

# West Byfleet Dialysis Unit


## Quality Report

Tavistock House  
Unit 11 Camphill Road  
West Byfleet  
Surrey  
KT14 6EW  
Tel: 01932 359140  
Website: [www.fmc-ag.com](http://www.fmc-ag.com)

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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

## Ratings

Overall rating for this location		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive?		Good	
Are services well-led?		Good	

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

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

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

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

# Summary of findings

## Overall summary

West Byfleet Dialysis Unit is operated by Fresenius Medical Care Renal Services Limited. The service has 25 dialysis stations which includes four isolation rooms. The unit is built on two levels and is a purpose built facility for the treatment of chronic kidney failure. The unit has the capacity to dialyse 120 patients.

Dialysis units offer services which replicate the functions of the kidneys for patients with advanced chronic kidney disease. Haemodialysis is used to provide artificial replacement for lost kidney function.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the unit on 11 February 2020.

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

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

### Services we rate

Although we have previously inspected the service we did not have a legal duty to rate it. During this inspection we rated it as **Good** overall.

We found the following good areas of practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored

the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Dialysis session ran two to three times a day apart from Sunday to support timely patient care.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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

- We saw the daily cleaning workload rota was not always completed. We noted there were boxes stored on the floor under the sink in the dirty utility, which could lead to contamination of the products within the boxes.
- We saw information printed on paper in the treatment area that was in poor condition and stuck to the wall with sticky tac. The paper was ripped and was not contained in a wipeable surface. This meant there was a possibility they could harbour germs and could not be cleaned effectively.

# Summary of findings

**Nigel Acheson** Deputy Chief Inspector of Hospitals  
(London and South)

# Summary of findings

## Our judgements about each of the main services

### Service

### Dialysis services

### Rating

Good



### Summary of each main service

Dialysis was the only activity the service provided. We rated this service as good because it was safe, effective caring, responsive and well-led.

# Summary of findings

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Good



# West Byfleet Dialysis Unit

**Services we looked at:**

Dialysis services

# Summary of this inspection

## Background to West Byfleet Dialysis Unit

West Byfleet Dialysis Unit is operated by Fresenius Medical Care Renal Services Limited. It is a private medical dialysis unit in West Byfleet, Surrey. The unit primarily serves the community of West Byfleet. The main referring renal unit was local hospital trust's renal department. There are on average 1350 treatments sessions delivered a month.

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury

We previously inspected the service in June 2017. At that time we regulated this service but we did not have a legal duty to rate it. We did highlight good practice and any issues that service provider needed to improve. As a result of the last inspection in 2017 we issued three requirement notices. During the inspection on the 11 February 2020 we found all the issues previously raised had been addressed and no regulatory breaches were found.

The unit's current registered manager has been in post since July 2017.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector. The inspection was overseen by Catherine Campbell, Head of Hospital Inspection.

## Information about West Byfleet Dialysis Unit

The main referring renal unit is a local NHS Trust. The trust's consultant nephrologist visits the dialysis unit weekly. The wider multidisciplinary team include: a dietician, psychiatrist, transplant nurse, blood transfusion nurse and the vascular access team also visit at varying times.

The unit operates from Monday to Saturday. Treatment is delivered across five treatment sessions. On Monday, Wednesday and Friday they operate between 6.30am and 23.30 pm (three treatment sessions) and on Tuesday, Thursday and Saturday between 6.30am and 18:30pm (two treatment sessions).

During the inspection, we visited the treatment areas where dialysis took place, clinical room, consulting rooms and the other non-clinical areas of the unit, such as the dirty utility, staff room, waiting areas, maintenance room and water storage area. We spoke with nine staff including; registered nurses, dialysis assistants, health

care assistants, reception staff, and a nephrologist. During our inspection, we reviewed nine sets of patient records and medicine prescription charts. We also reviewed eight staff files and spoke with four patients.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once in June 2017 however it was not rated at this time.

The service employed eight registered dialysis nurses and seven dialysis assistants and one health care assistant (HCA).

Track record on safety in 12 months before inspection:

No Never events, clinical incidents or serious injuries.

No incidents of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), hospital acquired Clostridium difficile (C.diff) or hospital acquired E. coli.

# Summary of this inspection

The service had received eight complaints and four compliments in the reporting period.

Services provided under service level agreement:

- Clinical and or non-clinical waste removal.
- Pathology and histology.
- Water treatment system maintenance.

- Laundry services and provision.

Other services were carried at the location and included pre-dialysis consultations, education sessions and phlebotomy services. These clinics were run by a local trust's renal unit. Fresenius Medical Care offered administrative support and phlebotomy upon request.



# 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?

#### Are services safe?

Good



We have not previously rated the service. We rated it as **good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- The service did not employ any medical staff but had consultant contact details in case of urgent need.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

#### However;

- We saw the daily cleaning workload rota was not always completed. For example, when a staff member was away on holiday, although the tasks were reallocated, the checklist was not signed for two weeks.

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- The dirty utility cleaning equipment was stored in a locked room ensuring it was safe from patients. However; we noted there were boxes stored on the floor under the sink, which could lead to contamination of the products within the boxes.
- We saw information printed on paper in the treatment area that was in poor condition and stuck to the wall with sticky tac. The paper was ripped and was not contained in a wipeable surface. This meant there was a possibility they could harbour germs and could not be cleaned effectively.

## Are services effective?

### Are services effective?

Good



We have not previously rated the service. We rated it as **good**.

because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Dialysis session ran two to three times a day apart from Sunday to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

## Are services caring?

### Are services caring?

Good



We have not previously rated the service. We rated it as **good**.

# Summary of this inspection

because:

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

## Are services responsive?

### Are services responsive?

Good



We have not previously rated the service. We rated it as **good**.

because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

## Are services well-led?

Good



We have not previously rated the service. We rated it as **good**.

because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant

# Summary of this inspection

stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services.






# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

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

# Dialysis services

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

## Are dialysis services safe?

Good 

We have not previously rated the service. We rated it as **good**.

### Mandatory training

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

Staff all used the Fresenius Learning Centre (FLC) which was the company e-learning platform. The FLC allowed Fresenius Medical Care to manage the entire learning and development process (online and live classroom) from enrolment and delivery, to testing, tracking, and reporting staff training. The majority of this training was completed via the FLC this also meant that staff received an electronic reminder when their annual update was due.

All permanent staff training is monitored by the clinic manager. This ensured training was always up to date. If training lapsed staff would be suspended from shift allocation until evidence of completion was received. Flexibank training records are retained centrally but could be accessed by the clinic manager if needed.

Staff completed regular mandatory training. The training offered included safeguarding, prevention of healthcare associated infections, sharps management, waste management, medicines management, records management, risk assessment, planned preventative maintenance, reporting of incidents, accidents and near misses, root cause analysis and management of emergencies and disaster management.

All new staff undertook an induction which included mandatory training in safety systems which included processes and practices linked to the care and management of dialysis patients. New staff were trained by preceptors and we saw evidence of this recorded in staff integrated competence documents. The competence document included induction, fundamental skills, advancing skills and management skills.

Staff followed standard operating procedures to minimise the risk of infection, electrolyte imbalance, symptomatic dialysis-related hypertension and accidental venous line disconnection. Specific training was also undertaken by relevant staff in NephroCare Hygiene Guidelines, NephroCare Standard (Good Dialysis Care) and Hepatitis B Immunisation Training.

We were told staff were able to seek support with any training by the nursing manager regional, as well the regional business manager, HR business partner, clinical teacher and nursing manager governance.

### Safeguarding

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

All clinical staff were required to undertake safeguarding training every three years. The clinic manager was the safeguarding coordinator for West Byfleet Dialysis unit. There was also a designated lead for children and adult safeguarding and an external expert for any further safeguarding advice.

# Dialysis services

All staff undertook safeguarding training including registered nurses, dialysis assistants, health care assistants and secretaries. People under the age of 18 were not treated within the clinic.

Visitors were not permitted to bring children into the clinical area due to the unsuitability of the environment. Staff completed children's safeguarding e-learning training every three years which gave staff a level of awareness around what they would do if they were told any worrying information about a child. Staff received level 2 training which was in line with national guidance. The intercollegiate guidance document "Safeguarding Children and Young People" (2014) states, all non-clinical and clinical staff that have any contact with children, young people and/or parents and/or carers should undertake safeguarding children level two training. This was an improvement since the last inspection.

Staff could locate and describe the Fresenius safeguarding policy and demonstrated a good understanding of their responsibilities in regard to safeguarding. They could explain the process of reporting, who to report too and who to ask if further support was needed. Staff reported feeling well supported in all areas of safeguarding.

We reviewed the safeguarding policy which included information on reporting suspected female genital mutilation (FGM) and contact details of the local safeguarding authority. We saw safeguarding contact numbers and a flow chart were also available in the staff room for staff to refer to.

## Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

West Byfleet dialysis unit had a designated Infection Prevention and Control Link Nurse. All clinical staff were required to undertake an annual assessment of competence in relation to infection prevention and control. The completion of this was monitored by the infection prevention and control link nurse.

We saw evidence of staff training and competencies on inspection and it was clear staff knew their responsibilities in relation to this. We found equipment

on the unit was visibly clean. The unit had a daily workload rota which included the cleaning of equipment, such as patient scales and wheel chairs. Each item on the daily workload rota was allocated a task, which was assigned to a member of staff. We saw the daily workload rota was not always completed. For example, when a staff member was away on holiday, although the tasks were reallocated, the checklist was not signed for two weeks.

There were sufficient hand washbasins available, in line with the Department of Health's Health Building Note (HBN) 07-01: Satellite Dialysis Unit. This included hand washbasins that were accessible by wheelchair patients. We also saw alcohol-based hand gel was available throughout the unit. We observed staff decontaminate their hands immediately before and after every episode of care in line with the WHO 'five moments of hand hygiene' and National Institute for Health and Social Care Excellence (NICE) quality standard (QS) 61, statement three. We reviewed the units hand hygiene audits. It showed between January and December 2019, compliance was 100% in five of these months. The lowest compliance was 85% August, as a result of this lower score the infection control lead conducted weekly audits to improve results. It was also highlighted in team meetings and reminders posted in the staff room.

All patients were routinely screened on admission to the unit for Meticillin resistant *Staphylococcus aureus* (MRSA), or Meticillin sensitive *Staphylococcus aureus* (MSSA). There had been no cases of either MRSA or MSSA in the past 12 months. We were told If any patients were identified as having MRSA, they were treated and then re-swabbed to see if they were clear of the bacteria. In addition, they would be isolated during their dialysis treatment. If patients were identified as being at risk with a potential or actual infectious condition, four side rooms were available, to reduce the risk of cross infection. For example, patients with a blood borne virus (BBV), such as hepatitis B (HBV) or hepatitis C virus (HCV), or other infections such as MRSA or MSSA.

Admission and routine monitoring for BBV was in place on the unit. Patients were screened for HBV, HCV, and human immunodeficiency virus (HIV). If patients were found to be positive for a BBV, they would be placed in

# Dialysis services

isolation for their treatment. For patients who were found to be carrying HBV, they would have a dedicated machine that was used for them alone. This was in line with the Renal Association Guidelines: blood borne virus infection.

Patients were placed in isolation if they returned from a holiday that required dialysis away from base, in an intermediate or high-risk country. The Department of Health advises there is an

increased risk of getting a BBV infection associated with dialysis abroad. Countries have been separated into low, intermediate, and high risk, and have made recommendations for action on returning following dialysis away from base. Patients, who had been abroad to an intermediate or high-risk country and had dialysis away from base, were routinely placed in isolation. This was in line with best practice guidance 'Good Practice Guidelines for Renal Dialysis/ Transplantation Units.' Patients used a dedicated machine during this period. There were two dedicated machines for patients returning from dialysis away from base, who fulfilled these criteria which were clearly signposted.

Machines were automatically put through a 'heat' disinfection sterilisation process between patients, as part of the dialysis machine cycle. We saw this was recorded on the dialysis machine and documented on the Fresenius computer database. In addition, once a week the machines would be put through a 'chemical' disinfection sterilisation cycle. We witnessed machines were routinely cleaned with a disinfection-based product following use on a patient.

The unit had a large water treatment room on site. Normal tap water standards are inadequate for haemodialysis and needs to be treated appropriately to remove impurities. A Fresenius technician would respond to a concern on site within four hours. On a daily basis specific nursing staff who had been trained, would undertake routine testing of the water, such as testing for water hardness, or changing of filters. If a problem was found, they were able to contact the outside contractor for advice. We saw records were kept of these daily checks, which were up to date and fully completed.

Water quality testing was also undertaken to test for micro-bacterial and endotoxin levels (bacteria that can

be dangerous for patients on dialysis). We saw the testing was undertaken monthly in line with national guidance. Records were kept of the results of these tests and we found these were up to date and fully completed.

Water supplies were maintained at safe temperatures and there was regular testing and operation of systems to minimise the risk of pseudomonas and Legionella bacteria. During our inspection, we saw copies of the records for flushing of water outlets. This is in line with requirement of Health and Safety Executive (HSE) L8; and Health Technical memorandum HTM04-01 A and B: guidance on the control of legionella. Recently a sink within the unit had tested positive and as a result the taps had been changed. The sink was then re-tested, and the unit was awaiting the results before the sink would be used again.

The dirty utility had a separate dedicated hand hygiene sink, a slop hopper and a separate deep sink for cleaning of equipment. This was in line with HBN 00-09: infection control in the built environment. Cleaning equipment was stored in a locked room ensuring it was safe from patients. However; we noted there were boxes stored on the floor under the sink, which could lead to contamination of the products within the boxes.

We saw information printed on paper in the treatment area that was in poor condition and stuck to the wall with sticky tac. The paper was ripped and was not contained in a wipeable surface. This meant there was a possibility they could harbour germs and could not be cleaned effectively.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The dialysis machines, chairs, and water treatment plant were maintained by Fresenius Medical Care technicians. All other additional dialysis related equipment was calibrated and maintained under contract by the manufactures of the equipment or by specialist maintenance/calibration service providers. We saw records were maintained relating to the maintenance and calibration of all equipment used at West Byfleet Dialysis Unit. We reviewed this and saw it detailed the dialysis machines by model type and serial number along with



# Dialysis services

the scheduled date of maintenance. We saw similar plans existed for dialysis chairs/beds and other clinical equipment including patient thermometers and blood pressure monitors. All 30 dialysis machines we looked at were on the spreadsheet and had been serviced within the last 12 months.

Fresenius had an in-house Facilities Management (FM) service which had been in place since January 2019. A dedicated FM team which included a manager and two helpdesk coordinators provided the clinic with reactive and planned preventative maintenance work. The clinic logged a call with the help desk regarding any facilities issue the call was then allocated a job number and priority level (priority one, most urgent to priority four, least urgent). This was followed up by the coordinators to ensure completion.

Annual electrical appliance testing was part of the planned preventative maintenance schedule managed by the facilities management team. We reviewed the electrical appliance test register which was kept on-site, and confirmed testing had taken place. We saw evidence this was also checked during the annual health and safety audit.

We reviewed daily chlorine test checklists which showed 100% completion of tests from January 2019 to December 2019.

There were several trollies in the dialysis treatment area with sterile disposable items, such as

syringes, needles, and gauze swabs. All items we looked at on the trollies were in date and the packaging was intact. The unit had enough dialysis machines for each of the 25 stations, and the two machines designated for dialysing patients returning from holiday. In addition, the unit had spare machines. This meant if a machine broke down nursing staff could use the spare machine while the technical engineer repaired the broken machine and not affect patient care.

There were sharps bins available throughout the unit and bins were assembled correctly, labelled, and dated. None of the bins were more than half-full, which reduced the risk of needle-stick injury. This was in line with Health Technical Memorandum (HTM) 07-01: Safe management of health care waste. Waste was correctly separated and in different coloured bags to signify the different categories of waste. All waste was kept appropriately in

bulk storage bins, in a designated area on the unit premises until collected. All of the storage bins were securely locked which was an improvement on our last inspection which found unsecured waste, including clinical waste and sharps bins.

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

We saw emergency equipment was kept on site and staff were regularly trained in its use. The unit had a patient transfer policy in place. When a patient was identified as deteriorating by nursing staff their concerns were immediately escalated to the clinic manager who would contact the consultant or renal registrar at the local commissioning trust. The unit would call 999 if further medical assistance was required. In the past 12 months there were 30 patients who were transferred from the service to another health care provider.

Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. Risks were managed positively. We reviewed nine sets of patient records and saw risk assessments which included pressure ulcer assessments, manual handling, iron deficiency, renal bone disease, fluid management and individual emergency evacuation plans. Patient referral letters and admission documents included documentation that the patient had been assessed by the consultant nephrologist as in a stable condition, and suitable for care within a satellite dialysis unit.

Alarms on the dialysis machines were answered quickly. Alarms would sound for a variety of reasons, including sensitivity to patient's movement, blood flow changes, and any leaks in the filters.

Patients were required to confirm their identity prior to treatment and administration of medicines. We witnessed staff confirmed patients name and date of birth, which was checked against the patient record, the dialysis or medicine prescription or dialysis card.

# Dialysis services

Four isolation beds were available at the unit. Staff were able to tell us the steps they would follow in the event they suspected a patient had sepsis. Sepsis is a potentially life threatening complication of an infection.

Handovers between the nursing staff ensured important information was passed onto each other. This included, but not limited to, all known risks, any incidents that may have occurred, patients attending or dialysis that day, and any other news.

All patients had their blood pressure (BP) monitored before, midway through treatment and after treatment. Staff told us if a patient felt unwell their BP would be reviewed hourly. Emergency antibiotics were administered for suspected infections following a discussion with the medical team. A framework was used to identify any patients with a potential infection; this included the review of any wounds and dialysis catheter exit sites for signs of infection prior to commencing treatment. Any concerns would be raised with the access team at the local commissioning trust.

We saw a first aid and eye wash kits were available at the nurse's station to be used in an emergency.

## Nurse staffing

**The service had 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.**

The unit worked to a predetermined patient to staff ratio and skill mix which was completed using an e-rostering system. This was completed eight weeks in advance to ensure the correct staffing can be achieved. There were eight dialysis nurses and seven dialysis assistants and one health care assistant (HCA) employed at the unit.

The clinic manager or nurse in charge also reviewed staffing on a daily basis to assess staffing levels based on the actual number of patients attending for dialysis and also for unexpected staff shortages caused for example by sickness and unavoidable personal issues.

When staff shortages were identified we heard that staff were happy to rearrange shifts and that there was good cooperation between staff members. We reviewed the off-duty rota for the past three months and saw there was good management of staffing.

If staffing numbers could not be arranged then a request would be made for bank staff. These were arranged through the Fresenius renal care 'Flexibank.' If this remained an issue then agency staff would be used. All Flexibank staff had undergone a full induction, mandatory training and worked within units ran by Fresenius Medical Care. If agency staff were used they undertook an induction and shadowing period and initial orientation for the unit.

In the past 12 months there were no occasions where agency staff were used at the unit. The unit had two vacancies for health care assistants and one for a dialysis nurse, at the time of inspection.

## Medical staffing

**The service did not employ any medical staff but had consultant contact details in case of urgent need.**

Two consultants visited the unit regularly. One visited weekly and another fortnightly to review patients. If a patient needed an urgent referral a renal registrar at the local NHS hospital was contactable via telephone. This also included out of hour's referrals.

Patients who needed urgent advice could contact the consultant. Staff told us that they were very responsive and that they rarely had trouble contacting them for advice. For any other non-urgent advice consultants could be contacted via email.

## Records

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

The unit ensured that the patient's dialysis record and clinical record were integrated into the patient's hospital record and communicated to their GP. The Fresenius Medical Care patient treatment database automatically

# Dialysis services

transferred patient data into the commissioning trust's clinical database system. This ensured consultant nephrologists had access to the patient records at all times.

When the unit received a new patient, we saw that there was a dedicated section of the transfer form to acknowledge that there has been data quality confirmation check. This ensured that the data provided reflected the correct patient information. This was also cross checked between paper records, the commissioning trusts information technology system and Fresenius Medical Care systems. We were told that if there were any discrepancies they would be investigated and documented.

We reviewed seven sets of patient records all were legible and in good order. Each set of notes we reviewed had a personal evacuation plan, detailing the needs of individual patients in the event of evacuation of the unit. Patient records included information such as the patients past medical history, what type of access for dialysis was used, and patient observations including weight. There were several risk assessments documented including falls, sepsis, and pressure ulcers. All risk assessments were completed followed national guidance.

We saw nursing notes of the treatment delivered, arteriovenous fistula and arteriovenous graft assessment records, care plan and medicine prescription charts. An arteriovenous fistula is a surgically created vein used to remove and return blood during dialysis) are regarded as the best form of vascular access for adults receiving haemodialysis. This meant there were clear records around the care being delivered.

Electronic records including records from the local commissioning trust and blood test results

were accessible to all staff attending the unit. Electronic records detailed dialysis sessions by date and time. Staff told us if a patient required treatment at the local commissioning trust for a period, they could continue to track their care, and provide the appropriate treatment on their return to the unit.

## Medicines

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

Lead responsibility for the safe and secure handling and control of medicines was managed by the Clinic Manager. The nurse in charge was the key holder for the medicine's cabinet on a day to day basis.

Medicines were stored in a locked room in locked cupboards or fridges. We reviewed checklists that showed fridge temperatures were monitored daily recording the maximum and minimum temperature in line with national guidance. If the temperature was outside of the safe limit there was a further recording undertaken in the afternoon. Any further unusual recording would be reported to the nurse in charge and clinic manager for action.

Staff undertook annual medicines management training and staff also undertook additional training on intravenous medicines. We witnessed staff checking patient's prescription charts prior to starting treatment and after completion to check the correct medication procedure was being used.

The visiting consultant would review patients and if there were any prescription changes these were typed up by them on the day of review. This was then sent electronically to the GP and commissioning hospital; changes were also stored on the West Byfleet Dialysis unit's records system and sent to the patient. This ensured effective and instant updating of all patient's prescription changes.

Fresenius had a medicines management policy that staff were required to read sign and date when they had read the policy. The policy outlined suitable arrangements for the recording, safe-keeping, handling, and disposal of medicines. We saw staff administering medicines following the policy; this included patient identification, checking medicines by two staff members; one of whom (the registered nurse) then administered the medicine. Prescription charts were clearly written, showed no gaps or omissions and were reviewed regularly.

The unit did not use or store any controlled drugs, controlled drugs are medicines that are liable for misuse and have additional legal requirements regarding their storage, prescription and administration.

The consultant prescribed medicines administered during dialysis. This included anti-coagulant (medicines

# Dialysis services

that help prevent blood clots), iron infusions, intravenous (IV) antibiotics for suspected and actual dialysis line sepsis. Erythropoiesis stimulating agents (ESAs) were also prescribed by the renal consultant.

We reviewed nine medicine administration charts. Allergies were clearly documented on each chart and we saw the allergies were confirmed on the electronic prescription chart. The clinic manager told us medicines were ordered weekly and would arrive at the unit by a courier in a locked medicine container. All stock had a handwritten date of arrival on the side to indicate which medicines should be used first, this was a simple but effective way to manage the rotation of medicine.

Medicines that are taken “as needed” are known as PRN medicines, PRN is a Latin term that stands for “pro re nata,” which means “as the thing is needed.” We saw PRN medicines were prescribed in all the prescription charts we reviewed. This included medicines such as paracetamol and oxygen. In the nine charts we reviewed we saw all patients had PRN’s prescribed. This allowed the nurses to administer the medicines in a timely manner when the patients required them.

We observed the appropriate checking of medicines prior to it being administered to the patient. Before administration of the anti-coagulant, the dialysis assistant checked the preparation, strength and expiry date both verbally and visually with a dialysis nurse. We reviewed nine medicine prescription charts and saw the anti-coagulant had been signed by two members of staff. We observed ampules of sodium chloride for flushes were checked by two members of staff, with one member of staff signing the drug chart at the end of the check. This was an improvement since the last inspection.

## Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

We saw processes around the Duty of Candour were clearly described in the services Clinical Incident Policy and the Being open and Duty of Candour policy. Staff we spoke with had a clear understanding of their responsibility’s in line with the Duty of Candour and although they could not think of a time it had been implemented could describe when it may be used with confidence. 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 them with reasonable support.

All staff had access to the online incident reporting system. Staff were able to tell us what was reportable as an incident. All incidents were reviewed by the clinic manager and reviewed by the nursing manager regional if needed.

There was shared learning between units and bulletins would be emailed to the clinic manager or all staff depending on the specific incident. A recent example was a reminder for all staff to double check the Central Venous Catheter (CVC) connection as a patient at a neighbouring unit had been disconnected leading to a bleed. The provider had now introduced a two person check to ensure this did not happen again.

Staff universally told us they felt able to report and raise incidents without fear of repercussions. There was an open culture within the unit and staff reported no hierarchy or inability to speak out if they had concerns.

Incident reporting fed into the integrated clinical governance framework and local clinic review process. This ensured oversight of not only individual clinics incidents but also other locations. All Incidents (clinical and non-clinical) were monitored centrally with clinic updates and learning bulletins distributed by the nursing manager governance to support lessons learned across the organisation.

Patient Safety Alerts were distributed centrally from the head office and were reviewed by the clinic manager for relevance.

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

# Dialysis services

Good 

We have not previously rated the service. We rated it as **good**.

## Evidence-based care and treatment

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

Patients physical mental health and social needs were holistically assessed. Prior to patients receiving dialysis, during and post dialysis all patients were reviewed by the nursing staff. This included documenting the patients' weight, temperature, pulse, and blood pressure along with any other medical issues raised by the patient including how they were feeling. Nursing review notes were completed by the nursing staff which was then put into the Fresenius electronic management system and the local commissioning trusts management system. This allowed staff at the local commissioning trust to review the patients nursing reviews. This followed best practice guidance.

The Fresenius policies we reviewed had version control and were in date, all were referenced to current best practice from a combination of national and professional guidance including the National Institute for Health and Care Excellence (NICE) and The National Service Framework for Renal Services in providing care for patients. An International Organisation for Standardisation (ISO) established accredited Integrated Management System (9001) ensured all policies and procedures supported best practice evidence, this was reviewed annually to ensure that the evidence base was current.

The unit had an audit programme in place which supported the care provided against its own policies, work instructions, and standard operating procedures. Audits undertaken included twice monthly nursing documentation and hand hygiene audits. After the nursing documentation audits any discrepancies were highlighted to the staff member involved and addressed at the time of the audit. For example, if a falls assessment

needed updating and had been highlighted in the audit, it would be written at the end of the audit, highlighted to the staff member to rectify, and then signed off when completed. This enabled a quick response and learning opportunity.

Documents held on the management system could be accessed by all staff and were password protected and version controlled. Staff were required to sign to say they have read policies. This was reviewed by the clinic manager for completion.

Dialysis access is an important marker of clinical care. Functioning arteriovenous fistulas (AVF) are regarded as the best form of vascular access for adults receiving haemodialysis. Functioning arteriovenous fistula is a surgically created vein used to remove and return blood during dialysis. Staff monitored and recorded patients' vascular access which included AVF/grfts and tunnelled catheters on a vascular access monitoring chart.

We saw there were measures in place to monitor vascular access sites. Staff completed a review of the patients' vascular site weekly and documented this. Any concerns would be raised with the local commissioning trusts access team where the patient would receive an appointment to be assessed.

Treatment delivered was managed in accordance with professional guidance, for example, Renal

Association, and the National Services Framework for Renal Services. For example, we observed during the inspection the nursing staff were using the rope ladder technique to cannulate AVF's this was in line with the Renal Association guideline 6.1, 'recommend that the rope-ladder and buttonhole techniques should be used for cannulation of AVF and rope-ladder for AVG'.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Patients were provided with hot drinks and biscuits during their dialysis treatment. There was a range available and patients were checked regularly to see if they needed further food or drinks. Patients who had diabetes were closely monitored and encouraged to bring in appropriate food or drinks as needed.



# Dialysis services

Staff talked to patients about the amount of fluid that would be removed during the treatment and asking patients if they were happy with the amount. Too much fluid removed could cause the patient to drop their blood pressure during treatment. Staff encouraged patients to regularly measure their fluid output balances. This was to support patients on the amount of fluid intake per day in order to prevent fluid overload.

Patients were screened for malnutrition and the risk of malnutrition on admission, using the nationally recognised Malnutrition Universal Screening Tool (MUST). Scores were then documented within the integrated care pathway records. We reviewed nine sets of medical records, which showed these had been completed correctly.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.**

We spoke with patients who said they were monitored for pain and we witnessed staff asking if patients were comfortable and checking they were ready when needles were being inserted.

Any issues identified with pain were discussed initially with the nursing staff that escalated concerns to the consultant. Patients who required an urgent review for pain management were referred to their General Practitioner (GP) or the consultant depending on the severity of the pain.

Any patient requiring long term local anaesthetic for the insertion of the dialysis needles would attend their GP and get a local anaesthetic cream prescribed that helps to numb the skin. This would be administered by the patient prior to coming to the unit. We were told by a patient that she arrived at the unit and had forgotten to apply the cream. The unit offered to do the procedure without the anaesthetic cream, but the patient said they would rather return the next day as it would be too painful. This was immediately rebooked, and her wishes were listened to.

Paracetamol was prescribed as an 'as required' medicine in prescription charts to support patients who may

develop a headache or pain at the site of the needles during dialysis. By prescribing paracetamol, pain management could be delivered in a timely manner by the nursing staff.

## Patient outcomes

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

Consultants led all clinical care and worked within the UK Renal Association Standards in relation to dialysis quality outcomes. We saw individualised treatment prescriptions were tailored to ensure best patient care outcomes with needs further assessed and planned in line with the prescription requirements, care pathways and care plans.

The unit contributed data to the UK Renal Registry. For example, patients' blood results were monitored each month. Bloods were individually reviewed monthly to audit the effectiveness of treatment and action improvements and changes to care provision that may improve patient outcomes.

Results and treatment data were captured by the provider database blood results fed into the commissioning trusts IT System. The Clinic manager, regional nurse manager and consultant can monitor and audit individual patient performance month on month to identify where improvements and maintenance in line with national standards could be made.

Submission of the unit's data was undertaken by the commissioning trust. The unit's data was combined with the commissioning trusts data and submitted as one data set. This data set only included patients under the direct care and supervision of the trust. Patients undergoing dialysis away from base were not included in the figures.

Clinical outcomes for renal patients on dialysis can be measured by the results of their blood tests. Quality assurance meetings took place monthly to review all patients' blood results, progress, and general condition with the consultant and clinic manager. All changes to treatment parameters or referrals to other services were coordinated by the clinic manager and reported to the clinical staff for further action. Outcomes and changes were discussed with all patients by their named nurse

# Dialysis services

and dietician. Results were collated on the commissioning trust and Fresenius computer database used at the unit. They provided customised reports and trend analysis so changes

could be made to patient's treatments to meet national standards.

Key performance indicators had been developed from the Renal Association module 2: clinical practice guidelines for haemodialysis. Fresenius had set targets relating to optimising patient conditions and experience. We reviewed the data in relation to this and saw the unit had been performing well against several indicators.

Some examples included the effective daily treatment times being equal to or greater than 240 minutes. In the reporting period, 60% of patients achieved these daily treatment times the target set for this quality standard was set at 60%, data showed the unit was in line with this standard. Treatment times are one of the variants that contribute to dialysis adequacy.

We saw that anaemia management had a target of 65% and the unit had achieved 72%. In people on dialysis, anaemia is treated with drugs called erythropoiesis stimulating agents (ESAs). Erythropoiesis stimulating agents replace the Erythropoietin (EPO) that is low in people with kidney failure, so they can make red blood cells.

The unit was achieving 77% against the infusion blood volume target of 69%. Blood volume monitoring is a tool used on haemodialysis machines to assess how well patients are tolerating fluid removal during haemodialysis treatments.

On a weekly basis patients' vascular access site was monitored and maintained to minimise failure. This was in line with national guidance. We saw data that confirmed vascular access management achieved 79.3%, this was better than the target set of 72%. An escalation policy was in place to address any vascular access issues. All staff we spoke to were aware of the procedures to follow.

## Competent staff

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

All staff were supported by the Fresenius regional nurse manager and the clinic manager to ensure the maintenance of standards and competence. All new staff undergo induction which included mandatory training in safety systems, processes and practices linked to the care and management of patients.

Preceptors trained new recruits and recorded training in integrated competence documents. We reviewed eight of these and saw they included induction, fundamental skills, advancing skills and management skills. All new staff were supernumerary for eight weeks and were assigned a preceptor who was also allowed two weeks supernumerary status. This meant that they were not be part of the establishment figures, but were additional to the workforce requirements.

Training for all staff included safeguarding, prevention of healthcare associated infections, sharps management, waste management, medicines management, records management, risk assessment, planned preventative maintenance, reporting of incidents, accidents and near misses, root cause analysis and management of emergencies/disaster management.

Staff in the unit had the relevant qualifications and memberships appropriate to their position, for example registered nurses had their Nursing and Midwifery Council registration. There were systems which alerted managers when staff's professional registrations were due and to ensure they were renewed. We reviewed 8 staff records which confirmed all professional registrations were up to date.

During our inspection we looked at eight induction records for registered nurses, dialysis assistants and HCAs. They had all been fully completed and clearly demonstrated staff were competent to do their specific jobs. This was an improvement since the last inspection.

Staff files were tidy and well organised with a standard approach. This meant staff and managers could easily find certificates or competencies. We saw mandatory training was up to date and each staff member had an individual training matrix. All staff on the unit completed competency assessments to ensure they had the skills and knowledge to carry out the roles they were employed to do. For example, staff involved in the dialysis of

# Dialysis services

patients had to complete various additional competencies such as 'demonstrating venous access' and 'competency document for registered nurses experienced in the field of haemodialysis'.

Staff were encouraged to undertake continuous professional development (CPD) and were given opportunities to develop their clinical skills and knowledge through training relevant to their role. Staff we spoke with had all undertaken further training since starting their roles. This included the clinic secretary who had undertaken several training opportunities to enhance her understanding, despite being non-clinical.

The unit had systems for supporting staff with learning and development. Data provided by the unit showed 100% of staff had an appraisal within the last 12 months. Yearly appraisals identified areas for development and an agreed timescale for completion.

Each year Registered Nurses, Health Care Assistants and Dialysis Assistants undertook an annual reassessment of competence which included a self-assessment and self-declaration alongside a manager appraisal to discuss any identified needs and further development. We saw this documented in the staff files we reviewed. Annual reassessment and annual appraisal also helped nurses align with their NMC revalidation requirements.

The unit had a policy which outlined the procedure to report suspension or unfitness to practice on clinical or professional grounds. We were told there were internal performance management systems used to manage staff who are not performing to the expected standards, however there had not been any recent examples where this had been used.

The Fresenius' Flexibank system allowed the unit to allocate shifts to staff who had already undertaken an induction programme with training and competency assessment in the same standards and procedures as the full-time permanent staff. This minimised any disruption to patients and meant only a short health and safety induction and an awareness of any local working practices was needed.

If staff undertook blood transfusions, they were required to undertake an initial competence assessment followed by a competency reassessment every three years.

## Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

The local commissioning trust provided all the specialist support for patients. This included the consultant, dietician, and vascular access team. Staff told us there were good lines of communication between the unit staff and the local commissioning trust supported by the consultants.

Monthly multidisciplinary team (MDT) meetings took place at the commissioning trust. The consultant and clinic manager attended these. The meetings also included a dietician, social worker and psychological input and support. During the MDT patients' most recent blood results and medicines were discussed and recorded in the electronic patient record along with any current care needs.

The dietician visited the unit every month this allowed discussions to take place around the patient's diet if necessary. Any verbal guidance given by the dietician would be followed up by written information which allowed the patient to read and refer to the information at their leisure. The dietician also attended the MDT meeting at the unit.

We observed within the unit, all staff worked collaboratively and well together to promote the health and well-being of the patients. Monitoring and support visits were also undertaken by the nursing manager regional, regional business manager, HR business partner, clinical teacher and nursing manager governance.

## Seven-day services

**Dialysis sessions ran two to three times a day apart from Sunday to support timely patient care.**

The unit had sessions from 6.30 am to 11.30 pm Monday, Wednesday, and Friday. On a Tuesday, Thursday and Saturday the unit closed at 6.30pm. This allowed for three treatment sessions of up to 24 patients on Monday Wednesday and Friday and two sessions on Tuesday, Thursday and Saturday. Evening sessions allowed many patients to continue to work while receiving treatment.



# Dialysis services

Staff and patients told us the unit would be as flexible as possible to allow patients to undertake personal appointments or family events.

There was access to dieticians, physiotherapists and occupational health care. Alongside this pathology and pharmacy input was provided by the local commissioning hospital and readily available.

## Health promotion

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

We saw several notices around the waiting areas which detailed why diet and fluid intake are so important for patients on dialysis. There were recipes available for patients to take home and leaflets readily available with advice on how to lead a healthier lifestyle.

There were regular newsletters given to patients that also included recipes and advice.

Patients were encouraged and supported to manage their own health care and wellbeing and maximise their independence. For example, by weighing themselves independently before treatment.

## Consent and Mental Capacity Act

### Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Fresenius had a consent policy in place. Consent to treatment means a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. In all nine of the patients records we reviewed, patients had been consented for their dialysis treatment when they started treatment. Written consent covered dialysis treatment along with the risks and benefits associated with the treatment. Staff we spoke with, on the unit were aware of the consent policy and the correct procedures to ensure patients gave valid verbal consent prior to treatment.

We observed a dialysis nurse placing the patient on treatment; the nurse checked the patient's

identification asking for their date of birth. During all the observation, we heard nursing staff ask patients if they were ready to be prepared for treatment. This was taken as verbal consent.

Staff received training in the requirements of the Mental Capacity Act as part of their mandatory training. Mental Capacity Act training was completed by 100% of staff at the unit. The clinic manager said that patients who lack capacity would be treated at the commissioning hospital.

Staff told us do not attempt cardiopulmonary resuscitation (DNACPR) were discussed at handover to ensure all staff had awareness of patients who may have one in place.

We saw patients signed their care records. This included consent to treatment, data protection information, and a section for advanced directives and DNACPR. We saw these were completed in all the patient records we reviewed.

## Are dialysis services caring?

Good 

We have not previously rated the service. We rated it as **good**.

## Compassionate care

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

Staff understood and respected the personal, cultural, social and religious needs of patients and took these into account. For example, they would try to accommodate patients who chose not to discuss health related issues with staff of the opposite sex.

Staff referred to themselves as patients "second family," due to the number of hours patients are required to attend the unit. It was evident that patients had a good rapport with the staff and interaction we observed were kind and compassionate.

Patients we spoke with described staff as "great, hard working and kind" and "nothing is too much trouble for them."

# Dialysis services

Nursing staff maintained patients comfort using additional pillows, pressure relieving aids and if

necessary a hospital bed. We saw when patients felt cold during treatment a blanket was offered. Staff understood patients' personal, cultural, social, and religious needs. We saw these were taken into account when planning treatment. For example, patient's dialysis sessions were planned around their work, social events, and hobbies.

Patients received treatment in shared areas, however, curtains were in place if a patient wanted privacy such as while they were being connected to the dialysis machine.

The unit had an annual patient satisfaction survey. The anonymised results were analysed and available for review in the unit alongside the local action plan. The action plan detailed areas where the unit could make improvements and was updated as these actions were completed.

The unit also collects feedback through a 'Tell us what you think' anonymous leaflet system which allowed patients to comment on the service using freepost direct to the Fresenius Medical Care head office. We saw the 'Tell Us What You Think' Leaflets in the patient waiting area to encourage comments, concerns or compliments to be shared. We were told feedback was shared with the regional business manager and actions (if any) were discussed with the unit.

The last survey at West Byfleet Dialysis Unit was completed on February 2018 and showed 89% of patients felt safe during their dialysis. It identified 86% agree the clinic was well run and 81% agree patient privacy was respected while discussing their treatment with the nurses.

## Emotional support

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

Relevant support could be arranged for patients at the unit in regard to financial support, emotional support and any additional needs. Staff worked in partnership with the nephrologist and social worker and physiologist of the renal unit at the commissioning trust.

We witnessed support being offered to a patient who was feeling low after the death of a patient on the unit. This had affected both staff and patients and staff mentioned the impact and the additional support they were offering to patients as a result.

The unit had a quiet room where patients can have confidential discussions about their care with any members of the multidisciplinary team should they so wish.

Staff encouraged patients to continue to go on holiday and participate in the management of their treatment.

We saw the 'Patient Guide' provided details of national and local support networks for patients and their loved ones. This included organisations such as the British Kidney Patients Association and the National Kidney Federation who undertake social events, and support networks for patients and their loved ones.

Staff reported that each patient received a card and celebration on their birthday. Patients confirmed this made them feel welcome and part of the unit.

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

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

Patients had a named nurse and patients we spoke with knew who this was and which consultant they referred to. The named nurse fed back patients treatment plans and clinical results including the blood test result and outcomes from the monthly multidisciplinary meetings. Patients described feeling part of their treatment and felt able to ask questions and felt listened too.

Staff spoke about the care they had for patients as many of them were long term. They understood when patients seemed different and we witnessed patients talking to staff members about their concerns and feelings openly.

We saw staff talking with patients about their treatment and they encouraged patients to take responsibility for parts of their treatment, such as weighing themselves prior to dialysis, undertaking blood pressure, measuring their temperature, and preparing the machine.

Patients could visit the unit with a family member or friend for a look around before starting treatment.

# Dialysis services

Fresenius had developed a 'Patient guide' which included information regarding blood tests, living with haemodialysis, vascular access, hygiene and infection control, diet and health and safety. Patients we spoke with said they felt informed about their treatment and blood results. We witnessed a consultation which allowed plenty of time for patients to ask questions and express any worries.

Patients we spoke with said they had access to the dietician regularly and were given advice on diet and fluid allowances. The information given allowed them to plan their diets and take responsibility to ensure they remained well while on dialysis. We also saw information throughout the waiting areas relating to diet and exercise.

## Are dialysis services responsive to people's needs?

(for example, to feedback?)

Good 

We have not previously rated the service. We rated it as **good**.

### Service delivery to meet the needs of local people

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

The premises met the recommended practice for haemodialysis facilities. The unit consisted of three main areas on two levels. The reception and waiting area, dialysis treatment room and services corridor were on the ground floor with the clinic rooms and an additional waiting area on the first floor. Each area was secure with electronic pass access. Patients arriving in the reception were required to be buzzed in through a secure door into the waiting area and then through another buzzed door into the treatment area. There were toilet facilities available on both floors which were also accessible for those with disability.

The service corridor contained all treatment storage, water room, maintenance room, kitchen, medication room and dirty utility room.

The unit was nurse led and patient management was based on a team nursing approach. Each patient was allocated a named nurse. The clinical manager was supernumerary and there was a registered nurse on duty at all times with a recognised renal qualification.

Patients and staff confirmed a flexible approach to the patient's dialysis sessions. We were given examples of changing dialysis days and or times to accommodate patient requests. Sometimes this meant a dialysis session being relocated to the commissioning hospital. Staff told us patients were always central to any decisions being made.

Dialysis services were commissioned by NHS England. The service specification for the unit was defined by the local commissioning trust and commissioners. Patients were referred to the unit by St Helier's Hospital renal team. Monthly contract meetings took place between the hospital renal team and Fresenius to discuss and monitor the service delivered against the defined specifications. In addition, through the collection of key performance indicators and quality outcomes. At the time of inspection west Byfleet was delivering on all of these quality outcomes.

The service provided haemodialysis treatment to patients following an individualised treatment prescription. Changes to these prescriptions were made during multi-disciplinary meetings. The outcome of these meetings and changes to care were discussed with the patients. This ensured individual patients received the most effective clinical treatment.

The unit accepted Dialysis away from Base (DAFB) patients. The DAFB requests come via the NephroCare Administration Manager to the dialysis unit. Once all relevant information had been collated the clinic manager would arrange all the necessary arrangements and the patient was put on the computer system by a member of the nursing team. This allowed the staff to allocate a dialysis station and arrange a prescription to be prepared for their arrival at the unit for treatment.

Patients who were admitted to hospital for more than three weeks were discharged from the dialysis unit. When the patient was well enough to be referred back to the unit, they would be referred back.

# Dialysis services

We saw that the unit's internet access had not been very effective, this had been added to the action plan and had been marked as completed. Patients we spoke with confirmed they had upgraded the internet facilities at the unit which had improved the service for them.

## Meeting people's individual needs

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

We reviewed the unit's acceptance criteria which was open and inclusive. The unit accepted patients who were over 18 years, have functioning haemodialysis vascular access, were clinically stable for satellite treatment and have medical approval.

Prior to arrival staff at the unit requested details regarding patient requirements to ensure all care needs could be met. Facilities were available at the unit to treat bariatric patients up to 220 kilograms, any patients over this weight would need to be treated at the commissioning hospital.

Patients were allocated a dedicated dialysis appointment time which took into consideration social care and work commitments. This also included ensuring day slot availability for the elderly, vulnerable or those with more complex care needs. Alongside the length of journey to the unit and the number of hours and days of dialysis.

The unit was easy to access, and had facilities for those with disabilities, for example, support bars and wide automatic doorways. Dialysis specific chairs were used with pressure relieving mattresses. We saw a selection of mobility aids and hoists were available for patients who could not transfer, and wheelchairs were used to assist patients to and from their transport. The unit had four single rooms for isolation.

Dialysis stations were each equipped with an adjustable haemodialysis chair or bed and, an individual television and access to free Wi-Fi. Screening to ensure privacy and dignity were provided alongside a patient sink. Refreshments such as tea, coffee and biscuits were provided during the patients' dialysis session.

The unit provided information in formats which supported and reflected cultural diversity with the patient guide available in a number of language options.

The clinic manager told interpreters were available through the commissioning trust. Staff described using family members if necessary, although this is not considered good practice within the healthcare setting. We were assured that family interpreting would not be used in the consent process or treatment planning, in these cases an interpreter would be used.

Staff told us adjustments could be made for someone living with learning disabilities or dementia; this could result in a carer being in attendance during treatment. Patients would sit on the same chair within the same bay, for the majority of the time. These meant patients could build friendship groups with the people they sat with. However, patients receiving treatment in the open area could request the closing of the curtains should they wish privacy from the other patients.

## Access and flow

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**

Referrals for admission were controlled by a local NHS Trust who contacted the unit to inform them that they had new patients that they wanted to admit into West Byfleet Dialysis Unit. Capacity and demand were reviewed at the monthly contract meetings. The unit had the capacity to treat 120 patients at the unit. During July, August and September utilisation of beds was reported at 77%. The unit report no waiting list, no cancellations and no delays in treatment in past 12 months.

Patients were assessed for their appropriateness to attend the unit by the local commissioning trust's renal team. Patients with acute kidney disease were treated at the local commissioning trust and only chronic, long-term dialysis patients were referred to the unit for treatment. The referral to the unit was completed by the renal matron who contacted the clinic manager informing them of the patient. The clinic manager would

## Dialysis services

conduct a review of the patient prior to attending the unit and would allow one week between a referral to admission to ensure all systems were in place to support the safe care of the patient.

Quality assurance meetings were held monthly to review all patients' blood results, progress and general condition with the renal consultants, access nurse, dieticians, transplant nurse and clinic manager. All changes to treatment parameters or referrals to other services were coordinated by the clinic manager and reported to the clinical staff for action. Outcomes and changes were discussed with all patients by the named nurses and dietician. Written information was also provided to ensure the patient had an ongoing record of their treatment outcomes.

All clinic letters were sent to patient's General Practitioner (GP) by the consultant on the day of review. Any urgent advice and referrals made between clinic appointments would be made to the Renal Registrar at a local trust. Fresenius provided clerical support for phlebotomy which was organised by the commissioning trust through appointments. By having these clinics in the unit, patients were able to access care close to home. It also allowed patients to start to develop a relationship with the unit prior to starting treatment.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

The clinic manager and regional nurse manager were responsible for the management of complaints within the unit. All complaints were discussed at Clinical Governance meetings to identify where service improvements were required across the services.

In the last 12 months data showed eight complaints had been received through the formal complaints system. Complaints were monitored centrally and this formed part of the risk profile for the unit. This ensured that complaints were handled appropriately, and units were accountable.

We reviewed these and saw one related to waiting times for treatment to start and another referred to poor Wi-Fi in the unit. The Wi-Fi had been upgraded following the complaint.

We spoke to two patients who said they did not know of the formal process to make a complaint but would speak to staff directly if they had any concerns.

In the last 12 months the unit had received four formal written compliments. The majority were thanking staff for care and kindness when caring for a relative at the unit.

'Tell Us What You Think' leaflets were available in the patient waiting area to encourage patient

comments, concerns, or compliments. We saw in the 'Patients Guide' a section described what the patients could do if they wanted to complain. As all patients were NHS patients they were also signposted to the local commissioning trust's Patient Advice Liaison Service (PALS) and complaints management system to raise any issues around the care and treatment they had received. This meant patients had the information available to them to raise a concern.

The unit followed the four C's (compliments, comments, concerns and complaints). This mirrored the process at the commissioning trust and was outlined in the unit's feedback policy. Complaints were taken seriously and handled sensitively, and we saw the feedback policy and statement of purpose displayed in the patient waiting area.

### Are dialysis services well-led?

Good 

We have not previously rated the service. We rated it as **good**.

### Leadership

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



# Dialysis services

We witnessed strong leadership and teamwork across the unit. Staff reported the clinic manager and nursing manager regional were approachable and the clinic manager was frequently seen in the treatment area interacting with staff and patients.

There were clear lines of accountability which all staff understood. Staff reported feeling supported and valued. Leadership understood the priorities for the service and worked together to achieve these. The chief executive had overall responsibility and accountability for clinical governance within the organisation. The medical director had responsibility for data protection and patient confidentiality.

The unit's clinic manager was the clinical governance lead and had corporate responsibility to ensure that their unit fulfilled its obligations through establishing and implementing a clinical governance plan to improve the quality of care in the unit. The clinic manager and nursing manager regional produced monthly clinical governance reports that were fed back to the medical director and Fresenius Medical Care Renal Services Board.

## Vision and strategy

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

The main aim of all Fresenius units was to provide safe, effective quality care for adults with End Stage Renal Disease (ESRD) combining cost effective dialysis care with the Bio Adequacy approach as a global strategy. The vision and strategy fell into four main categories as listed in the statement of purpose:

- The Patients: Our objective is to increase the life expectancy and to improve the quality of life of patients with ESRD.
- Our Employees: Our objective is to bind qualified employees to the company and promote their personal professional development.

- Our Shareholders: Our objective is to ensure the continuous development of the company by attractive returns for its Shareholders.
- For the Community: Our objective is to justify our various social responsibilities, to follow legal requirements and safety standards and contribute to the maintenance of our environment.

Staff we spoke with were aware of the aims of the unit and felt that the vision of the unit was to provide the best care for its patients. We saw the strategy and aims of the unit in the staff room posted on the wall for all staff to see. The core values across Fresenius Medical care were:

- Quality, honesty and integrity
- Innovation and improvement
- Respect and dignity

We saw these values promoted in the unit and they were also on the first page of the employee handbook which all staff are required to read before starting work at the unit.

## Culture

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

Staff on the unit universally reported feeling supported and enjoyed work on the unit. We spoke to staff who had been internally promoted into higher roles and they spoke enthusiastically about the support they were offered to do this.

Several staff we spoke with had worked for the unit for several years. The unit had recently won the Fresenius gold award for employee excellence (2018), the award recognised the unit's employee retention and training targets. Leadership and staff were proud of this achievement and the award was on display in the staff room.

# Dialysis services

Patients we spoke with confirmed they felt able to raise any concerns and worries that they may have. We saw an open culture was evident and staff and patient interactions were positive friendly and professional.

Equality and diversity were promoted in the employee handbook and local policies. We saw that decisions concerning recruitment, promotion, dismissal or any other aspect of employment were based on the needs of the business and not any assumptions based on sex, race, age, disability, gender reassignment, sexual orientation, married or civil partnership status, pregnancy or maternity, religion or belief. Employees told us they were encouraged to raise with management any discriminatory behaviour and poor attitudes they encountered at work.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

Clinic manager monitors and leads on delivering effective governance and quality monitoring in the dialysis unit, supported by the wider Fresenius Management Team. Staff within the unit were supported locally by the nursing manager regional and regional business manager whose key responsibility is to monitor the performance of the unit. The nursing manager regional reports to the clinical governance sub-committee.

Clinical governance was overseen by the clinical governance sub-committee of the board (CGC). This sub-committee was chaired by the medical director. The purpose of the committee was to monitor the performance of the organisation to ensure that the necessary clinical governance, quality processes were in place to assure quality in clinical care. Governance was framed under five objectives, identifying and managing exceptions; providing clinically effective services; developing and empowering staff; engaging patients and providing open management. The CGC received minutes from the monthly clinical governance meetings of each Dialysis Unit and any reports on serious incidents. They

also reviewed monthly clinical variance reports from each Dialysis Unit alongside the outcomes of monthly audits of performance against the Renal Association Standards and performance against key performance indicators.

Staff we spoke with understood the governance structure and who they should report to, for example the dialysis assistants reported any concerns to the clinic manager who in turn reported to the regional nurse manager.

## Managing risks, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

Staff had a clear understanding of the risks associated with dialysis management. Risk assessments for service users, staff, facilities, and equipment were regularly undertaken. The risk assessments were developed in line with national guidelines, updated and relevant training provided as needed. We saw evidence the risks were reviewed regularly by management.

We reviewed several risk assessments and audits to ensure that risks were low. These included flushing of water points, nursing documentation reviews, and weekly fire safety checks.

There was a local risk register in place for West Byfleet dialysis unit. Staffing was currently on the risk register as the unit had vacancies for one nurse and two dialysis assistants. All risks were discussed every three months with the regional business manager. Staff we spoke with had a good understanding of what a risk was. They were clear who they would raise this with, that it would be acknowledged, and action taken.

We reviewed the Clinical Risk Management policy dated 12 January 2018. The aim of this policy was to ensure that risk management and risk assessment was an integral element to day to day management practice.

The unit underwent an annual Health and Safety audit, we saw these documented with any actions noted and signed when completed. An example was a local risk where the water pressure was lower than expected. This was documented and then signed when the issue had been fixed.

# Dialysis services

Management of MHRA alert notices within clinics was the responsibility of the Clinic manager. Once reviewed they were sent to the regional nurse manager if applicable to the unit. Affected equipment or products were dealt with according to specifications in alert notice for example remove them from service. To ensure completion all staff were required to read the alert and confirm by signing and dating the front page that they understand the content. A risk assessment was then undertaken, and a copy of the alert kept with this in a folder within the unit.

A tailored Emergency Preparedness Plan (EPP) was in place for West Byfleet Dialysis Unit detailing the plans in place for the prevention and management of potential emergency situations. All staff were aware of this plan and undertook training and site evacuation drills for which evidence of completion was maintained within the unit. The plan included defined roles and responsibilities, emergency contact details for emergency services, public services and utilities, key headquarter personnel, and neighbours. The plan addressed a number of situations that could arise including fire, loss of Electricity and loss of Computer Systems and Data.

The EPP also included facilities and business recovery plans and incident reporting to further ensure business continuity.

## Managing information

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The unit contributed data to the UK Renal Registry. For example, patients' blood results were monitored each month as dictated by the commissioning trusts consultant. Bloods were individually reviewed monthly to audit the effectiveness of treatment and action any changes to care provision that may improve outcomes.

The clinic manager, regional nurse manager and consultant could monitor and audit individual patient performance month on month to identify where improvements and maintenance in achievement of national standards can be made.

A report summarising each dialysis unit was produced for all units by the Fresenius data manager and Medical Director. This was shared monthly with the nursing manager regional who worked with the clinic manager to address improvement areas. As part of the integrated clinical governance review and reporting, a report defining the unit's achievement of the Renal Association standards was sent to commissioning trust clinicians.

A summary of complaints was reported at the quarterly management review meeting. If any trends were seen these were communicated in monthly regional managers meetings.

We witnessed the safe keeping of all clinical records and correspondences, privacy screening of such material, and to the adherence of the Data Protection Act (1998). Confidential waste bins were available and medical notes were stored in a locked room on the unit.

## Engagement

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

The unit had annual patient and employee satisfaction surveys, the last one was undertaken in 2018. We heard examples where action had been taken as a result of these surveys. For example, patients were now given an introductory session to dialysis when they first dialysed in the unit.

The action plan for these areas was available for patients to review progress in the patient waiting area of the dialysis unit.

The clinic secretary produced a newsletter for patients. This included a variety of interesting information for patients undertaking dialysis. It included advice and information on how to access help, information on patients within the unit (with consent) that may have had an interesting story, any changes in staffing, and reminders among other items.

The relationship with the commissioning trust was efficient and staff at all levels felt part of the wider team



## Dialysis services

caring for the patients on the unit. There was a list of contacts at the nurses' station and staff we spoke with were aware who to call for specific needs, for example, a dietician or psychological needs.

### **Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services.**

We heard examples where the consultant and clinic manager were trying to constantly work together to improve the service. On the day of inspection, they had discussed a change in the management of clinics to benefit the patient flow.

The clinic manager, regional nurse manager and consultant could monitor and audit individual patient performance month on month to identify where improvements and maintenance in achievement of national standards could be made.

# Outstanding practice and areas for improvement

## Areas for improvement

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

- The provider should ensure that cleaning checklists are completed to gain assurance around them being regularly undertaken.
- The provider should ensure stock is not stored on the floor of the dirty utility.
- The provider should consider ways to display information so that it can be cleaned effectively.