Diaverum UK Limited

North Ormesby Dialysis Unit

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	**Inadequate**
Are services well-led?	**Inadequate**

Summary of findings

Overall summary

We rated it as inadequate because early in the inspection process we found numerous significant concerns and issued two warning notices in relation to the safe care and treatment of patients and the management and oversight of the service. We have placed the service in special measures. We found the following concerns:

- The service did not always provide safe care. There was insufficient attention to safeguarding. The service did not always control infection risk well. Staff did not always assess, monitor or manage risks to people who use the service. Equipment was not always checked to ensure it was safe to use and medication was not managed safely. There was little evidence of learning following incidents.
- The service was not always well-led. Leaders did not always have the capacity to lead effectively. Risk was not always managed and oversight in relation to governance processes was not always robust. Policies were not always reviewed and actions plans in relation to poor audit outcomes were not always considered or developed. The service did not always operate effective procedures to evidence that all staff employed were fit and proper persons. The service did not always engage well with patients and the community.

However:

- Most staff had training in key skills and service had enough staff to care for patients and keep them safe. The clinic was visibly clean and the environment had recently been refurbished. Records were stored securely.
- Post inspection, the provider demonstrated a willingness to improve.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis services	Inadequate 	We had not previously rated this service. We rated this service as inadequate due to significant concerns across two domains. See summary above for details.

Summary of findings

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Summary of this inspection

Background to North Ormesby Dialysis Unit

North Ormesby Dialysis Unit is operated by Diaverum an independent healthcare provider. It is contracted by NHS England to provide renal dialysis to NHS patients over the age of 18. Patients are referred to the unit by the local NHS trust.

The service is on the site of North Ormesby Medical Village in Teesside. It is a 20 station unit (comprising of 14 stations in the main area, two side isolation rooms and a four bed bay) providing haemodialysis for stable patients with end stage renal disease/failure six days a week. There are no overnight facilities. There are two to three dialysis treatment sessions a day which includes a twilight treatment session on Monday, Wednesday and Friday. The main referring unit is a local NHS renal unit. Patients typically live in the nearby South Tees and surrounding area.

The provider registered this location in April 2022 and the service has a registered manager in post since this date.

We inspected this service using our comprehensive inspection methodology.

The service is registered with CQC to undertake the regulated activity of treatment of disease, disorder or injury.

We have not inspected this service before.

How we carried out this inspection

The team inspecting the service comprised of a CQC lead inspector and a specialist advisor. The inspection was overseen by Sarah Dronsfield, Deputy Director of Operations.

Our inspection took place on 20 April 2023, using our comprehensive inspection methodology. The inspection was announced with short notice to ensure the service was operational on the day of our visit and enable us to observe routine activity.

During the inspection visit, the inspection team;

- inspected and rated two key questions
- completed five clinical observations
- looked at the quality of the environment and observed how staff interacted with service users
- spoke with the registered manager
- looked at a range of policies, procedures and other documents relating to the running of the service
- spoke with five service users and their families

Summary of this inspection

We also reviewed recruitment and professional registration documents and general information provided to us by the service.

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

Areas for improvement

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

Action the service MUST take to improve:

- The provider must ensure that staff continue to have the required level of training or skills to enable them to recognise the potential risk and protect vulnerable adults and children from abuse. (Regulation 12)
- The service must ensure equipment used for the safe care and treatment of patients is checked and records are completed regarding these checks.
- The provider must have robust procedures in place for the identification, monitoring and escalation of risk. (Regulation 12)
- The provider must have robust procedures in place for the early identification of deteriorating patients to ensure timely care and treatment (Regulation 12)
- The service must ensure safe medicines management in all areas, specifically in relation to transcribing (Regulation 12).
- The service must ensure robust oversight and management of incidents and ensure incident grading is clear and themes from incidents are shared across the speciality. (Regulation 17)
- The provider must ensure robust oversight of medication management processes, including the regular auditing of medication administration records (Regulation 17)
- The provider must have effective governance processes to ensure the safe and effective delivery of care. This must include post audit action planning and outcome monitoring to improve patient outcomes. (Regulation 17)
- The provider must ensure policies are regularly reviewed to ensure they reflect national guidance and current best practice across the speciality. (Regulation 17)
- The provider must have the processes in place to ensure that staff are safely recruited, suitably qualified, competent, skilled, and experienced persons to ensure provision of a safe service. The manager must ensure that they meet the requirements of Schedule 3 and 4 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. (Regulation 19)
- The provider must ensure key information is shared consistently across all staff groups, including risk and performance monitoring data (Regulation 17)
- The trust must ensure it collates staff feedback is used for trend and theme monitoring and used to improve governance and risk oversight. (Regulation 17)

Action the service SHOULD take to improve:

- The service should ensure incidents themes and / or adverse patient outcomes are categorised to support learning across the service.
- The service should continue to monitor handwashing practice across the clinic and ensure best practice is followed.
- The service should review the admission pathways and criteria to ensure safe ceilings of care are identified.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dialysis services	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Inadequate

Dialysis services

Safe	Inadequate
Well-led	Inadequate

Is the service safe?

Inadequate

We rated safe as inadequate.

Mandatory training

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

We reviewed the annual education and training plan, which included a clear description of what mandatory training was required for each role within the organisation and when it needed to be completed. Mandatory training topics included data protection, fire safety, hand hygiene, sharps management and basic life support.

The provider also supported both registered nurses and dialysis assistants with basic dialysis education programme.

Staff received and kept up-to-date with their mandatory training. We reviewed the units mandatory training compliance matrix and saw the compliance rate was 99% for all staff working at the unit. The registered manager told us that they were provided with regular training figures and updates from head office which had resulted the high compliance figure.

Most training was delivered by the provider through an electronic portal and we saw the provider had effective processes to ensure staff training was maintained.

The provider also ensured all registered nurses were provided with drugs calculation assessments and ongoing competency-based assessments.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have all of the training required to keep people safe.

Staff received training specific for their role on how to recognise and report abuse. Staff received training specific for their role on how to recognise and report abuse. The provider's safeguarding lead was the nursing director for the organisation, who had undertaken level 4 safeguarding training.

The service did not provide treatment to children and young people, however nurses and dialysis support workers completed safeguarding training for both adults and children. During inspection it was unclear as to which level of training staff had received, as training records including certificates did not show the level of safeguarding training undertaken. This is not in line with intercollegiate guidance, which outlines the appropriate level of training required for each staff group. Following inspection, the provider submitted data to show that all staff at the unit had completed

safeguarding adults and children's levels 1 and 2 training. However, the clinic manager had also only completed levels 1 and 2, which is not in line with intercollegiate guidance which outlines a higher level of training required, due to the additional oversight responsibilities. Following inspection, the provider reviewed and revised the policy in relation to safeguarding adults and ensured that training levels were outlined for each staff group type. The clinic manager had completed safeguarding level 3 training.

The policy however did not include 'PREVENT' guidance, which aimed to identify people at risk of radicalisation. However, training for staff was provided.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to articulate areas of particular concern, for example those patients who were at higher risk during the pandemic due to isolation or failure to attend regular dialysis sessions.

The provider had not raised any safeguard alerts in the last twelve months.

Cleanliness, infection control and hygiene

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

Cleaning arrangements were provided through a third party contract. We saw the clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. We requested infection prevention and control audit data from the provider and saw compliance was generally high.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

We observed staff wearing personal protective equipment (PPE) and ensure they washed their hands prior to and following patients care. However, we observed six staff who did not follow the 'WHO' guidelines in relation to hand hygiene best practice. We reviewed the providers 'standard precautions and safe work practices' policy and saw that staff were expected to follow five moments for hand hygiene practice.

We requested hand hygiene audit data from the provider and saw recent handwashing compliance was generally high with a small number of moments which were not completed by staff. However, we did not see an action plan in which to improve this.

We observed poor aseptic non touch technique (ANTT) practice during five separate clinical procedures. These procedures involved the connection or disconnection of the dialysis line. This is a risk as poor ANTT practice increases the risk of contamination and the transmission of infection. We brought the concerns relating to poor ANTT practice to the immediate attention of the provider, who took steps to improve staff training in relation to ANTT and ensure understanding was embedded through further observation of clinical practice.

Following inspection, the provider submitted further audit data to evidence improvements across handwashing techniques and ANTT practice and further training for all registered general nurses in ANTT competency.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service was compliant with DHSC HTM 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste.

Spill wipes were available in key locations and included equipment to help staff contain bodily fluid spills and other similar risks.

Staff monitored access site infections.

We reviewed the providers health and safety policy and saw it was in date and had recently been reviewed.

Environment and equipment

The design, maintenance and use of facilities and premises did not always keep people safe. Staff were trained to use specialist equipment; however staff did not always carry out daily checks of specialist equipment or store COSHH chemicals safely.

The design of the environment followed national guidance. The service was compliant with the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09 in relation to clinical environment design and HBN 00/10 in relation to infection control in the clinical environment. The environment had recently undergone a full refurbishment.

Patients could reach call bells and staff responded quickly when called. We observed positive and timely interaction during our inspection.

We saw dialysis machines were serviced in line with manufacturer guidelines, as part of a third party contract.

Portable electrical appliances were checked as part of an annual maintenance programme with stickers in place to show testing had taken place. However, we saw the defibrillator machine did not have a sticker in place, although as the machine had been purchased less than 12 months ago the item machine was within currently warranty. Following inspection, the provider implemented a 'next test due' sticker process for clarity.

Staff did not always carry out daily safety checks of specialist equipment. We reviewed the providers resuscitation trolley and saw that the trolley was not always checked in accordance with the providers own policy, which states the trolley and equipment on the trolley should be checked every day. We saw gaps in the recording of the trolley and the equipment checks across February, March and April 2023 which were not escalated or addressed. We brought this immediate attention of the provider, who took steps to embed provider policy in regard to these equipment checks. Following inspection, the provider submitted equipment checking audits to provide further evidence of improved practice.

Staff did not always manage chemicals subject to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) in line with national requirements, in relation to storage and use. We reviewed the cupboard in which these chemicals were stored and found it to be unlocked.

Staff carried out daily water testing checks and we found the records to be up to date and comprehensive. Records we reviewed showed that staff carried out the correct procedures in regard to flushing of water outlets to prevent contamination of the water supply.

Staff disposed of clinical waste safely and in line with DHSC Health Technical Memorandum (HTM) 07/01 (2013) in relation to the safe management and disposal of healthcare waste.

We saw the provider had sufficient equipment to provide care and treatment.

We saw the provider carried out fire evacuation drills due to the detection of smoke in the unit.

Assessing and responding to patient risk

Staff did not always complete or update risk assessments for each patient and removed or minimised risks. Staff did always have systems to identify or respond to patients at risk of deterioration.

Incidents we reviewed demonstrated that staff responded promptly to any sudden deterioration in a patient's health.

A national warning scoring (NEWS) system was used by the provider when patients were identified as deteriorating. For example, when the patients vital signs indicated a cause for concern. Following inspection the provider submitted incident reports which included the use of NEWS scores for these patients. However, the unit did not routinely use a recognised national warning score (NEWS) system for all patients.

Patients received care on a long-term basis and staff maintained an ongoing review of patient's needs. Risk assessments were completed for patients known to have a specific risk such as nutritional risk, falls and venous needle dislodgement. We saw also a generic risk assessment form which could be used to risk manage risk from minor to catastrophic risks within the clinic.

However, we saw risk was not managed for patients who routinely shortened their dialysis treatment. Risks associated with shortening dialysis treatment time includes high potassium levels affecting heart rhyme and excess fluid build-up in the lungs, breathlessness and raised blood pressure.

Patients wishing to terminate their dialysis early were asked to sign a form to acknowledge that they accepted the risks associated with shortening of treatment time, however this risk was not escalated to the responsible consultant or referring health care professional. The provider did not have a plan of care in which to safely manage these ongoing risks. The providers policy 'Against medical advice' stated that the clinics medical director will meet with the patient to ensure the patient understands medical advice given and is fully informed and consents. However, there were no records to evidence these discussions. We brought this to the immediate attention of the provider who took steps to further educate the patients as to the risks and develop an individualised care plan around shortened treatment.

The unit was equipped with emergency equipment including an automatic external defibrillator (AED), oxygen, and breathing support equipment.

A sepsis box was available in line with national guidance.

The provider had an established patient admission pathway procedure; however, the registered manager told us they would only accept mobile patients due to the increased risk of falls. Following inspection, the provider submitted the inclusion criteria, which included acceptance to the unit for patients with mobility constraints.

The unit had access to an on-call consultant nephrologist at the NHS trust, for urgent clinical discussions and referrals while the service was in session.

Inadequate

Dialysis services

Staffing

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff to keep patients safe. The team included five staff every session with a patient ratio of 1:4 which was in line with national standards. Managers ensured the skill mix of staff was appropriate depending on the numbers of patients receiving dialysis each day. We saw the provider used a headcount calculator tool to determine the numbers of staff required in accordance with patient numbers.

The provider told us there was a minimum of two registered nurses on every shift in the unit, both of whom experienced in haemodialysis, with one acting as Nurse in Charge. The Nurse in Charge was skilled to a minimum of band 6.

The registered manager told us it had not always been possible to be super nummary for some time, due to staffing vacancies. However, a deputy manager had recently been appointed to provide additional support for the registered manager.

The service did not employ doctors and the NHS trust always had a consultant nephrologist and renal registrar on call.

Renal nurses when appointed were supported with additional training which was competency based and included specialist equipment training, ANPP, central venous catheter management, medicines management and basic dialysis management.

Healthcare assistants supported the daily running of the clinic. Healthcare assistants also undertook dialysis and renal care training to ensure their skills met patient need. Training for dialysis assistants included technical elements such as central venous catheter management and a 6-month clinical package.

The registered manager maintained links with nearby associated units to ensure appropriate staffing numbers were maintained in the event of sickness or annual leave. There were no vacancies at the unit at the time of inspection and there was no bank or agency staff in use at the time of inspection.

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.

We reviewed five sets of patient records and saw entries made pre and post dialysis as well as entries made for any variances during the period of dialysis. These included each patient's consent, the latest haemodialysis prescription, blood borne virus test results, and COVID-19 status. All staff could access patients records easily.

The registered manager outlined the electronic access into NHS data base systems to ensure the most up to date blood results were available at all times, prior to treatment.

Records were stored securely and encrypted by the provider. Staff had access to secure database platforms in which to access blood results and referral information. The service archived records in hard copy and digitally and used service level access agreements with the referring trust about storage and access.

Each registered nurse held a caseload of dialysis patients.

There were no information governance breaches.

Medicines

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

Renal consultants based in the NHS trust prepared haemodialysis prescriptions in advance of treatment. The service did not have prescribing staff, however we saw nurses transcribe additional medicines such as paracetamol and oxygen routinely for patients, as and when patients required these items. Transcribing is the copying of medicines information for the purposes of administration, it cannot be used in place of prescribing to issue or add new medicines or alter/ change original prescriptions.

We reviewed five medication administration charts and saw on four separate charts that both paracetamol and oxygen had been transcribed by the renal nurses at the unit. However, none of these entries had been signed by a medical or nurse prescriber, as is required in accordance with Royal Colleague of Nursing guidance. On one occasion paracetamol had been administered to the patient, without an appropriate signature in place. This was a risk of potential harm to patients because medicines may have been administered in error.

We reviewed an additional three medication administration records and saw start dates were missing for the drugs prescribed. This is a further risk to patients as accurate records must be maintained for each person receiving medicines support under The Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Medicines requiring refrigeration were stored in a fridge, which was locked and the temperatures were checked daily. Staff were aware of the action to take if the temperature recorded was not within the appropriate range.

However, we saw the room in which medicines were stored and the cupboard in which intravenous fluids were stored were not locked. This is a further risk to patients as medicines are not stored securely as required under the regulated activity or the providers own medicines management policy.

We brought this to the immediate attention of the provider, who took steps to review all patients' drugs administration records and provide additional training for all nurses at the unit.

Following inspection, the provider submitted medication administration audits and training confirmation, to provide further evidence of improved practice.

Incidents

Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, the classification and grading of incidents was not clear.

Inadequate

Dialysis services

Staff knew what incidents to report and how to report them. We reviewed the electronic incident reporting database and saw incidents were recorded and reviewed appropriately.

The service had reported no never events in the last 12 months.

We reviewed incident data for the last 12 months and saw 580 incidents were logged using the electronic database system. The highest number of incidents were patient related. We spoke with the registered manager regarding the themes and trends identified from the last twelve months, but they were not aware of any trends.

We reviewed the providers policies in relation to incident management and saw they did not provide staff with any specific guidance as to how incidents should be rated or when duty of candour should be triggered. The providers policy and guidance in relation to the reporting of sentinel incidents and serious incidents was also contradictory. Both types of these incidents were defined within the providers policy as being serious physical or psychological injury or involving death, however the policy provided different guidance as to how these incidents should be reported and escalated.

The registered manager told us that incidents reported through the electronic database would automatically send an email alert to the unit manager for review and subsequent grading. However, the lack of clear guidance for staff posed a risk of possible delay in the reviewing of serious incidents, which may result in a possible reoccurrence of incident and potential patient harm patient harm.

Staff we spoke with understood the duty of candour; however, the lack of a clear grading system would potentially prevent a clear trigger for duty of candour.

The provider maintained a record of patient safety alerts and communicated these with staff within the unit.

During inspection we asked managers for themes and trends of incidents which had occurred at the unit, but this was not known.

Is the service well-led?

Inadequate

We rated it as inadequate.

Leadership

Leaders had skills and abilities to run the service. However, local leaders did not always have the capacity to lead effectively.

The registered manager for the unit held significant experience in renal services and had worked as the unit's manager during its transition from the original renal service provider to the current provider.

A deputy manager had only recently been appointed and the registered manager spoke of significant change within the unit within the last twelve months, which had resulted in a high staff turnover. The registered manager explained that the previous year had been challenging and had not always been able to work supernumury. Therefore, some aspects of the management role had been sacrificed in order to provide clinical care in the absence of daily registered nurse availability.

Senior managers within the organisation provided some additional oversight and support during particularly difficult periods and provided some leadership support in the absence of a deputy manager.

The provider ensured all clinic managers complete a series of quality and compliance linked training topics. These included risk management, managing safely, completion of root cause analysis and managing a safe clinic environment and fire safety.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.

The organisation had an overarching vision to provide 'life enhancing renal care, because everyone deserves a fulfilling life'. The overarching strategy for the organisation was to achieve this vision through being 'the most trusted and valued independent sector dialysis provider to the NHS'.

The organisation also held a vision to transform the industry through patient centric digital innovations, delivering and broadening access to the highest quality of care. At local level, managers told us they were dedicated to enhancing the lives of renal patients.

The provider outlined their values as 'competence, passion and inspiration delivered every moment of every day throughout the global network'.

The unit ensured links with local stakeholders were maintained and dialogue with trust colleagues remained ongoing. Current contract provision had been agreed at a regional level, although there was limited evidence of external stakeholder engagement in relation to strategy development, the needs of the local community were met through commissioning contract monitoring.

Leaders we spoke with told us there had been significant change in the last 12 months, however they felt confident moving forward with the organisations vision and values and expressed confidence in the sustainability of the organisation within the region due to the recent clinic stability.

Culture

Staff felt supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

The provider told us they strived for a culture of 'true care' and that the culture was the foundation of how all staff work. Culture was based across three associated behaviours which were competence, passion and inspiration.

The registered manager told us that the culture within the service had improved over the last 12 months due to stability following the transition and new staff recruitment. Managers told us they were focussing now on enhancing staff wellbeing.

The provider had developed a 'speak up' policy to encourage all staff to raise concerns or issues, without fear of blame.

We asked the provider for a copy of the latest staff survey which was basic and did not explore further some of the reasons in which staff gave a negative response. The provider had developed an action plan in response to staff stating they felt there was little opportunity to communicate within the team and felt some of the current clinical practices were restrictive. We saw action was taken by the provider to improve both areas with the introduction of huddles and star employee concepts. The provider had also undertaken a 'You said, we did exercise' in which actions were taken by the provider in response to staff feedback. Areas of staff concern included pay and conditions, staff turnover, training and wellbeing. We saw improvements had been made across all areas within the last six months including new pay arrangements and staff support portal which offered staff benefits and counselling and advice services.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff were not always clear about their roles and accountabilities and did not always have regular opportunities to meet, discuss and learn from the performance of the service.

We saw the provider had a governance structure, outlining escalation processes, clinical and operational quality assurance arrangements and clinical review.

We saw regular board meetings and regional manager meetings, however, we saw a lack of oversight across several areas of the unit's governance processes across several operational areas. For example, policy review, audit results and follow up and staff recruitment records.

We reviewed the providers policy in relation to registered nurse clinical competency processes. The policy outlined a requirement for registered nurses to submit a curriculum vita and ensure that their professional qualification registration was verified by the organisation at the point of recruitment. However, in five nurse records that we reviewed, these registration records were missing, indicating that these documents had not been checked by the provider.

We also reviewed professional nurse registration checks and again saw that these records were missing for several nurses. We brought this concern to the immediate attention of the registered manager who advised that recruitment processes were managed centrally and was not aware of missing documents. Following inspection, the provider who took steps to replace these documents and improve oversight of all recruitment and retention processes.

There was a nominated consultant nephrologist clinical lead for North Ormesby Dialysis Clinic from South Tees NHS trust, with six additional consultants referring into the unit. However, staff told us that only one consultant visited the unit on a regular basis to review patients.

Some policies in regard to risk were not routinely reviewed. For example, the providers policy 'Reporting procedure – steps to be taken following an accident or serious incident' had not been reviewed since implemented in 2020. We saw three separate incident reporting procedures which did not reflect current incident reporting practice.

We also reviewed the providers risk management policy; however, this had not been reviewed since 2019.

The unit had in place an operations induction action plan to support the transition from the original renal care provider to Diaverum. Most points points of action were shown to be complete, however key areas such as staff competency, patients falls risk assessments were shown as ongoing. These actions were originally added in November and December 2022.

We reviewed fire evacuation procedures were completed when smoke was detected within the unit. However, key points of learning following these drills which were not followed up or reviewed. This posed a risk to staff and patients as learning had not been shared to mitigate potential further risk of harm.

Recent audits for handwashing and IPC were not followed up with action plans to drive improvement and we saw equipment checks which were not completed across several months.

We requested regional management meeting minutes, but these were not formally completed and did not appear to have a structured consistent agenda to ensure all key areas were consistently discussed.

We requested audit themes and trends, but the registered manager was unable to provide these.

Therefore, the provider did not always have effective oversight of local governance processes including risk management, patient outcome monitoring and operational outcomes.

Management of risk, issues and performance

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

There was a clinical governance committee as part of the Diaverum group strategy and we saw clear clinical governance processes aligned to staff roles to ensure performance of the quality of care was consistently collated. The local clinic manager was responsible for monitoring and leading on delivering effective clinical governance and quality monitoring in the dialysis clinic, supported by the wider management team. Data was collected by the clinic manager and reported monthly to the trust team where it was input to the UK renal registry.

The provider had developed a clinical risk management policy which was detailed in regard to risk management principles and risk assessment processes, however local risks were not escalated or reviewed. For example, clinical concerns relating to the patient terminating dialysis early was not escalated, equipment checks had not been completed across several months and had not been escalated as a concern and we saw poor transcribing processes, which led to the administration of medication, without a suitable prescribing record.

In addition, NEWS scores were not completed for patients receiving dialysis, which posed a potential risk to patients who may deteriorate suddenly and require urgent escalation.

We requested a copy of the providers risk register, but this was also not provided. Therefore, systems to manage and escalate risks, issues and performance were not effective.

The registered manager had regular contract review meetings with the host NHS trust. However, they were not always minuted and there was no system in place to track actions.

We spoke with the registered manager regarding recent themes and trends identified as part of the incident management process, but they were unable to recall this information.

We saw local management meetings were inconsistent and requested to review recent meeting minutes, but they were not provided.

However, the provider had developed business continuity plans in the event of an emergency or business interruption.

Information Management

The service collected data and analysed it. Data or notifications were consistently submitted to external organisations as required.

Staff completed training in documentation, data protection, record keeping, and information governance. We saw national data was used as a bench mark across all clinics and shared with clinic managers to drive improvement.

Staff also shared data with referring NHS trusts using secure systems. They used dual systems for IT and information management as some processes were duplicated between the provider and the host NHS trust. Both organisations provided IT support to local staff.

We saw notifications were submitted to external regulators as were necessary.

Engagement

Leaders and staff actively did not always engage with patients, staff, equality groups, the public and local organisations to plan and manage services. There was limited collaboration with partner organisations to help improve services for patients.

The provider told us they carried out an annual patient satisfaction survey as a requirement of their contract with the NHS trust. We requested the results of the most recent patient survey, but this was not provided.

We saw the provider involved local stakeholders in the recent refurbishment of the clinic and actively encourage suggestions in which to make the environment better for patients using the facilities.

Learning, continuous improvement and innovation

Leaders encouraged innovation and participation in research.

The provider had recently rolled out Treatment Guidance System (TGS) which was an internally designed system developed to guide all care givers through the dialysis treatment in a consistent way. The system records via a fetch button the relevant data required from the dialysis machine.

This frees up time for the care givers allowing them to spend a greater amount of time with the patient. Data was currently being collated at the time of inspection.