Baxter Healthcare Limited

Baxter Education Centre Northwest

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated it as inadequate because:

- Safety was not given sufficient priority, making people who used the service at risk of potential harm. This was because staff were not provided with the appropriate level of safeguarding training and did not always understand how to protect patients from abuse. The service did not always control infection risk well. Staff did not always manage medicines well. Staff did not always assess and minimise risks to patients. The service did not manage safety incidents well and did not always learn lessons from them. The service did not always ensure that equipment was safe for use and used in a safe way.
- People were at risk of not receiving effective care or treatment. This was because care and treatment were not always provided in line with national guidance and evidence-based practice. Managers did not monitor the effectiveness of the service and make sure staff were competent. Care and treatment was not always provided with written or verbal consent of the relevant person.
- The service did not always meet people's needs. We did not see evidence that the service made reasonable adjustments for all people with protected characteristics to access the service. Complaints were not recorded, lessons learned were not always effectively shared and there was limited oversight.
- The delivery of high-quality care was not assured by the leadership and governance. Leaders did not always have the skills and abilities to run the service well. Leaders did not operate effective governance systems and processes to identify, assess and mitigate risks to the health, safety and welfare of people who use the service. Leaders did not assess, monitor and improve the quality and safety of the service they provide. The service did not have a vision for what it wanted to achieve and a strategy to turn it into action

However:

- Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness and respected their privacy and dignity
- People could access the service when they needed it and did not have to wait too long for treatment.

Following this inspection, due to the concerns we found, we told the registered manager they were failing to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served two warning notices under Section 29 of the Health and Social Care Act 2008. The warning notices related to Regulation 12(1) Safe care and treatment and Regulation 17(1) Good governance. We also served one requirement notice in relation to Regulation 11(1) Need for consent.

We are placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis services	Inadequate 	

Summary of findings

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Summary of this inspection

Background to Baxter Education Centre Northwest

Baxter Education Centre Northwest is run by Baxter Healthcare Limited. Baxter Education Centre is a residential training facility where staff teach NHS patients how to manage their peritoneal dialysis. The service delivers training to approximately 185 patients each year. The centre does not see patients under the age of 18 years but does offer training to parents of children who required dialysis. These parents attend the centre for training without the child.

Baxter Education Centre Northwest in Swinton, Manchester opened in June 2018. The registered manager had been in post since the centre opened.

The Baxter Education Centre employed a supervisor, two nurses and a night housekeeper. Patients are referred to the service through their own NHS Trust. The centre was open five days per week and closed at weekends.

This location had not been inspected before.

The building had a small entrance hall with a secure reception area. On the ground floor there were two adjoining clinical training rooms each with a storeroom, one sluice room, one meeting room, a plant room, two toilets, a cleaning storeroom and an open plan kitchen/living area for patients. Upstairs there were five bedrooms with adjoining ensuite bathrooms, one meeting room, one staff kitchen, one staff toilet, a server room, a large storeroom and a cleaning storeroom.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected the service using our comprehensive inspection methodology. Two inspectors carried out the inspection on 8 December 2021. On the day of inspection, we spoke to one member of staff, the registered manager, two patients and one carer.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure care and treatment of service users is provided with the consent of the relevant person. (Regulation 11(1))
- The service must ensure the safe and proper management of medicines. (Regulation 12(1)(2)(g))
- The service must ensure that they have robust systems in place to assess the risk of, prevent, detect and control the spread of infections. (Regulation 12(2)(h))

Summary of this inspection

- The service must ensure that incidents are reported and investigated to identify opportunities for learning and to prevent reoccurrence of incidents. (Regulation 12(2)(b))
- The service must ensure that risk assessments relating to health, safety and welfare of people using the services are completed and reviewed regularly and that staff respond appropriately and in good time to peoples changing needs. (Regulation 12(2)(a))
- The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (Regulation 12 (2)(c))
- The service must ensure that equipment used for providing care or treatment to a service user is safe for such use and used in a safe way. (Regulation 12(2)e))
- The service must ensure that systems and processes to identify, assess and mitigate risks to the health, safety and welfare of people who use the service are effective. (Regulation 17(2)(b))
- The service must ensure that processes to assess, monitor and improve the quality and safety of the service they provide are effective. (Regulation 17(2)(a))

Action the service SHOULD take to improve:

- The service should ensure that they maintain securely an accurate, complete and contemporaneous record in respect of each service user.
- The service should ensure they make reasonable adjustments to enable service users to receive their care and treatment.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inadequate

Dialysis services

Safe	Inadequate
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Inadequate

Are Dialysis services safe?

Inadequate

Mandatory training

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

Staff received and kept up to date with their mandatory training. All staff were required to complete a programme of mandatory training each year. The manager told us that protected time was provided for staff to complete this.

Training modules included basic life support, fire safety, customer care, dignity in care, infection prevention and control, information governance, moving and handling and conflict resolution.

At the time of our inspection, all staff were 100% compliant with the mandatory training requirements.

Staff told us that mandatory training was comprehensive and met the needs of patients and staff.

Mandatory training was delivered electronically, and staff were informed by managers when training was required.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities and for people living with dementia.

Safeguarding

Staff did not have the appropriate level of safeguarding training and they did not always know how to apply it. The service did not always work well with other agencies to protect people from abuse.

Staff received level two safeguarding adults and children training on how to recognise and report abuse which is not in with national guidelines for safeguarding training. They should have received level three. The service had a safeguarding lead who had received level three safeguarding training.

The service had policies for safeguarding adults and children. However, these policies did not outline how staff should refer patients who were not from the local area to the relevant local authority safeguarding team. The policies did not include the actions that staff should take if their concerns were urgent. This meant there were risks of abuse not being acted upon.

Staff, including the service safeguarding lead, did not always understand their role in recognising and reporting children at risk of abuse and how to protect them. This meant there were potential risks to children.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. However, equipment and the premises were visibly clean.

The service had a policy for infection prevention and control which had been reviewed and updated in September 2021. However, this policy did not make any reference to COVID-19 precautions and the guidance was not in line with the most up to date best practice guidelines. The service did not have a separate policy which outlined COVID-19 requirements.

The policy stated that patients with MRSA and clostridium difficile were not permitted to attend the Baxter Education Centre. Following our inspection, the registered manager told us that the referring service was responsible for screening patients before they attended the education centre. However, the service level agreement did not outline this requirement. There was a risk that patients could attend with an infection that had not been identified

The clinical training rooms and bedrooms had carpeted floors which was not in line with the Department of Health, Health Building Note (HBN) 00-10. These areas were at risk of contamination from bodily fluid spillages. The registered manager told us that the carpets were cleaned annually, however, the infection control policy did not outline how this was managed or monitored. This risk was also not included on the service risk register.

The chairs in the training room and bedrooms were covered in fabric. This was not in line with the Department of Health, Health Building Note (HBN) 00-09 which states that soft furnishings (for example, seating) used within all patient areas should be covered in a material that is impermeable, preferably seam-free or heat-sealed. These chairs were used by patients learning to manage their own dialysis, so they were at risk from bodily fluid spillages.

The service did not perform any audits of infection control, hand hygiene or the use of personal protective equipment. This meant there was no way the registered manager could be assured around these standards.

The service had a contracted cleaner who worked from 7am to 10am five days per week. A supervisor attended regularly to monitor cleaning standards and provided the registered manager with a monthly report. The most recent report identified no concerns and no actions were required.

The staff also contributed to cleaning; however, we did not see that the service provided any guidance or kept any record of this.

We observed staff following infection control principles including the use of personal protective equipment (PPE) and cleaning equipment after patient use.

All areas of the building were visibly clean and tidy.

Infection prevention and control training was mandatory for all staff and 100% of staff had completed it. All staff had also completed a one off COVID-19 training module.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The registered manager told us that all staff received training in the use of specialist equipment. However, they were not able to provide us with evidence of this training.

The registered manager told us that staff performed equipment checks as part of the daily use of equipment. However, they were not able to provide us with evidence that these checks were taking place.

Blood pressure machines and scales which were used by patients during their stay were not calibrated. The registered manager told us that faulty machines would be replaced, however, there was a risk that incorrect readings would not be identified unless they were outside of normal parameters.

The building was secure and could be accessed by ringing a doorbell. The facility also had lockable external gates which were secured at night and accessed by fob or by pressing a buzzer to which staff would remotely allow access. There was also external CCTV which recorded 24 hours per day seven days per week.

The registered manager told us that dialysis machines were maintained by Baxter repair services. The service also had a building maintenance contract with an independent provider. Staff told us that they always experienced a quick response when they reported equipment or building faults and that replacement equipment was delivered on the same day to meet the needs of the patient in the event of an equipment failure

The registered manager told us that portable appliance testing (PAT) was completed annually. We saw that electrical items had stickers displaying the date that they were last tested. All electrical items that we saw were within date.

The service had a contract to ensure that clinical waste was disposed of safely. Staff disposed of clinical waste in appropriate bins and waste was stored securely whilst awaiting collection by the contractor.

The service used some single use dialysis equipment. We reviewed a sample of these and found that they were stored safely, in sealed packets and were within their expiration date.

The service had a defibrillator and oxygen for use in the event of an emergency. We saw that staff checked this equipment regularly.

The service had enough suitable equipment to help them to safely provide training to patients.

The service had fire extinguishers which were regularly checked by an external provider. They also had evacuation equipment at the top of the stairs and fire blankets in the kitchen.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks.

Staff completed a pre-admission call with patients approximately one week before their arrival. The service had a standard template which included prompts for the pre-admission call and for data collection on arrival. Not all relevant information was collected in order to keep people safe whilst they stayed at the centre or to tailor the care to meet their individual needs.

Staff did not complete falls risk assessments on older people in line with National Institute for Health and Clinical Excellence (NICE) guidelines 'Falls in older people: assessing risk and prevention'.

Inadequate

Dialysis services

We reviewed five sets of patient records and found that the next of kin contact details were not always recorded for patients. The registered manager told us that these details were not included if they were staying with the patient. However, patients and relatives could leave the building during their stay so there was a risk that next of kin details could be required in an emergency.

Staff did not collect information about a patient's resuscitation status. When we discussed this with the registered manager, they did not demonstrate that they understood that patients could be receiving active treatment but also have a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place.

Allergies and dietary requirements were not routinely recorded or confirmed on admission. There is a risk that patients or relatives could be exposed to allergens in the clinical training environment but also in the food provided by the centre.

Staff told us that they completed an online training module in sepsis awareness. However, the registered manager told us that staff did not receive training in sepsis and that this was not part of the mandatory training requirements for staff. This meant there were risks staff may not recognise signs of a life-threatening medical emergency.

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Not all staff, including agency staff, received a full induction.

The service employed three nursing staff, one of these was the clinic supervisor. The registered manager told us that staffing was monitored closely and that in the event of unexpected staff absence, patients could be trained at home by the Baxter field training team, or that in extreme circumstances patients would be referred back to their NHS renal team. The service did not have a staffing policy which outlined minimum staffing requirements.

All three nurses had been working at the centre since it opened. The night housekeeper had recently left the service and this role was being covered by a regular agency healthcare assistant. The service did not have any other agency staff use.

Staff told us that they lone worked every day in the clinic at the start and the end of the working day. The building was also staffed by only one non-clinical housekeeper overnight from 7pm to 7am.

The service had a lone working policy but this was a policy for all Baxter services and did not outline local requirements. For example, the Baxter nursing lead told us that staff wear a security call device when working alone, however, this was not included in the lone working policy. Lone working was not listed on the service risk register and we did not see evidence that a lone working risk assessment had been completed in line with the service lone working policy.

The registered manager could not tell us how they were assured that the healthcare assistant who was lone working overnight had received the relevant training and that they were competent. Patients that we spoke with told us that they felt a nurse was needed overnight as they had experienced some side effects of treatment which they were not told about, and they did not feel the support from a helpline was enough. There was a risk that the housekeeper may not have the knowledge or training to act appropriately in an emergency.

There were no medical staff at the centre as the medical responsibility for patients remained with the referring hospital.

Inadequate

Dialysis services

Records

Staff kept records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, the service did not have a process to prevent notes being inappropriately changed or updated.

The service held a patient record for each patient who attended the service. Records were electronic and stored securely.

All staff could access records easily. The business continuity plan for the service did not outline how records would be accessed in the event of a power or internet outage. For example, accessing clinical information or next of kin details in an emergency.

All five records that we viewed were clear and readily available. However, records were not stored in a way that prevented them from being edited inappropriately at a later date or by someone else. The service did not have an audit trail in place to monitor this.

Staff shared a training summary to the referring renal team once the patient had completed the training which outlined what training they had received and their level of competence. We reviewed five sets of records and found that these summaries contained relevant information.

The service did not perform audits of documentation so the registered manager could not tell us how she was assured that staff were completing the required documentation to an acceptable standard.

Medicines

The service did not always use systems and processes to safely record and store medicines.

The registered manager told us that no medicines were prescribed or administered by staff in the service. Patients brought their own supply of medicines with them and self-administered all medication. Each bedroom had a lockable medicines cupboard in the ensuite bathroom. Patients held the keys to these cupboards along with their room keys.

We asked for a copy of the service medicines management policy. The registered manager provided a copy of the service protocol for the safe administration of medicines. This outlined the process which staff must follow when administering medication which we were told staff at the service do not do. The policy did not outline the requirements for confirming what medications patients were bringing with them, storage requirements for medication, access to the medications fridge out of hours or how patients own controlled drugs must be recorded or stored.

Dialysis fluid was not stored in a temperature-controlled room. Ambient temperatures were recorded and we saw that the recorded temperature had reached 29c in the month prior to inspection. The centre used four types of dialysis fluid; one should not be stored above 25c for long periods. When we discussed ambient temperatures with the registered manager, they told us that none of the fluids had a maximum storage temperature and that no action was required when the room temperature was high. This meant they did not understand the potential implications of fluid being stored outside of the manufacturers recommendations which put patients at risk of using fluid which was no longer fit for use.

The service had a lockable medicines fridge which was stored in a locked storeroom. We saw that staff were checking and recording fridge temperatures every day that the clinic was open and there had been no temperature breaches recorded. Staff told us that medications which required fridge storage would be stored in there. However, it was not clear how patients would access this medication out of hours when all clinical staff had left the building. This could pose a risk to patients who may need this medication in an emergency.

During our inspection, we saw that one carer had brought a medication with them which required refrigeration. The staff only became aware of this as the patient was being discharged from the centre. There is a risk that relatives or carers could bring medication to the centre and they would not be stored correctly which could pose a risk to patients, visitors and staff.

The service did not hold a stock of any medications other than glucose gel which could be used if a patient experienced low blood sugar (hypoglycaemia). The glucose gel was stored with emergency medical equipment which was in a room which was not secured throughout our inspection. The service policy for the management of a patient who experienced a hypoglycaemic episode did not contain any guidance for staff on the storage and use of glucose gel. There was an incident of hypoglycaemia recorded on the clinical episode register and glucose supplements had been self-administered by the patient. It was not recorded if this was patients own or from the service stock.

Medication awareness and management was included in the mandatory training requirements for clinical staff and we were told that all staff had completed this. However, some staff that we spoke with told us that they had not receive medicines management training.

A list of patient medications was recorded on admission documentation. Patients own controlled drugs were recorded in a separate log.

Allergies were recorded on the referral documentation by the referring clinician; however, allergies status were not included in the pre-admission checks that were performed by nurses at the clinic.

The registered manager subscribed to safety alerts and was able to give examples of when they had been acted upon. The Baxter UK nursing lead was also subscribed to cover this role in the event of the registered manager being absent.

Incidents

The service did not always manage patient safety incidents well. Staff did not always report incidents appropriately. Managers did not investigate incidents and lessons learned were not always shared with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service had an electronic incident reporting system. The registered manager told us that the service had no reported incidents since they opened in 2018. However, they had a clinical episode register which staff reported when patients had received unexpected care or treatment. There were 14 episodes reported on this register and these were not reported as incidents and had not been investigated to identify any learning. The registered manager was not able to show us how they would have oversight of incidents on the system if any had been recorded.

Staff did not receive incident reporting training or duty of candour. Not all staff that we spoke to understood duty of candour legislation.

Learning from incidents was not listed as an agenda item for clinical governance or team meetings.

Inadequate

Dialysis services

A slips, trip and falls module was included in the mandatory training requirements. 100% of staff had completed this module.

Are Dialysis services effective?

Requires Improvement

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.

We reviewed a sample of policies during our inspection and found that not all the service policies were comprehensive and in line with up to date best practice guidelines. For example, we saw that the safe disposal of sharps policy referenced guidelines on the control of infection, in residential and nursing homes dated 1996.

We saw that there were printed copies of out of date policies in the clinic. However, the service did store policies electronically so that all staff could access them easily. This meant that staff were at risk of following guidance which was not up to date.

The service did not have an audit programme in place to monitor service quality against its own policies or national guidelines. The registered manager was unable to tell us how they were assured that the service was being delivered in line with best practice.

Nutrition and hydration

Staff did not monitor dietary and fluid compliance. However, they did give patients enough food and drink to meet their needs. The service made adjustments for patients' individual needs.

Patients with specialist nutrition and hydration needs were not monitored for compliance. Patients received training in monitoring fluid balance but staff did not have oversight of this. Patients individual nutritional needs were discussed during their pre-admission phone call but were not monitored during their stay.

The centre had a fridge and freezer stocked with food which patients would self-serve during their stay using the kitchen facilities provided. Patients were also allowed to bring food with them in a sealed labelled container.

The service did not have access to support from a dietician and staff informed us that this advice and support would be provided to patients by the referring hospital.

Patient outcomes

The service did not always monitor the effectiveness of care and treatment. They did not always use the findings to make improvements.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. When we asked the manager and staff about audits, they did not demonstrate that they understood what audit was and its purpose.

The service had a set of key performance indicators (KPIs) that they measured each month. We requested the most recent performance data, but the registered manager did not provide us with all of this information**.** These KPIs were not listed as an agenda item at the service clinical governance meetings. They had been discussed at a team meeting but there was no record of any actions identified or changes made as a result.

The service monitored how many patients remained on dialysis therapy 90 and 365 days after training. The data for the year to date showed that 86% of patients remained on therapy after 90 days which was below the service target of 90%. The data for the year up to the date of our inspection showed that 69% of patients remained on therapy after 365 days. The service did not have a target for this. The registered manager was not able to tell us how this data is used to improve the service being delivered.

The service monitored patient confidence immediately following their training and again approximately four weeks after training. Confidence was scored on a scale of one to six, six being the most confident. The service had received 47 confidence scores for 2021 up to the day of our inspection. The data collected immediately after training showed that 90% patients scored either five or six, and 10% of patients scored between one and four. The data collected approximately one month after training showed that 96% patients scored either five or six, and 4% of patients scored between one and four. The registered manager was not able to tell us how this data was used to improve the service being delivered.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

On the day of our inspection we asked to see records of employment checks for staff in line with schedule three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager was unable to provide these. Following our inspection some records were provided by the Baxter UK nursing lead. However, we did not see evidence that checks of professional registration were performed regularly, or that revalidation dates were monitored. The managers also did not provide evidence that health declarations, curriculum vitae, qualification certificates and employment references were obtained at the time of recruitment.

On the day of our inspection, we asked the registered manager about staff induction. They told us there was no induction programme or document for staff and was unable to tell or show us how they were assured that staff in the centre were competent to work independently. Following the inspection, the Baxter UK nursing lead provided us with an induction timetable, however this appeared to relate a different Baxter location. They also provided a clinical competency workbook. We were told that the service did not hold a record of these completed documents, so we were not able to see that all staff had received a full induction.

The registered manager was not able to tell us about how the agency housekeeper who was lone working at night had been inducted and had no records of any training or induction that they had been given.

Staff were encouraged to attend team meetings. However, when they were unavailable, minutes were not always comprehensive enough for staff to know what has been discussed.

The managers told us that performance and competency was assessed weekly. However, the registered manager told us that this was not a structured process and no record was made of this.

Staff told us that they received a monthly one to one meeting with a manager. Staff had objectives which were recorded on the human resources system and monitored monthly. 100% of staff had received a structured appraisal.

Staff told us that they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Multidisciplinary working

Nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

All patients who attended the service were referred by clinicians at NHS hospitals. The service sent a training summary to the referring clinician after the patient had been discharged from the centre.

The registered manager told us that the service worked closely the NHS hospitals. Staff reported good communication and effective working relationships with the NHS referring teams.

Staff told us that they had a good working relationship with their colleagues and that they supported each other well. Staff told us that they also had access to a medical liaison team at Baxter who could support with any clinical queries.

Health promotion

Staff gave patients practical support and advice to lead healthier lives. However, the service missed some opportunities to provide health promotion advice.

Staff assessed some health needs on admission and provided support for individual needs. However, the service did not collect patient information on smoking status or alcohol intake on admission, and we did not see any health promotion material on display for these topics.

The service had some information promoting healthy lifestyles and support in patient areas.

Each patient received an individualised training pack which supported their training and treatment needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not seek written or verbal consent for all care and treatment. They knew how to support patients make informed decisions about their care and treatment but did not record this. The service did not monitor compliance with national guidance to gain patients' consent.

The registered manager told us that they did not gain written or verbal consent from patients who attended the service as patient attendance was considered as implied consent. The service did not collect information from the referrer to confirm that the treatment programme and referral had been discussed with the patient.

The service had a patient consent policy; however, it did not outline any requirement for written consent or for consent to be recorded.

The service did not monitor compliance with consent requirements.

Inadequate

Dialysis services

The service did record if the patient had consented to a follow up phone call after they had been discharged from the centre.

The registered manager also told us that the centre was currently offering patients the opportunity to provide dialysis waste products for a clinical trial which was being run by a local laboratory. This trial was looking at devices which could alert patients if there were abnormalities with the waste fluid. Patients were required to provide written consent to take part in the trial.

Training in the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS), the Mental Health Act, learning disabilities and dementia was part of the mandatory training for all staff. 100% of staff were in date with this training.

Staff told us that it would be unlikely that they would have a patient at the centre who was subject to DoLS as most patients who attend the clinic are attending to learn how to manage their dialysis independently.

Are Dialysis services caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Feedback that we received from patients on the day of inspection was positive.

We observed that patients had the opportunity to ask questions during the training and that staff supported patients to understand the training that was being delivered.

Staff understood and respected the individual needs of patients and how they may relate to care needs.

All staff had completed the mandatory dignity in care and customer care training modules.

The service did not have a policy on the use of chaperones and staff did not receive chaperone training. The registered manager told us that patients were entitled to bring someone with them to the training facility if required. The staff delivered very little direct patient care, however in the event that this was required, there is a risk that an appropriate chaperone would not be available.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They did not always record patients' cultural and religious needs.

Staff told us that extra support was available for patients via the referring trusts.

Inadequate

Dialysis services

We observed staff providing reassurance to patients who needed it.

Staff told us that they identified additional needs during the pre-admission call and that they gave patients and those close to them help, emotional support and advice when they needed it.

The service did not routinely collect information about cultural or religious needs before or during admission in order to tailor their care and support them.

Understanding and involvement of patients and those close to them

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

Patients could bring a relative or carer to stay with them during the training.

We observed staff welcoming patients and their relatives to the centre. Patients and relatives were given a building tour and information about fire procedures.

We observed a group training session for approximately 90 minutes during our inspection. Staff used visual aids and demonstrations to help with patient and relative understanding. Staff encouraged patients and relatives to take part in a knowledge quiz before they were discharged.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The service had picture guides available for patients who could not read, or whose first language was not English.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Are Dialysis services responsive?

Requires Improvement

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. Training sessions were booked dependant on patient need and staff availability.

Patients could be referred to the service by 16 NHS trusts in the north of the country. Patients could also be referred from the south if needed but these patients tended to be referred to the other Baxter Education Centre location.

Prior to the COVID-19 pandemic, the service delivered training for patients in parenteral nutrition. The registered manager told us that the demand for this service had significantly reduced and that they had not delivered this training for approximately two years. This change to the service had allowed more dialysis training sessions to be held to meet the needs of the referring trusts.

Inadequate

Dialysis services

Patients were provided with supporting information with was tailored to their training needs.

Facilities and premises were appropriate for the services being delivered.

Meeting people's individual needs

We did not see evidence that the service made reasonable adjustments for all patients with protected characteristics to access the service. However, they coordinated care with other services and providers.

We saw no evidence that the service made adjustments for all groups of people with protected characteristics. For example, we did not see any facilities to support people of different faiths.

The service did not have a policy which outlined inclusion or exclusion requirements. Staff told us this was due to the nature of the facility and that patients were either required to be self-caring or bring a carer with them. This is because patients are required to be able to manage their dialysis as they would at home without the support of centre staff. This requirement was included on the referral form., However, the lack of inclusion and exclusion criteria meant that it was not clear who could be referred the service.

The service had training information available in picture format and large print.

Referrers were required to identify if a patient did not speak or understand English. The referring NHS hospital were required to provide an interpreter for patients who required one. This requirement was outlined in the service level agreement.

Training was delivered in small groups of up to five patients. This had been reduced to three since the start of the COVID-19 pandemic. Working in small groups enabled staff to tailor the training to meet the needs of the patients.

The centre had facilities for patients with disabilities including car parking, a lift and toilets with disabled access. The centre was also very spacious which made it easy for patients with wheelchairs to move about.

The service had suitable facilities to meet the needs of patients and relatives/carers during their stay. The kitchen had a washing machine, microwave, fridge and freezer. All bedrooms were twin rooms to allow patients to bring a relative or carer. Each bedroom had ensuite bathroom facilities.

Access and flow

People could access the service when they needed it and received the right care promptly.

Then centre received referrals from NHS hospitals and dialysis units around the UK for patients who wanted to self-manage their peritoneal dialysis at home.

The registered manager told us that the clinic did not have a waiting list. Patients were booked in at a time which suited their clinical need. If no slots were available, patients could be offered training at home by the Baxter field training team.

Managers worked to keep the number of cancelled sessions to a minimum. In the previous 12 months there had been no cancelled appointments due to non-clinical issues.

Inadequate

Dialysis services

Learning from complaints and concerns

Complaints were not recorded and lessons learned were not always effectively shared. However, it was easy for people to give feedback and raise concerns about care received. The service investigated and responded to them but there was limited oversight.

The service had a complaints policy and staff knew how to handle complaints. However, the policy did not outline how complaints should be recorded.

The registered manager told us that there had been two complaints in the last 12 months. However, the service did not keep a log of all complaints, so there was a risk that if the registered manager was absent, complaints may not be managed or followed up appropriately.

The service did not have a process in place for independent review of complaints. The registered manager told us that if a patient was unhappy with the outcome of a complaint, they would be directed to contact the Care Quality Commission (CQC). Investigating and responding to complaints is not within the remit of CQC.

The registered manager told us about a change that had been made in the centre following a patient complaint. However, learning from complaints and incidents was not a standing agenda point on clinical governance or team meetings.

Patients, relatives and carers knew how to complain or raise concerns. Information about how to make a complaint was included in the welcome pack which was present in each bedroom.

Are Dialysis services well-led?

Inadequate

Leadership

Leaders did not always have the skills and abilities to run the service. However, they were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

During our inspection, the registered manager did not always demonstrate that they had the skills and abilities to manage the service safely. For example, they did not demonstrate that they understood the purpose and importance of clinical audit, and they did not demonstrate that they knew how to safely store medicines.

There was a clear leadership structure within the service. The clinic had a supervisor who was the registered manager, and they reported to the Baxter UK nursing lead.

Staff told us that leaders were visible within the service and although face to face contact with some members of the leadership team had reduced due to COVID-19 restrictions, contact had been maintained virtually.

The registered manager was counted as part of the frontline staff who delivered training.

Staff reported that they felt well supported and that they had opportunities to develop their skills and knowledge.

Inadequate

Dialysis services

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood the provider vision but did not knew how to it applied to this service.

The registered manager was able to tell us about the Baxter vision of 'saving and sustaining lives'. However, they were not able to tell us about a vision or strategy for the UK renal team or Baxter Education Centre Northwest.

The manager provided a copy of the statement of purpose which listed the company values and mission but not a vision or strategy. The service was not always meeting the points of its mission. For example, the mission outlined that they would complete regular auditing to monitor the quality of the service. However, the registered manager was unable to provide any audits for the centre.

Staff were aware of the Baxter vision and they told us that they felt involved in the development of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service did not always promote equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service had a whistleblowing policy which outlined the steps that staff could take to raise any concerns that they might have and how these concerns would be managed.

Staff felt the organisation had a culture of openness and honesty and was open to ideas for improvement.

Staff that we spoke with felt supported and valued by managers and the organisation.

Not all staff that we spoke with understood duty of candour and their responsibility to be open and honest with service users.

The service did not have and equality, diversity and inclusion policy. However, staff spoke highly of the equality and diversity training that they received and the culture within the service.

Governance

Leaders did not operate effective governance processes. Some staff were unclear about their roles and accountabilities. Whilst staff had opportunities to meet, we did not see evidence that the monitoring of safety and quality were discussed and any learning from the performance of the service was used to make improvements.

We reviewed a sample of policies and found that they were not fit for purpose and in some cases not available. The lack of central oversight of policies was on the service risk register, however this risk had was recorded as last reviewed in 2016, the service opened in 2018.

The service did not have an incident reporting policy providing guidance to staff about how to report incidents and how they should be investigated. The registered manager was not able to show us how they would have oversight of all incidents which may be reported in the clinic.

The service did not have a policy for the safe storage of medicines or dialysis fluids. They did not take action when dialysis fluids had exceeded the manufacturer recommended storage temperature.

The service infection prevention and control policy had not been updated to include COVID-19 precautions.

The service policy did not have a policy for the management of patients in an emergency situation or for a deteriorating patient. There was no guideline for staff to contact 999 in an emergency.

The sharps injury policy was not fit for purpose and referenced out of date guidelines for nursing and residential homes.

The resuscitation policy was not fit for purpose. It did not include comprehensive guidance for staff including the management of patients with a DNACPR order in place. The registered manager told us this was because people using the service were receiving active treatment and would therefore not have a DNACPR in place. People with a DNACPR in place do continue to have active treatment.

The missing persons policy did not include appropriate guidelines for staff to follow.

The service did not have an admissions policy with clear inclusion and exclusion criteria.

The service did not have a policy for equality, diversity and inclusion.

The service had no audit programme and the registered manager was not able to evidence how they were assured of safety and quality.

We reviewed minutes from the service clinical governance meetings in July, October and November 2021. Clinical audit and monitoring of safety and quality were not discussed at these meetings. National best practice guidelines were also not discussed.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events.

The service had a risk register which was a central document shared by the Baxter UK renal team. The registered manager told us that this was reviewed annually. However, the risk register showed that none of the risks had been reviewed and updated since 2016 which was prior to this service opening. Following the inspection, we were provided with another copy of the risk register. Although this contained more up to date information, some risks had not been reviewed since 2017. The likelihood and consequence were also not rescored after mitigations had been implemented.

Not all known risks were recorded on the risk register and appropriately assessed and mitigated. For example, lone working staff.

Not all risks had appropriate mitigations in place, and likelihood and impact scores were not regraded after mitigation, so the outstanding level of risk was unknown.

The building fire risk assessment was last completed in June 2018 with a recommended review date of July 2019. The risk assessment had six recommended actions which were to be completed either immediately or within one month- none of these actions were recorded as complete.

The service had a business continuity plan in place which had recently been reviewed but had not been tested.

Risk assessment training was included in the mandatory training requirements. 100% of staff had completed this training.

Information Management

Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, the service did collect some reliable data.

During our inspection, the registered manager told us that they did not have access to all the required information to perform their role. For example, staff personnel files and staff induction and training records.

Records were electronic and stored securely. However, the records could be accessed at any time by all staff so there was a risk that records could be edited inappropriately. The service did not have a system in place to prevent or monitor this.

The service had an information governance policy.

Information governance awareness was included in the mandatory training requirements. 100% of all staff had completed this training.

The service had contracts in place with NHS trusts to provide training in peritoneal dialysis. The referring trusts provided the prescriptions and treatment plans.

Training summaries were shared with the referring trust once the patient had been discharged. These were sent securely by NHS email.

Engagement

Leaders and staff actively and openly engaged with patients and staff. However, this information was not always used to plan and manage services.

We reviewed team meeting minutes from April, October and November 2021. There was no record of who attended these meetings, and the minutes were not comprehensive enough to allow staff who couldn't attend to catch up on the content of the meeting. We were told that no team meetings took place between April and October 2021.

Feedback was gathered from patients and relatives after they had completed their training. We reviewed the summary of results from the patient feedback gathered in 2020 and the overall results were positive with all four aspects of the feedback (facilities, training, confidence and housekeeping) scoring above 90%. However, the registered manager was unable to tell us how this feedback had been used to improve practice.

Inadequate

Dialysis services

The registered manager told us that Baxter carried out a staff survey called the 'best place to wok' survey. We saw the 2021 results which were collated for both Baxter Education Centre locations (Manchester and Kew). The results had improved in all areas since the 2019 survey. We saw that the results of this survey had been shared with the registered manager. We did not see that any actions had been taken to addresses areas which scored low or that this was discussed in the team meeting minutes that we reviewed.

Learning, continuous improvement and innovation

We did not see any evidence that staff were committed to continually learning and improving services.

There was limited understanding of quality improvement methods and the skills to use them. Leaders did not encourage innovation. However, at the request of an external agency the service was supporting a local research project.

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 11 HSCA (RA) Regulations 2014 Need for consent The service did not ensure that care and treatment of service users was always provided with the consent of the relevant person.

This section is primarily information for the provider

Enforcement actions

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 • The service did not ensure the safe and proper management of medicines. (Regulation 12(1)(2)(g)) • The service did not ensure that they have robust systems in place to assess the risk of, prevent, detect and control the spread of infections. (Regulation 12(2)(h)) • The service did not ensure that incidents are reported and investigated to identify opportunities for learning and to prevent reoccurrence of incidents. (Regulation 12(2)(b)) • The service did not ensure that risk assessments relating to health, safety and welfare of people using the services are completed and reviewed regularly and that staff respond appropriately and in good time to peoples changing needs. (Regulation 12(2)(a)) • The service did not ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (Regulation 12 (2)(c)) • The service did not ensure that equipment used for providing care or treatment to a service user is safe for such use and used in a safe way. (Regulation 12(2)e))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not ensure that systems and processes to identify, assess and mitigate risks to the health, safety and welfare of people who use the service are effective. (Regulation 17(2)(b))

This section is primarily information for the provider

Enforcement actions

- The service did not ensure that processes to assess, monitor and improve the quality and safety of the service they provide are effective. (Regulation 17(2)(a))