the relative of a patient whose first language was not English.
- Patients and those close to them were able to find further information or ask questions about their care and treatment during their monthly meeting with their named nurse and as part of their clinic appointment with their consultant nephrologist. A wide range of dialysis specific leaflets were also available to patients and patients we spoke with confirmed they had, at some time during their treatment, accessed such leaflets.
- The clinic was Wi-Fi capable and patients could access the internet or 'Patient View' through the use of a computer tablet. Patient View allows renal patients to view their latest test results online, along with clinic letters and information about diagnosis and treatment.

Emotional support

- Patients had access to a renal social worker or renal psychologist through the referring NHS trust. All the patients we spoke with were aware of this support but none had requested it, citing the nursing staff as their main avenue for accessing emotional support.
- As part of their monthly meeting with their named nurse patients had an opportunity to discuss any additional support they needed or how they were feeling generally.
- We spoke with the nursing staff about providing emotional support for patients. Staff felt they were able to signpost patients appropriately if necessary and saw recognising and providing support to patients as an important part of their job.

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

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.

Meeting the needs of local people

- Information about the needs of the local population and the planning and delivery of services was agreed collaboratively with the referring NHS trust and local

commissioners. The clinic provided services through a contractual agreement with the referring trust and did not have direct communication with the commissioners.

- Progress in delivering services against the contractual agreement was monitored by the referring NHS trust through key performance indicators, regular contract review meetings, and measurement of quality outcomes including patient experience.
- The unit met the recommended practice for haemodialysis facilities: Health Building Note 07-01: Satellite dialysis unit. For example, the unit was located on the ground floor and had its own dedicated entrance, the entrance was easily accessible to patients using wheelchairs or walking aids and dedicated parking spaces, including disabled parking spaces, were available.
- Access to the clinic was by established routes, with a bus stop at the end of the road. Most patients used hospital arranged transport to and from the clinic. A small number of patients used private transport.
- The clinic did not have a transport user group. Transport was provided by an external provider under a service level agreement. The clinic receptionist maintained a monthly log of any transport concerns however, this had not been maintained for several months prior to this inspection. Data had been collected for May 2017 and showed eight concerns had been identified. The clinic manager told us a meeting was due to be arranged with the transport provider but that this had not yet been arranged. Concerns identified at clinic level were escalated to the referring NHS trust 'transport improvement team' through the bi-monthly contract meetings.
- The National Institute for Health and Care Excellence (NICE) quality standard (QS72) states adults using transport services to attend for dialysis are collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis. The service did not collect data to monitor transport services against this standard. NICE guidance suggests, patient transport is an essential part of patient experience for adults receiving hospital or satellite-based dialysis, which requires frequent travel between their home and the treatment centre. Poor transport can undermine good dialysis care and can have a major impact on a person's quality of life.

Service planning and delivery to meet the needs of individual people

- Services were planned to take account of the needs of different people, for example, on the grounds of age, disability, gender and race. For example, staff could access interpreting services for patients who did not speak or understand English, patient information leaflets were available in the clinic including information on how to raise a concern or complaint and could be translated into languages other than English as required and access to the clinic was sensitive to the needs of those patients living with a disability.
- The Accessible Information Standard (NHS England) aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read and understand and with support so they can communicate effectively with health and social care services. We saw many examples of where care was delivered in a way that demonstrated regard for the needs of individual patients. For example, a patient with a hearing impairment and a patient whose first language was not English.
- Our review of four patient care records demonstrated to us where staff had considered individual patient needs for example, age, disability, race and religion or belief. This meant discrimination was avoided when making care and treatment decisions.
- There was provision for patients attending for haemodialysis to be able to visit the toilet before dialysis commenced with the toilets being located within close proximity of the clinical area. We observed nursing staff providing assistance. During our inspection we saw a patient with the need for regular toilet visits nursed in a side room with a dedicated toilet.
- Services were planned, delivered and coordinated to take account of people with complex needs, for example those living with dementia or those with a learning disability. Staff told us of one patient

receiving treatment at this clinic who had a learning disability. In order to maintain regular communication with the patient's relative a communication book was in place where any concerns would be documented and discussed with the relative at the earliest opportunity. For those patients living with dementia the clinic manager was in the process of introducing the 'all about me' booklet. We saw booklets available in the clinic but this had not yet been started nor were we made aware of when it would start. All about me is a resource for people with dementia to tell healthcare providers about themselves, their needs, likes, dislikes and interests.

- Individual televisions and computer tablets were available during a patient's dialysis session and patients were encouraged to bring in personal items of equipment or pillows or blankets to aid their comfort.
- Arrangements were in place to support patients to go on holiday in the United Kingdom (UK) and/or abroad. Holiday plans were discussed as part of the patient's monthly meeting with their named nurse. Patients would identify a dialysis unit at the location they wished to visit and make the initial contact. The chosen unit would contact the clinic where staff would then make the necessary arrangements for the patient to receive dialysis treatment whilst on holiday. Most of the patients we spoke with had dialysed 'away from base' at some time during the course of their illness and all described the clinic staff as being "very helpful" in arranging the details.
- Services were planned so that patients could participate in their own care. For example most patients measured their own weight, one patient was involved in self-needling and one patient set up their trolley prior to their dialysis treatment commencing. Self-needling means that the patient put the dialysis needles into their own fistula. 'Shared-care' competency checklists were available to support this and we saw where these had been reviewed monthly by the patient's named nurse.
- Arrangements for those patients who might need additional counselling were available through the renal psychologist at the referring NHS trust.

Access and flow

- A range of haemodialysis sessions were available taking into consideration the working, cultural and family responsibility needs of the patients currently receiving treatment at the clinic. Dialysis sessions were available Monday, Wednesday and Friday 6.15am to 11pm and Tuesday, Thursday and Saturday 7.30am to 6.30pm. Staff and patients told us of times when sessions would be changed to accommodate a patient's individual circumstances. However, one patient raised concerns with us and told us they had been waiting over six months for a 'morning slot.'
- The average level of utilisation of capacity in the clinic for January 2017? to June 2017 was 92%. This meant the clinic did not have a surplus of available capacity.
- Referrals to the clinic for dialysis treatment came through the consultant nephrologist at the referring NHS trust. Where there was no capacity to accept the referral, the patient was placed on a waiting list. At the time of our inspection there were four patients on the waiting list for dialysis treatment.
- When a patient was identified as requiring dialysis treatment at this clinic the referring NHS trust would accommodate the patient until a permanent slot could be made available. However, due to high demand on the service and limited availability, patients could be sent to another dialysis clinic for an undetermined period of time. There was constant communication between the consultants, lead renal nurse and the clinic about which patients should receive priority once there was capacity. Options for increasing capacity, development of new facilities and exploring other methods of increasing capacity were reviewed periodically and capacity discussions took place on a regular basis with the referring NHS trust. For example, during a period of low capacity and following a capacity review with the trust, the clinic had recently been able to provide dialysis treatment to an additional eight patients.
- For the reporting period January 2017 to June 2017, 94% of patients were treated within 30 minutes of their appointment times for treatment. The location did not monitor the waiting time for patient transport after the end of haemodialysis. Information received following our inspection cited transport delays and staffing as the main causes of delays to treatment.

- There were no planned dialysis sessions cancelled for a non-clinical reason in the 12 months preceding this inspection.
- Generally, patients were informed of any delays or disruption to their treatment verbally by the nursing staff. Three patients we spoke with raised concerns about delays and told us they were aware of the reason for the delay but were not always aware of how long the delay would last for.
- The clinic had a dedicated consultant who visited the clinic every week. These visits were to conduct planned clinic appointments for patients but offered the flexibility of seeing additional patients if requested.

Learning from complaints and concerns

- Complaints posters and leaflets were visible in the clinic waiting area in addition to information leaflets about other organisations such as the Kidney Patient Association (KPA) and the referring NHS trust's complaints management system. Most of the patients we spoke with were aware of how to make a complaint.
- When a patient was transferred to this service, both the patient and family received a patient booklet that included information about the clinic's complaints policy and procedure. Patients we spoke with confirmed they had received this.
- Feedback boxes were available in the patient waiting area. These were designed for patients or family members who wished to remain anonymous.
- A complaints policy and procedure was in place. The complaints procedure had a five-staged approach to complaints; receive, record, process, respond and report and outlined the timescales appropriate to raise/resolve them and provided an escalation procedure in order to progress complaints that were not resolved in the initial stages. All complaints were reviewed during the clinic manager's one to one meeting with the area manager and discussed at the bi-monthly contract meetings with the referring NHS trust.
- The service monitored verbal and written complaints. For the reporting period January 2017 to June 2017 the service received one written and two verbal complaints. In line with the organisation's complaints procedure all three complaints were investigated by the clinic manager. Feedback from complaints, including lessons learned, was shared through staff meetings. Minutes we reviewed demonstrated where shared learning had taken place. For example, following a complaint raised regarding communication between the clinic and a local NHS trust a communication/transfer sheet had been put in place.
- The clinic did not have an active 'patient user group'. A patient user group consists of a number of patient representatives who meet to share their views to positively influence change.

Are dialysis services well-led?

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.

Leadership and culture of service

- The clinic was led by a clinic manager (the registered manager), supported by a regional practice development nurse, area manager and nursing director.
- The registered (clinic) manager at the time of our inspection had been in post since August 2014. However, we were formally notified before our inspection that the registered manager would no longer be in post from 11 August 2017. The registered manager of the unit was a registered nurse with experience in renal nursing and a formal renal qualification.
- Following our inspection we asked the provider to tell us what plans were in place to provide managerial support at this location. We were told, a member of staff, with previous experience as a clinic manager and also an area manager, was to commence in post for a two-month period on 10 July 2017 whilst recruitment for a permanent clinic manager was underway, this was to be extended if required. Additional support was also being provided to the clinic by another clinic manager from within the organisation.

- Throughout this inspection we observed staff who were passionate about delivering high quality care and this was reflected in the patient feedback received. However, staff morale was 'low' and the team appeared 'fragile.' Feedback from patients and staff was mixed with recurring negative reference to the leadership of the clinic. During the inspection we noted there had been a high turnover of staff in the last year. A recent peer review carried out by clinic managers from other locations within the organisation also identified concerns around the leadership of the clinic.
- The clinic manager was supported by a regional area manager. One to one meetings for the clinic manager were held monthly with the area manager. Feedback from senior managers, including the clinic manager, suggested a 'disconnect' between the level of support the clinic manager felt they had received and the level of support the organisation felt they had provided. We saw evidence to suggest support had been put in place to address for example, staffing issues and saw where personal objectives had been put in place for the clinic manager. However, actions identified had only been in place since November 2016. Feedback from the clinic manager suggested concerns around staffing had been raised over a much longer period of time.
- The clinic manager described a good working relationship with the referring NHS trust. This was supported by information received from the referring trust before this inspection. We received information from the referring trust describing the service as well led from a quality and performance perspective. However, concerns were raised in relation to the clinic manager undertaking a lot of clinical sessions because of vacancies which, they felt, limited the clinic manager's ability to effectively manage the team.
- The clinic manager appeared focussed on the team delivering the quality of care that reflected the purpose of the organisation. They demonstrated an understanding of performance and patient outcomes. However, there were inconsistencies between what the clinic manager told us and what was actually happening. This suggested the clinic manager did not have oversight of the clinical practice in the unit or the required skills to undertake their role. For example, whilst they recognised the current staffing issues as a challenge to good quality care they were unable to articulate to us actions that had been put in place to address them. Assurance that staffing issues had been appropriately addressed was provided to us after our inspection by a more senior member of staff within the organisation.
- Clinic staff described senior leaders within the organisation as visible and approachable and felt confident in raising concerns.

Vision and strategy for this core service

- There was an organisational vision, developed by the provider, in place for the clinic, to be "the first choice in renal care." This was supported by three organisational values: competent, inspiring and passionate and an overarching organisational mission to "improve the quality of life for renal patients." We saw the vision and values displayed in the staff room.
- The organisational vision and values were discussed by the area manager at individual clinic team meetings. Although the team minutes we reviewed did not demonstrate where these discussions had taken place, staff we spoke with confirmed discussions had taken place and were able to talk to us about their understanding of the vision and values.
- We observed staff to mostly demonstrate the values of the organisation. Without exception all staff were clearly passionate about delivering a good service. However, feedback from some staff and patients suggested a lack of confidence in the leadership of the clinic and we identified concerns around the competencies of staff with regards to the use of some medical devices.
- A strategy for achieving the organisation's mission included; focussing on improving the quality of life for patients, implementing patient care coordination in clinics, pursuing operational efficiency, increasing the number of clinics and being a great place to work. Progress against delivering the strategy was monitored and reviewed through for example, clinical audit, clinical performance measures and patient and staff feedback.
- Staff demonstrated to us a good understanding of the organisation's strategy and we observed aspects of

their day to day work that contributed to achieving the strategy. For example, delivering care in line with national guidance and standards, achieving good outcomes for patients and working effectively as a team.

- The clinic worked closely with the referring NHS trust and through reporting and monitoring of key performance indicators, regular contract review meetings, and measurement of quality outcomes including patient experience, ensured the organisation's strategy aligned to that of the referring trust.

Governance, risk management and quality measurement

- The organisation had systems in place for quality assurance and clinical governance that included; risk assessments, auditing and monitoring, training and development and work-force planning. However, locally, governance and risk management processes were not effective. There were inconsistencies between what the clinic manager told us and what was actually happening which suggested the clinic manager did not have an oversight of the unit. For example, with medical device training and the current position of the dialysis machines.
- A risk register was held at a local level and maintained by the clinic manager. Risks were rated depending on their significance and subsequent mitigating actions were identified. The clinic manager told us a risk regarding staffing had been entered on the risk register in April 2017 and we saw the completed template for this risk. However a risk register document dated May 2017 did not show this risk. We discussed this with a senior manager within the organisation who told us the risk had not been completed with the detail that the organisation would expect to see. For example, the detail of the risk was not descriptive and there were no mitigating actions suggested to reduce the risk. The clinic manager had been asked to update the risk. In the interim, a staffing action plan had been put in place to support the clinic. The risk register had two further active risks identified; healthcare professional recruitment and staff training.
- Without exception, every member of staff we spoke with, including the clinic manager, raised concerns regarding the staffing levels in the clinic. Concerns included the high use of agency, staffing skill mix, short-term secondments of staff from other units, high turnover of staff and poor leadership within the clinic. We saw the provider had taken the appropriate steps to ensure that there were sufficient numbers of suitably qualified, skilled staff to carry out daily tasks. However, we were not assured appropriate steps had been taken to address morale within the unit.
- We were not assured there were effective arrangements in place for always identifying, recording and managing risks. Concerns identified by the inspection team had not been identified on the risk register nor did the clinic manager have an awareness of our findings. For example, consideration had not been given to the training of staff in safeguarding children and young people, we could not be assured some policies reflected evidence based guidance or that the content had been reviewed in line with current national guidance, staff training had not been carried out on the use of specific medical devices, a dialysis machine identified on the first day of our inspection was overdue for service.
- At our unannounced inspection the machine had not been serviced but remained in patient use. In addition the clinic manager was not aware of the replacement programme for these machines and the provider 'medication preparation and administration' policy was not fit for purpose. This policy was not specific to the UK regulations and good practice guidance and lacked scope and detail. The policy did not specify a review by date or detail any reference documents to assist staff in safe medicines preparation and administration.
- We formally wrote to the provider, following this inspection, asking them to confirm what training staff had received in the use of specific medical devices and if the dialysis machine that had been overdue for service had been serviced. Information received confirmed staff had not been trained. In order to address this the provider submitted an action plan with plans to train relevant staff by 1 August 2017. In the interim period staff were trained and competency

assessed by the interim clinic manager as and when they were to use a specific medical device and an individual risk assessment was to be carried out. The dialysis machine had been serviced on 14 July 2017.

- The interim registered manager updated us on medical device training on 11 August 2017. As of this date all staff had been trained and competency assessed to use the blood glucose monitor, all but one member of staff had been trained to use the ECG and intravenous volumetric pump machines and three staff required training and a competency assessment to use the weigh scales.
- The lead for governance and quality monitoring at this location was the clinic manager. The lead for clinical governance was the lead consultant nephrologist from the referring NHS trust. Working arrangements with the trust were managed through a monthly performance report that included; patient access, morbidity and mortality, patient safety, patient and staff experience, clinical audit and water surveillance. Bi-monthly contract meetings were held at the trust and attended by the clinic and area manager. Minutes we reviewed from meetings held with the referring trust demonstrated where discussions had taken place regarding the clinic's monthly performance report.
- Clinic manager meetings were held six-weekly with the nurse director. This was an opportunity to share information across locations, discuss 'local' performance and receive any organisational updates, minutes we reviewed for October 2016 and January 2017 demonstrated where discussions and shared learning had taken place. However, there had been no attendance at either meeting by the clinic manager from this location, on one occasion this had been due to staffing issues in the clinic, and minutes for the February 2017 meeting had not been made available to us. We could not be assured the clinic manager had sufficient oversight of shared learning or performance across the organisation which might have been relevant to this clinic.
- We saw a comprehensive assurance system in place with service performance measures, which were reported to, and monitored by, the referring NHS trust. For example, an audit was carried out annually to assess clinical practice in line with local and national guidance, the unit participated in the UK Renal Registry through the referring trust and clinical performance measures (CPM) had been set by the provider as a measure of the performance of individual units in relation to haemodialysis. Where non-compliance had been identified we saw appropriate action plans in place to improve performance.
- Staff meetings were held within the clinic bi-monthly. We reviewed four sets of minutes for these meetings and saw where discussions around incidents, performance and risk had taken place. However, risks we identified during this inspection had not been previously recognised.

Equality and Diversity

- All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. A WRES report was not produced at this location.

Public and staff engagement

- The service engaged with the British Kidney Patient Association (BKPA) advocacy service. Information received before our inspection described a well led service and patients were receiving safe care that was responsive to their needs.
- The clinic actively engaged with staff and patients as part of their continuous quality improvement. Processes in place to foster engagement included; an external six-monthly patient survey, direct access for patients to senior managers, suggestion boxes and feedback cards, engagement with local, regional and national BKPA advocates and an annual staff engagement survey.
- Results for the February 2017 staff survey showed an overall score of 3.9 out of possible score of 5. The clinic scored lowest (2.9) for, "The company supports my training and development plan" and highest (4.4) for "In my daily work, I contribute to the achievement of the company goals". The staff survey also gave staff the opportunity to add personal comments. Positive

comments included for example, the leadership of the clinic, the working environment, communication and feeling valued. Negative comments included for example, staffing levels, lack of motivation and leadership of the clinic.

- Staff we spoke with understood the value of raising concerns and, on the whole, felt appropriate action was taken as a result of concerns raised. Following our inspection we received a copy of the action plan developed as a result of the recent staff survey. We saw where actions had been identified for all concerns raised. However, as of 1 July 2017 none of the actions had a 'due date' and none had been completed. We could not be assured therefore, that concerns identified as a result of the staff survey would be addressed in a timely manner.

Innovation, improvement and sustainability

- In order to raise morale within the clinic and encourage appreciative, supportive relationships amongst staff the clinic manager had developed a 'staff of the month' board. Patients and staff were asked to nominate individuals where they felt the individual had 'gone the extra mile'. This had been recognised by the area manager as good practice and plans were in place to share it throughout the region.
- Service delivery was reviewed periodically and capacity discussions took place on a regular basis with the referring NHS trust. During a period of low capacity and following a capacity review with the trust, the clinic had recently been able to provide dialysis treatment to an additional eight patients.
- Staff were focused on continually improving the quality of care delivered through a comprehensive programme of audit which included for example, treatment adequacy, infection control, vascular access, documentation and patient satisfaction.
- Renal Association guidelines suggest that machines should be replaced between seven and ten years' service or after completing between 25,000 and 40,000 hours of use for haemodialysis, depending upon an assessment of machine condition. All 15 dialysis machines in use in the clinic had completed less than 25,000 hours of use. The clinic manager was not aware of the replacement programme for these machines.
- The provider had developed a patient app to empower patients to take an active role in their health. The 'd.CARE' app gave patients 24-hour access to their medical data. The tool also included non-medical features to increase the user experience. Patients would, for example, be asked how they were feeling at the same time each day. They could then rate their general condition, add notes as to why, and cross-check information against their medical data from previous months. Staff at this clinic were actively encouraging patients to use this app and we saw information leaflets throughout the clinic. We did not speak to any patients who were currently using the app.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff receive training in safeguarding children and young people in line with intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff that have any contact with children, young people and/or parents/carers should be trained to level two.
- The provider must ensure staff receive training on the use of specific medical devices; weighing scales, intravenous volumetric pumps, blood pressure monitors, vascular access monitor and the electrocardiography (ECG) machine.
- The provider must ensure the arrangements for governance and performance management operate effectively.
- The provider must ensure policies are in date and have a review date specified in order that policies reflect evidence based guidance and that the content had been reviewed in line with current national guidance.

Action the provider SHOULD take to improve

- The provider should ensure the call bell system is in full working order.
- The provider should ensure specific processes are in place to manage challenging behaviours for example, acute confusion, delirium or worsening dementia.
- The provider should ensure personal emergency evacuation plan's (PEEP) are in place in order to safely evacuate patient's from the clinic in the event of an emergency.
- The provider should consider collecting data to monitor transport services against the National Institute for Health and Care Excellence (NICE) quality standard (QS72): adults using transport services to attend for dialysis are collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis.
- The provider should consider having an active 'patient user group'.
- The provider should consider collecting, reporting, monitoring and publishing their WRES data and take action where needed to improve their workforce race equality.
- The provider should consider the use of a pain assessment tool to assess and manage the pain of individual patient's.

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 12 (1) (2) (e): Care and treatment must be provided in a safe way for service users, the things which a registered person must do to comply include: ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way. **How the regulation was not being met** Staff training had not been carried out on the use of specific medical devices; weighing scales, intravenous volumetric pumps, blood pressure monitors, vascular access monitor and the electrocardiography (ECG) machine.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (2): Systems and processes must be established and operated effectively to prevent abuse of service users **How the regulation was not being met** Staff had not received training in Safeguarding Children and Young People (Level 2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

17 (1) (2) (b): Systems or processes must be established and operated effectively, such systems or processes must enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

How the regulation was not being met

- Effective arrangements were not in place for identifying, recording and managing risks.
- Some provider policies did not have a review date specified in order that policies reflected evidence based guidance and that the content had been reviewed in line with current national guidance.
- An effective plan was not in place for the servicing of dialysis machines in addition to, a replacement programme in line with Renal Association guidelines.
- The 'medication preparation and administration' policy was not specific to the UK regulations and good practice guidance and did not include reference documents to assist staff in safe medicines preparation and administration.
- The provider did not have a policy in the clinic for the positive identification of patients.
- The provider must ensure an effective management structure is in place to support the clinic team following the resignation of the registered manager at the time of the inspection. In doing so, the management structure must receive appropriate support to address the morale within the clinic.
- Action plans did not always have a 'due date' as well as a completion date in order to monitor that actions were addressed in a timely manner.
- The appraisal process did not support staff or encourage staff to develop in their role.
- Not all staff understood the requirements of the duty of candour regulation.
- The location did not monitor the time patients were taken off dialysis.