Great Bridge Kidney Treatment Centre

Quality Report

Great Bridge Kidney Treatment Centre
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Date of inspection visit: 02 April 2019
Date of publication: 19/08/2019

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Great Bridge Kidney Treatment Centre is operated by Diaverum Facilities Management Limited. It was awarded the contract as part of a partnership agreement with the local NHS trust. It provides haemodialysis services for adult patients living with end-stage kidney failure. The centre has 24 dialysis stations including four isolation rooms.

The nurse-led centre was supported by renal consultants employed by the NHS trust. The centre's manager was responsible for the day to day management of the centre and dealt with all daily nursing and patient queries. The nursing director for Diaverum Facilities Management Limited has overall responsibility for nursing staff.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on the 2 April 2019.

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 this service has been inspected previously it was not rated. This is the first rated inspection for Great Bridge Kidney Treatment Centre.

We rated it as **Requires improvement** overall because:

- The service had suitable premises and looked after them well. However, did not ensure that spare essential equipment was provided for the safe delivery of dialysis.
- Staff kept detailed records of patients' care and treatment. However, not all paper records had been updated with the most recent information available in the electronic versions.
- The service did not always manage patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers did not always thoroughly investigate incidents and lessons learned were not always shared with the whole team and the wider service.
- Leaders had the integrity, skills and abilities to run the service. However, they did not always understand or manage the priorities and issues the service faced.
- The provider had a vision, values and a strategy for what it wanted to achieve. The vision and values had been adopted at local level however, we saw no local level strategic plans.
- Processes were in place to provide a systematic approach to governance however, we found the documentation and completion of these processes to be limited.
- The service had systems for identifying risks however, these were not always effective.
- The service did not always have documented evidence that staff had learnt from when things went well and when they went wrong. However, the service was committed to promoting training, research and innovation.

However

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

Summary of findings

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff completed risk assessments for each patient.
- 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 service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- The centre planned and provided services in a way that met the needs of local people.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. We also issued the provider with three requirement notices.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis services	Requires improvement 	This was single speciality service which we rated overall as requires improvement. We rated the domains safe and well led as requires improvement and the domains effective, caring and responsive as good.

Summary of findings

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Requires improvement

Great Bridge Kidney Treatment Centre

Services we looked at
Dialysis services

Summary of this inspection

Background to Great Bridge Kidney Treatment Centre

Great Bridge Kidney Treatment Centre is operated by Diaverum Facilities Management Limited. The service opened in 2014. It provides haemodialysis services for adult patients from a local NHS foundation trust who are living with end-stage kidney failure. The service has 24 dialysis stations including four isolation rooms.

The nurse-led centre was supported by renal consultants employed by the NHS trust. The centre's manager was responsible for the day to day management of the centre and dealt with all daily nursing and patient queries. The nursing director for Diaverum Facilities Management Limited has overall responsibility for nursing staff.

The centre primarily serves adults from one NHS trust. It also accepts referrals from outside the area for adults who may be visiting the area on holiday.

The centre's manager had been registered with the CQC since December 2016.

Great Bridge Kidney Treatment Centre is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.

Great Bridge Kidney Treatment Centre was previously inspected in May and June 2017 using our comprehensive inspection methodology. The inspection in 2017 was not rated as at the time CQC had the power to inspect but not rate dialysis services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two specialist advisors with expertise in renal dialysis.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on the 2 April 2019.

Information about Great Bridge Kidney Treatment Centre

Great Bridge Kidney Treatment Centre is a purpose-built building. The service provides haemodialysis to adults and is registered to provide the following regulated activity:

- Treatment of disease, disorder and injury.

The centre is open six days per week and offered morning, afternoon and twilight (evening) appointments on Monday, Wednesday and Friday from 6:30 to 23:30. The centre offered morning and afternoon appointments on Tuesday, Thursday and Saturday from 06:30 to 18:30.

The centre had a good relationship with the local NHS trust, to provide coordinated care between the two services. There were scheduled weekly clinics for patients held by the consultant nephrologists employed by the NHS trust and monthly multidisciplinary team meetings, which included the consultant nephrologist, clinic manager, nursing staff, dietitians and the NHS trusts satellite dialysis coordinator.

During the inspection, we spoke with six staff members, seven patients, reviewed five sets of patient records and reviewed various other documentation.

Summary of this inspection

In the reporting period 1 February 2018 to 1 February 2019

- There were 18096 haemodialysis sessions. Of these 100% were NHS funded.
- There were no overnight stays during the same reporting period.

Track record on safety

- In the past 24 months 16 patient deaths had occurred whilst they were receiving ongoing dialysis treatment. Six of these deaths were unexpected

In the past 12 months the service had recorded.

- No Never Events
- Five serious incidents
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- One surgical site infection (hospital acquired)
- One formal complaint.

Services provided at the centre under service level agreement:

- Clinical and general waste removal
- Cleaning of premises
- Maintenance and calibration of dialysis equipment.
- Maintenance of water treatment plant
- Supply and removal of oxygen cylinders
- Supply and laundering of bed linen
- Social services

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?

Requires improvement 

We rated it as **Requires improvement** because:

- Staff kept detailed records of patients' care and treatment. However, not all paper records had been updated with the most recent information available in the electronic versions.
- The service did not always manage patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers did not always thoroughly investigate incidents and lessons learned were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service had suitable premises and looked after them well. However, did not ensure that spare essential equipment was provided for the safe delivery of dialysis.

However

- The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- 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.
- Staff completed risk assessments for each patient. Staff kept clear records and asked for support when necessary.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service mostly followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Are services effective?

Good 

We rated it as **Good** because:

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- 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 monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Are services caring?

Good 

We rated it as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

Good 

We rated it as **Good** because:

- The centre planned and provided services in a way that met the needs of local people.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously and investigated them. However, we were not assured that lessons learned were always shared with staff.

However,

- The service took account of patients' individual needs. However, limited information was accessible in other languages.

Are services well-led?

Requires improvement 

We rated it as **Requires improvement** because:

Summary of this inspection

- Leaders had the integrity, skills and abilities to run the service. However, they did not always understand or manage the priorities and issues the service faced.
- The provider had a vision, values and a strategy for what it wanted to achieve. The vision and values had been adopted at local level however, we saw no local level strategic plans.
- Processes were in place to provide a systematic approach to governance however, we found the documentation and completion of these processes to be limited.
- The service had systems for identifying risks however, these were not always effective. The service had plans to cope with both the expected and unexpected.
- The service did not always have documented evidence that staff had learnt from when things went well and when they went wrong. However, the service was committed to promoting training, research and innovation.
- The service collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards. However, this information was not always effectively shared.

However

- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and services collaborated with partner organisations effectively.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Dialysis services

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

Are dialysis services safe?

Requires improvement

We rated it as Requires Improvement:

Mandatory training

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

- Mandatory training was provided through a combination of face to face and e-learning. At the time of our inspection mandatory training compliance was a 100%.
- Mandatory training was completed in basic life support, fire safety, hand hygiene, medication management and data protection annually. Further training on a three-year cycle was provided in the subjects of Mental Capacity Act (2005), personal protective equipment, sharps management, duty of candour and anaphylaxis. The practice development nurse had devised a yearlong rolling programme of training and updates to enable staff to plan in when their training was due.

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.

- Mandatory training in safeguarding was provided. Staff were trained to safeguarding adults and children level 2. At the time of our inspection, 91% of staff had completed safeguarding adults' level 2 and 96% had completed safeguarding children level 2. The clinic manager was trained to safeguarding adults level 3.
- Staff we spoke to knew how to protect people from abuse. Staff we spoke to were confident in escalating and reporting any safeguarding issues.
- A safeguarding adults with care and support needs policy and a separate child protection policy were in place and in date. However, the policy did not outline what level of safeguarding training staff members should be trained to or the frequency in which the training should be completed.
- Staff told us that no children were allowed on the premises. If a patient was having repeated issues with child care that meant they were having to miss appointments, then arrangements would be made for their dialysis sessions to be delivered from the trust site where more appropriate safeguarding arrangements were in place.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

- The provider had an infection control policy that applied to all its satellite clinics. The policy outlined staff and patient responsibilities relating to good hygiene practices and how to maintain the environment.
- All areas of the unit we visited were visibly clean. Cleaning schedules for daily and weekly cleaning tasks

were displayed. We saw that high and medium risk areas and daily cleaning tasks were consistently completed. Cleaning apparatus was appropriately colour coded and segregated within the storage room.

- The service conducted quarterly infection control audits. These audits covered nine areas of the clinic including clinical and non-clinical areas, storage and waste segregation. We reviewed two of these audits and saw 97% compliance was achieved in quarter four of 2018 and quarter one of 2019. We saw that where areas of non-compliance had been reported individuals were informed for example, it was noted that cleaners had been informed after it was found buckets in the cleaner's cupboard had been stored on top of each other and that the cleaner's room was not well maintained. However, the maintenance of the cleaner's cupboard was also an area of non-compliance on the quarter one audit conducted in 2019. No action plans were created following the infection control audit completion.
- We reviewed two cleaning audits for the clinic. Cleaning at the unit was carried out by a third-party provider with audits receiving sign off from the clinic manager. Results recorded were 90.47% in February and 87.2% in March 2019. We saw that repeated areas were marked as non-compliant on both audits. The clinic manager had recorded they were unhappy with the consistency provided in the February audit despite this, compliance decreased further in the March audit. No further actions in relation to cleaning audit results were listed and problems with cleaning audits were not entered onto the clinics risk register.
- Personal protective equipment for example, gloves in a range of sizes were available across the treatment area. Throughout the inspection, we observed staff using the correct personal protective equipment and washing their hands between patient contacts. However, we saw a staff member wearing a stoned ring within the treatment area who, when questioned stated that the policy did not say 'no diamonds' in rings. When we received the general infection control policy it stated no rings to be worn by employees at all. Therefore, we could not be assured that all staff were aware of their responsibilities in relation to infection control.
- Hand hygiene posters were on display by each sink. We saw hand hygiene posters describing the five moments of hand hygiene were on display and hand disinfectant was readily available. During our inspection, we saw staff washing their hands in line with best practice recommendations. We reviewed meeting minutes that had previously stated hand hygiene had been very poor. We reviewed the last three hand hygiene audits which were at 80%, 100% and 70%, reasons for non-compliance in the audits that achieved under 100% were not listed.
- The unit had four isolation rooms. These rooms could be used for those with a confirmed infection risk and for those returning from holiday. Although none were in use for infectious patients at the time of our inspection, we saw barrier stations were set up outside the rooms with action posters alerting staff and visitors to the infection risk on the doors.
- The water treatment system was maintained in line with best practice recommendations and we saw the relevant checks had been conducted that morning before the first patient received treatment.
- Central venous access devices were audited monthly. Staff assessed the insertion site, dressing and antimicrobial lock to ensure there were no issues with ongoing care through the venous catheter. We saw audit results from March and April 2019 and saw that these both achieved 100%

Environment and equipment

The service had suitable premises and looked after them well. However, did not ensure that spare essential equipment was provided for the safe delivery of dialysis.

- The unit was purpose built to provide dialysis treatment.
- The dialysis unit had dedicated parking including disabled bays and patient transport areas. Access to the centre was controlled. Access to the unit was controlled via an intercom system linked to the main reception desk or the nurse's station. Electronic fobs controlled the access to the treatment area from the

reception and into other areas such as stores and the water treatment area. These systems ensured that only authorised persons could access the appropriate areas.

- The centre was all on one level and so was wheelchair accessible throughout. The waiting room had ample seating including bariatric provision and male and female toilets.
- The main treatment area was separated into three bays and four side rooms which could be used for isolation. Five nursing stations were located across the treatment areas.
- Individual dialysis stations were adequately spaced out allowing for space between each patient in line with the Department of Health building requirements (Satellite dialysis units: planning and design HBN 07-01). Each bay had an individual call bell to draw the attention of nurses if needed. Once pressed an audible alert sounded and a light above the individual station was illuminated to draw attention to the correct patient.
- An external provider remotely monitored the water treatment equipment 24 hours a day, seven days a week.
- The centre had spare dialysis machines that were serviced and ready to be used in the event of machine failure to allow patient treatment to be uninterrupted. Machines that needed serving or maintenance were removed from the treatment area and clearly labelled as not for use.
- An external provider provided a fully comprehensive servicing program of the dialysis machines and we saw an up to date service agreement between the centre and this provider. Dialysis machines were serviced annually, and we saw evidence of this. Quarterly audits were carried out on all elements of maintenance and repair to ensure that the correct procedures were in place and being adhered to.
- Consumable stock items were stored appropriately and within their expiry dates. We checked six items of other medical equipment including suction machines and electronic blood pressure machines and found that they all had regular servicing performed.
- Emergency resuscitation equipment was available and stored securely. The centre had an emergency trolley and two emergency grab bags with basic life support equipment within the main treatment area. All were easily accessible if needed in an emergency. We saw that this equipment was checked daily and weekly. We checked ten items, all were within their expiry dates. The provider had an emergency equipment and medication policy which was last reviewed in December 2015. We were told that this policy was currently under review at the time of our inspection.
- The main store room was clean and tidy with items stored off the floor. All staff were responsible for monitoring stock levels. Health care assistants were responsible for stock rotation. We saw adequate amounts of stock and equipment was available in various sizes where appropriate.
- Systems were in place for the segregation and correct disposal of waste materials such as sharp items and those contaminated by bodily fluids. This included secure sharps containers with temporary closure ability for the safe disposal of needles. Clinical waste was appropriately separated before disposal with all bins being labelled appropriately.
- The centre only had one set of weighing scales, we raised this as a breach of regulation in our last inspection. Staff told us if these were to stop working or develop a fault staff would use a patients last recorded weight to estimate their weight for the treatment session. We were told the maintenance provider for the scales had a 24-hour response target and so they could be fixed the same or the next day. Patients requiring dialysis often have varied weights between sessions and this is used to determine their level of treatment. No immediate mitigation plans were in place to minimise risk to patients whilst awaiting the scales to be fixed. This posed a serious risk to patients that too much or too little fluid may be removed during their treatment and that the effectiveness of their dialysis session would be impacted.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. Staff kept clear records and asked for support when necessary.

- A sepsis policy was in place and staff could describe the steps they would take in the event of an acutely unwell patient. The centre used a haemodialysis satellite unit sepsis screening tool, which was implemented in March 2018 and adapted for dialysis units from national guidance. A flow chart documented actions to take while also taking into account known side effects and symptoms of dialysis treatment. We saw these flow charts on display at the nursing stations in the treatment area. Staff told us that if sepsis was suspected the relevant bloods would be sent from the unit and antibiotics may be prescribed if stocked on the unit, with arrangements for the patient to be transferred to the acute trust then made.
- Protocols were in place to transfer patients to urgent care providers. Policies were in place that covered the deteriorating patient with transferring patients to alternative providers being an action step at various stages. If a patient was to be transferred, a transfer sheet would be completed with all relevant patient details that would accompany them to hospital. Staff would also complete a situation, background, assessment and recommendations (SBAR) sheet as part of the transfer process. Staff told us if a patient was acutely unwell or haemodynamically unstable or experienced a vascular access bleed staff would call 999 for assistance.
- Patient records had photos in place to ensure correct patient identification, patient labels for their treatment and signed in date consent for haemodialysis in place
- Risk assessments prior to treatment commencing had been performed and documented in patient notes. We saw evidence of risk assessments for falls, mental capacity, pressure injuries and manual handling had been completed. We saw that patients who had been highlighted as high risk of pressure sores were provided with appropriate pressure relieving equipment such as pillows and air flow mattresses and were turned every two hours.
- The majority of dialysis bays could be seen from the five nurses' stations spread across the four bays. However, some were not always in line of sight as they were behind the nurses' stations in the corner of the room. The isolation rooms also were not fully visible as the nurses station by these rooms was within an alcove however, patients were checked hourly as a minimum during their treatment.
- Patients were advised on the importance of attending their regular dialysis sessions. Posters were on display explaining the importance of regular dialysis and advising patients to discuss any issues with attending appointments. When a patient missed a dialysis session an alternative session would be offered and we were told staff would discuss the reason for the missed session with the patients. If repeated sessions were missed the patient would be reviewed by the consultant.
- Staff were able to describe the steps they would take in handling any patients who became aggressive whilst receiving treatment.

Nurse staffing

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

- The centre employed one manager, one deputy clinic manager, three senior staff nurses, eight staff nurses, three dialysis support workers and six health care assistants
- Staffing establishment was determined using a headcount calculator model devised by Diaverum, based on renal workforce planning guidelines and the centres contractual requirements. The clinic manager informed us that they were currently under established by 0.8 whole time equivalent for nursing staff. Interviews were planned to recruit a further nurse during the week of our inspection.
- The clinic manager assessed staffing levels daily. Any shortfalls for the next day were identified and covered by the centres existing staff or bank staff.
- The staff to patient ratio for the centre was set at one qualified member of staff to four patients. A qualified staff member was counted as either a registered nurse or a dialysis support worker. The renal workforce planning group advises that the staff to patient ratio during dialysis should be between one member of staff to three or one member of staff to four patients.

The skill mix provided should be between 70% nurses to 30% healthcare assistants to 50% of each staff group. We saw that skills mix of nurses to healthcare assistants was equal to or above 50:50 for all shifts. The provider's rostering procedure stated that a minimum of two registered nurses should be scheduled to each shift.

- On the day of our inspection, the staffing levels were four nurses, one dialysis support worker, two health care assistants, and one nurse was off sick. A member of bank nursing staff arrived by lunch time to cover the shortfall.
- Staff we spoke to told us that the patient to nurse ratio was not always maintained. However, evidence provided to us post inspection highlighted that the staff to patient ratio had not been met on only one occasion since December 2018.
- We observed a nursing handover and saw that this was not formally documented despite issues with patient care being discussed. We were told important details were put into a diary that staff had access to. When we reviewed this diary at the end of the day important detail discussed in the morning handover had not been documented within it. This presented a risk that not all patient information was being communicated between all staff members.
- The provider had developed an internal bank staff system of experienced dialysis nurses who could be used to cover any staff shortfalls. The centre would only use external agency staff in exceptional circumstances.
- Management discussed staffing levels at regional meetings. We saw in meeting minutes that staffing levels, sickness and retention strategies were discussed. Sickness absence rates over the three months before inspection were reported as being 2%.

Medical staffing

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

- Two dedicated consultant nephrologists provided medical oversight of all the patients at the centre. One consultant covered patients who attended on Mondays, Wednesday and Fridays while the other consultant oversaw the patients who attended on the remaining days. The two consultants worked together and would see each other's patients if needed in the event of sickness or annual leave.
- We were told how four to five outpatient clinic sessions were performed each month to review patients care and treatment. Nurses told us they felt able to escalate any patient of concern to medical staff. Any urgent patient issues were escalated to the renal registrar on call and consultant in charge at the commissioning trust.

Records

Staff kept detailed records of patients' care and treatment. However, not all paper records had been updated with the most recent information available in the electronic versions.

- Patient records were available in both electronic and paper format. During the inspection, we had concerns that patients' paper records that were mainly used while delivering treatment were not fully up to date. Patients' last consultant clinic letters were stored within their electronic records and not their paper records, meaning nurses may not be fully aware of any updates regarding the patients' treatment unless the electronic record was checked first. Staff would have to check electronic versions of patients record to get the most up to date information and we were not assured that this happened consistently.
- The referring trust had their own electronic patient records system that Diaverum staff had access to, this system aimed to ensure people involved in delivery of the patient care had access to view blood results and clinic letters and patient progress. However, we could not be assured that all nurses were checking this prior to a patient's dialysis session to check for any updates.
- The service completed dialysis and care plan audits monthly. We reviewed the audits performed in December 2018, January 2019 and February 2019. The audits were detailed and covered 21 different criteria including checking that care pathways were reviewed and completed, prescription charts were up to date and risk assessments had been reviewed. Audit results showed the service achieved 100% compliance in December 2018 and January 2019 with 99%

compliance recorded in February 2019. However, we noted that in January 2019's audit 96% compliance was achieved on one particular question 'Have all risk assessments been completed and up to date' despite this 100% compliance was achieved overall for that month. Therefore, we were not assured that sufficient attention would be drawn to the area of non-compliance within the audit.

- We saw that consultant nephrologist communicated with patient's GPs effectively and copies of letters were stored on the electronic patient records.

Medicines

The service mostly followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

- Staff monitored the temperature of medicines fridges daily. For the month before our inspection the actual, minimum and maximum temperature of the fridges had been recorded and action taken where necessary.
- We saw that oxygen cylinders were stored in line with national guidance and in designated areas of the centre.
- The service did not have a nominated pharmacist but could contact the pharmacy department at the referring trust for support if needed.
- The referring trust employed a lead dialysis co-ordinator who was a nurse prescriber and worked across the satellite dialysis units, they could update or prescribe new medications as needed for patients. Medications they could prescribe included intra venous antibiotics for suspected or confirmed dialysis line sepsis, erythropoietin, intra venous iron for anaemia management.
- Medication prescriptions were audited monthly as a part of the patient documentation audit. We reviewed drug charts within patients notes. One patient had two current drug charts, posing a risk that drugs may be administered twice. We raised this at the time of our inspection and it was immediately rectified. We also noted that one diabetic patient did not have any glucogon prescribed so may experience a delay in treatment if they were to experience a hypoglycaemic episode during treatment we were told this would be rectified following our inspection.

Incidents

The service did not always manage patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers did not always thoroughly investigate incidents and lessons learned were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- The service had an electronic incident reporting system and staff received training on how to use it. Staff we spoke to knew how to access the system and report an incident.
- We reviewed two sets of staff meeting minutes and saw that although incidents were an agenda item individual incidents and outcomes had not been discussed.
- The clinic manger told us the highest number of reported incidents were in relation to patients missing treatment sessions or treatments being ended early.
- We were told how, after two needle stick injuries to staff planned needle training had been brought forward in response in an attempt to prevent more incidents.
- In the 12 months before our inspection the service reported five serious incidents, three falls and two venous line dislodgements.
- The service reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Leaders could describe the duty of candour process. Duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety

incidents and provide reasonable support to that patient. Zero duty of candour notifications had been made by the service in the months before our inspection 12 months.

- Root cause analysis investigations (RCAs) were completed after serious incidents. We reviewed two root cause analysis investigations during the inspection. These were completed on two different templates this meant there was no consistent systematic approach to the investigations. The clinic manager completed both investigations, this is not best practice as no external view on the incident was sought. No assessment of risk level or impact assessment was made as a part of the investigation. Analysis of the incidents were brief and lacking wider background details. We saw sections of the RCA template had been left blank such as the outcome review section, recommendation/solutions, actions and steps, person responsible and timescale/ milestones. We reviewed staff meeting minutes for the months after the investigations had been completed and no overview, learning or conclusion from the investigation was shared with staff. We saw in Midlands area team meeting minutes from December 2018 that the quality of RCAs and the importance of learning outcomes was discussed. However, during the meeting no RCA investigations or findings were shared across the clinic managers.
- RCAs for falls were completed on a further template. We reviewed two of these after the inspection. They covered a range of criteria including environmental, fall risk factors and other clinical details. We saw that one was completed in November 2018 which was over a month since the incident had occurred. The investigation and its recommendations were not shared with staff within the staff meeting which took place after the investigation had been completed.
- We reviewed both the management of serious medical incidents policy and the reporting and follow-up of clinical incidents policy neither mentioned who held responsibility for performing the investigation into serious incidents. The policy for reporting and follow-up of clinical incidents cited the serious medical incidents policy to hold the information needed to assess a clinical incident in respect of its severity. However, this information was brief and provided limited assistance in the categorisation of incidents. Neither policy set out time frames in which investigations into incidents should be completed.

Safety Thermometer (or equivalent)

- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The service produced a monthly performance report which it shared with its staff and referring trust to monitor the performance of the centre.

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

Good

We rated it as **good** because:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- Overall, we saw that staff delivered dialysis therapy in line with clinical guidelines published by the UK Renal Association and accredited by the National Institute for Health and Care Excellence (NICE).
- The centre provided haemodiafiltration to patients. This form of dialysis is considered best practice because it can lower the risk of developing complications associated with dialysis treatment and can provide better patient outcomes.
- All patients had monthly blood samples taken which were analysed by the referring trust. These were reviewed each month during the multi-disciplinary quality assurance meeting and any changes to patients' prescriptions made as necessary.
- The service accepted patients who were receiving dialysis away from base. Dialysis away from base is the term used to describe arrangements made for a patient to receive dialysis in a different centre to the one they were referred to. This may be due to holiday or attending commitments for personal and business

purposes. A specific holiday coordinator was in place to help patients with all the arrangements to have dialysis away from their usual base. A designated machine would be used for those returning from holiday and this was clearly marked. Blood tests for blood borne viruses would then be completed every two weeks for three months until bloods were clear before the patient could them be treated in the open treatment area.

- The UK Renal Association's clinical practice guidelines on vascular access for haemodialysis recommends 80% of all long-term dialysis patients should receive dialysis treatment through 'definitive access' such as an Arteriovenous fistula (AVF) or arteriovenous graft (AVG). At the time of inspection 73% of the patients at the service had definitive access in place.
- Staff recorded patients' weight, temperature, pulse and blood pressure at the beginning and end of each dialysis treatment, this is in line with clinical practice guidelines published by the UK renal Association. However, no secondary set of scales were available so in the event of breakdown staff estimated a patients' weight based on their weight at the previous session.
- Patient with fistulas had regular vascular access reviews. Vascular access sites were monitored every treatment by the nurse and audited on a monthly basis. Vascular access surgeons reviewed patients approximately every three months, if needed staff could refer patients with access issues to be urgently seen by the vascular team at the referring trust.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

- Patients with renal failure need to follow a strict diet and require fluid restriction to maintain a healthy lifestyle.
- Staff provided patients with at least one hot drink and biscuits during their therapy sessions. We saw that the service had acted on patient feedback and now provided soy milk for lactose intolerant patients.
- A water cooler was available in the reception area for patients and those accompanying them to their treatment.
- The service did not provide meals however, had approached a local sandwich company to deliver pre-ordered items to the centre, which patients funded themselves. Patients could also bring their own snacks and food to consume during their treatment.
- The referring NHS trust provided nutrition support to all patients. Patients were reviewed monthly by the dietician. The dietician also attended the monthly quality assurance meetings.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

- Patients told us that staff checked if they were experiencing any pain during their treatment. Pain relief was available when needles were inserted.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- The referring NHS trust reported to the UK renal registry for all dialysis patients it had referred and therefore the centre did not directly contribute data to the registry. One of the centre's two consultants had the responsibility of collating and reporting the information from the satellite clinic.
- Patient outcomes against renal association standards were reviewed monthly at multi-disciplinary team meetings. The renal association recommends that every patient with end-stage chronic renal failure receiving dialysis three times a week should have a urea reduction ratio (URR) of >65%. For the months December 2017 to December 2018 inclusive the service achieved an average of 96.2% patients with a URR of >65%. Further recommendations outline that patients should aim to achieve an equilibrated Kt/V of >1.2, for the months of December 2017 to December 2018 the clinic achieved this level for 92.1% of patients.
- Patient transport services were provided by a private taxi firm and a patient transport ambulance service.

- Patients we spoke with did not report long delays in waiting for their treatment once they had arrived at the clinic.

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 monitor the effectiveness of the service.

- The clinic manager had completed specialist renal nursing courses and could support staff in the delivery of treatment.
- All staff had received an appraisal in the three months before the inspection. We reviewed two completed appraisals and saw that these were completed in line with company values with reflection and goal setting for the next year.
- A system was in place to monitor staff competency. Staff competencies were tracked by the clinic manager and updated in staff files. Competency assessment were competed in infection control and aseptic non-touch technique (ANTT) yearly. Education sessions were also held throughout the year covering hand hygiene, water awareness, and falls prevention and management.
- There were link nurse roles for various roles such as infection control, diabetes and blood borne viruses. Link nurses attended additional training to enable them to provide further insight to staff and to support patients in the management of their conditions.
- The provider employed a practice development nurse that provided support and training to all Diaverum clinics within the central region. We saw that a midlands education and training plan had been put in place for 2019. Sessions were a mix of online training or participatory sessions led by the practice development nurse for the region or a link nurse.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

- Three haemodialysis liaison nurses employed by the referring trust acted as the liaison between the dialysis service and the trust. The role included co-ordinating care for new patients being discharged from hospital or to update on the condition of current patients who had been admitted. There was also a nurse prescriber who was available to update prescriptions if necessary if consultants were unavailable.
- The referring trust provided two dedicated consultant nephrologists and dietician support to the patients receiving dialysis at the centre.
- We reviewed multi-disciplinary team meeting minutes from February and March 2019 and saw that these were attended by nurses, consultants, the haemodialysis liaison nurse and dietician.However, we noted that no dietician report was noted within the minutes and no actions were listed in order to prevent recurrent 'did not attends' which were discussed in the meeting. We saw some areas where actions were identified but it was unclear from meeting minutes if this had been completed.

Seven – day services

The centre did not currently provide a seven-day service.

- The centre did not provide a seven-day service.
- The centre opened six days per week and offered morning, afternoon and twilight (evening) appointments on Monday, Wednesday and Friday from 6:30 to 23:30. The centre offered morning and afternoon appointments on Tuesday, Thursday and Saturday from 06:30 to 18:30.

Health promotion

- Leaflets were available in the waiting area about keeping active and reducing falls risks, copies of Kidney Care UK magazine were also available. Information was available to patients on the increased risk of flu for dialysis patients to book in for jabs.

Consent and Mental Capacity Act

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Requires improvement

Dialysis services

- It was provider policy to gain written consent when a patient was first referred for dialysis treatment and for this to be updated annually.
- We reviewed five patient records and saw signed consent for treatment was present in all folders.
- Staff received training in relation to the Mental Capacity Act (2005) at the time of inspection 100% of staff had completed it.

Are dialysis services caring?

Good

We rated it as **good** because:

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

- Staff treated patients with kindness and compassion. We observed staff interacting in a polite and supportive way with patients and their families and seemed to have a good rapport with all patients in their care.
- One patient told us 'staff are very caring and I am able to get help when needed' another patient told us 'the staff are very friendly'.
- Thank you cards from patients and their families were displayed in the waiting room. Comments included 'You are all amazing and like a family for us' and 'Thank you for all the support you have given during this tough time'
- We saw that privacy screens were available for use within the treatment area to provide privacy for a patient at their request. We saw these in use during our inspection when a patient became unwell during treatment to give them privacy from other patients in the treatment area while staff attended to them.
- During their treatment all patients had access to individual televisions and access to free Wi-Fi facilities.
- Patients we spoke with were happy with the care that they received, felt able to raise concerns to staff and did not report any issues with transportation arrangements.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Staff could refer patients to the psychologist at the referring trust if they felt it appropriate and we were told how consultants would also contact a patients GP to request they be referred to local mental health support if need.
- If staff identified any social care needs, the patients GP and community social services would be contacted.
- The service actively informed patients of education days and events for patients and their families, offered by the commissioning trust's Chronic Kidney Disease team or the Kidney Patient Association.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- Patients we spoke to felt informed about their care and any changes to their treatment. One patient told us that 'I can be involved as much as I want to be'.
- Patients told us they were informed of their monthly blood results and could ask any questions about their treatment.

Are dialysis services responsive to people's needs?

(for example, to feedback?)

Good

We rated it as **good** because:

Service delivery to meet the needs of local people

The centre planned and provided services in a way that met the needs of local people.

- The referring NHS trust contracted the centre to provide haemodialysis services for its patients. The service reported its progress in delivering the service against the defined specifications at monthly quality assurance meetings and through the collection of key performance indicator and quality outcomes.
- The space, size and configuration of the centre was appropriate to meet the needs of the specialist patient group and met the requirement of the Department of Health building requirements (Satellite dialysis units: planning and design HBN 07-01). The centre was on one level and was accessible for those with mobility needs. Disabled parking bays and toilets were available. Dialysis treatment bays had enough space to allow each patient some privacy during their treatment. Isolation rooms could be used by those who wanted more privacy if they were not in use.
- There was adequate seating available in the waiting area of the centre with space for wheelchairs and two chairs suitable for bariatric patients. There were two consulting rooms for appointments with consultants or dieticians to be undertaken.
- Patients had flexibility and choice with their care. Staff would support patients in making arrangements to receive dialysis on alternative days if needed.
- Wi-Fi access was available to patients. We saw patients using mobile devices while receiving their treatment.
- Transport was provided by private taxi and an ambulance patient transport service. Patients we spoke to were happy with their transport arrangements.

Meeting people's individual needs

The service took account of patients' individual needs. However, limited information was accessible in other languages.

- The centre had a large waiting area with room for wheelchairs and seating suitable for bariatric patients. The centre was also able to offer beds to receive dialysis in if patients were assessed as suitable.
- A hoist was available to transfer patients from wheelchairs to dialysis chairs when required.
- Various literature was available within the waiting room but there was no literature or signage available in any languages apart from English. Staff told us they thought information could be downloaded from the website in different languages however, management confirmed this was not possible.
- We were told how translation services would be used if required to explain the dialysis procedure and gain consent upon the patients first appointment.
- Protocols were in place for the management of patients living with dementia and staff has knowledge of them. Staff told us that in general the service did not treat patients with complex needs or significant co-morbidities. These patients received their dialysis at the trust site where more support was available on site.
- A holiday co-ordinator nurse was available to support those who wished to have dialysis away from base. Information was displayed about dialysis away from base in the waiting area, with posters of locations patients could have their treatment transferred to for a short time. Patients who wished to enquire about dialysis away from base were asked to speak with staff.
- The service was starting to offer the shared care initiative which promoted patients to be involved with their own dialysis treatment. Staff members had started to receive the training in how to break down the dialysis process to enable patients to set up and administer their own treatment if they wished.
- We were told how all patients had access to patient view which was an online support package which contained a range of dialysis information. We discussed this with patients with some telling us they had chosen not to use it.

Access and flow

People could access the service when they needed it.

- All patients were referred for treatment at the centre from the local NHS trust. Treatment was co-ordinated between the centre and referring trust with patient preferences for treatment days being taken into account. At the time of our inspection treatment was available six days per week and offered morning, afternoon and twilight (evening) appointments on

Monday, Wednesday and Friday from 6:30 to 23:30. The centre offered morning and afternoon appointments on Tuesday, Thursday and Saturday from 06:30 to 18:30.

- The centre was accessible to patients. A bus stop and a train station were located very close to the centre and parking, including designated disabled bays were available outside the centre.
- Patients were offered alternative appointment times if they could not make a treatment session for any reason and support was offered to ensure patients did not miss dialysis sessions. Patients could access support from the service between treatments if needed. A 24-hour computer patient view was available with learning materials and information about living with chronic kidney failure.
- Clinic utilisation for the service for the three months before our inspection was December 90%, January 95% and February 99%. At the time of our inspection there were no patients on the waiting list to receive dialysis at the centre.
- In the three months before our inspection 96% of patients had their dialysis session started within 30 minutes of their appointment time.
- The centre reported no cancelled dialysis sessions for non-clinical reasons in the three months before our inspection.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them. However, we were not assured that lessons learned were always shared with staff and informal complaints were followed up in a timely way.

- Patients were provided with information of how to make a complaint about their care and treatment. We saw information on display for the patient advice and liaison service (PALS) and their contact details. Patients we spoke with, told us they felt able to speak to staff as and when concerns arose did not need to use the formal complaints process. Patients we spoke with felt comfortable and able to raise any concerns they had with their named nurse or the registered manager.
- Complaints were responded to appropriately. In the 12 months before our inspection, the service had received three complaints, with one being managed under the formal complaints procedure. One complaint related to equipment availability, one around being moved dialysis bays and the other one in relation to reported racism. We reviewed each of these complaints during the inspection and saw they had been reviewed and managed. The formal complaint was investigated with the input of local staff and regional Diaverum management representatives.
- A provider wide complaints procedure was in place. The policy stated that verbal or written acknowledgement of the complaint should be given within two days, with a full response being given within 20 days unless being treated as an ongoing complaint. The one formal complaint we reviewed was handled in line with the policy. The two complaints not managed under the formal complaints procedure were still logged upon the complaint management system however, these the system noted that responses to these complaints were not given until four and six months after they were reported. Therefore, we could not be assured that informal complaints were followed up in a timely way.
- We reviewed staff meeting minutes from November 2018 and January 2019, no complaints, incidents, themes or lessons learned were discussed. This meant we were not assured that lessons learned were always shared with staff
- Patients could provide feedback in different ways. Patients could provide feedback on their service through the friends and family test, feedback boxes within the waiting room and a commissioned patient survey twice per year. The service conducted patient satisfaction surveys and used the results to evaluate their service provision and act on any concerns that were reported.

Are dialysis services well-led?

Requires improvement

We rated it as **requires improvement** because:

Leadership

Requires improvement

Dialysis services

Leaders had the integrity, skills and abilities to run the service. However, they did not always understand or manage the priorities and issues the service faced.

- The service was led by a clinic manager who held a formal renal qualification. Staff we spoke with told us that manager was visible and easily approachable. The manager's office was located within the treatment area which meant they were available to staff and patients. A regional practice development nurse and area manager also assisted in management and oversight of the centre.
- The local management team did not demonstrate a full understanding of the risks at the service systems for identifying and managing risks were not always used effectively by the management team. For example, when we asked about the centre not having access to a secondary set of scales the issue did not seem to be recognised as being of importance. This issue was also raised at the last inspection and was not present on the centres risk register.
- We saw that various meetings were held and attended by local and regional management. However, all minutes we reviewed had a lack of detail and assurance that actions had been taken and that learning had been distributed to the necessary staff.
- The leadership from the centre and Diaverum worked closely with the referring trust and had regular established communication channels.

Vision and strategy

The provider had a vision, values and a strategy for what it wanted to achieve. The vision and values had been adopted at local level however, we saw no local level strategic plans.

- The mission and vision of Diaverum were displayed in the main waiting area. The mission was to 'improve the quality of life for renal patients' with the vision to be 'the first choice in renal care'.
- The Diaverum philosophy of care standards were displayed in the waiting room, these focused on putting the patient at the heart of the service. These standards explained what staff aimed to do as part of their work for example, treat patients as individuals, respect their privacy and dignity and to maintain a safe environment. We saw that appraisals were completed in line with these standards**.**
- We were told how strategic priorities were set at provider level however, we did not see these priorities referenced in any documents we reviewed at local level. No local strategy document was in place to ensure that centre was aligned to the provider objectives. We were told that one was due to be formulated.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose.

- Staff were happy working for the service. Staff we spoke with were happy in their role and described it as a friendly supportive team to work in. Staff told us that they felt supported in their role and were able to raise concerns.
- Staff worked collaboratively to provide joined up care. Staff from all professions worked and interacted well together to provide care to patients.
- A good work life balance was promoted among the staff. Staff were not allowed to work more than five days per week.
- The provider had a Workforce Race Equality Implementation (WRES) implementation plan with data collection of WRES data taking place across April 2019 upon a new Human Resources platform. No previous WRES data had been published for the service.

Governance

Processes were in place to provide a systematic approach to governance however, we found the documentation and completion of these processes to be limited. For example, minutes had no information documented under patient complaints and concerns, infection control, documentation or auditing. No learning from incidents or complaints or concerns was discussed or shared.

- The leadership team co-ordinated with the referring trust and their staff on a regular basis, they attended monthly quality assurance meetings and contract review meetings.
- We reviewed the minutes for quality assurance meetings from February and March 2019 and found these lacked details around the discussions held and actions completed to improve care. For example, reasons for patients not attending were discussed but no themes, actions or interventions were discussed.
- The referring trust and Diaverum held monthly contact review meetings to discuss performance data from each Diaverum clinic. We saw these were well attended by staff from both parties. We saw that complaints and RCAs were discussed but there was limited documented discussion around learning or changes to practice as a result shared between the satellite clinics and with the trust. We were told that audits of renal catheter ongoing care audits and hand hygiene were discussed monthly in the contract review meetings however, we saw no evidence of renal catheter audits being discussed within the minutes we reviewed.
- We reviewed staff meeting minutes from November 2018 and January 2019. These were completed in limited detail with sections of the agenda not discussed. For example, the November 2018 minutes had no information documented under patient complaints and concerns, infection control, documentation or auditing. No learning from incidents or complaints or concerns was discussed or shared. It was not possible to tell who had attended the meeting and who had given apologies as all names were included in a single list.
- We saw that in the February 2019 minutes, the attendance area of the meeting record had been changed so it was possible to see who was present at the time of the meeting. We saw the risk register was discussed but no detail was recorded into any change's, mitigations or updates, just the items of the risk register were listed.
- We reviewed two root cause analysis reports and found that there was no consistent approach and they lacked oversight at a corporate level. Investigations lacked sufficient detail to understand the process. We were told that root cause analysis reports were reviewed by the area manager and practice development nurse however, no evidence of this review process was noted within the reports. After our inspection we were provided with e-mail evidence that RCAs were reviewed and questioned by the area manager.
- During our inspection, we reviewed two staff files. We felt that both did not have adequate references in place. Although both files had two references as specified by the company policy, we found that the references gave very limited or no detail of the employee's previous employment, one did not provide the dates of the previous employment. Of the two references in the first file, one had no dates of employment and limited detail contained, the second had dates of employment but no detail. The second file contained a character reference covering nine months prior to employment, with the second reference covering a six-month time period again containing limited detail.
- We were not assured that effective arrangements were in place to ensure that notifications were submitted to external bodies as required. For example, it is a statutory requirement for the Care Quality Commission to be informed when a patient dies while a regulatory activity is being provided or where their death may have been a result of the regulated activity or how it was being provided. Information submitted prior to the inspection stated that 15 patient deaths had occurred within the 24 months before our inspection with six of these deaths being unexpected. The Care Quality Commission had only received notification of four of these deaths.

Managing risks, issues and performance

The service had systems for identifying risks however, these were not always effective. The service had plans to cope with both the expected and unexpected.

- A programme of internal audit and monitoring was in place. All audit information was reported to Diaverum and the referring trust monthly to manage risks, issue and performance.

- Business continuity plans were in place. These included; IT fault and failure, Power Supply Failure, Water Supply Failure, Loss of Heating, Staffing shortages, Water treatment plant failure, Telephone systems failure and Inclement weather.
- A risk management policy was in place that outlined staff members responsibilities in regards to reporting, monitoring and assessing risk.
- The centre had a risk register that was kept by the clinic manager and reviewed monthly. We saw that some risks had remained on the risk register for a prolonged period of time such as two call bells not working and the patient dishwasher not working remaining open on the risk register for 10 months. One of the three main risks described by the clinic manger was not present on the risk register. Stock was being stored in the corridor while repairs were made, although this had been risk assessed it had not been placed on the centres risk register. The service only had access to one set of weighing scales that are vital to the safe delivery of dialysis treatment, this was not documented on the centres risk register. Therefore, we could not be assured that all risks to the service were being appropriately identified, reported and mitigated.

Managing information

The service collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards. However, this information was not always effectively shared.

- Staff had access to accurate information to allow them to do their job. Staff we spoke with, told us they had access to the right information to do their job well. Staff had access to internal systems to access policies, updates and training. Staff could access the referring trusts electronic patient record system allowing them to easily see relevant information for each patient.
- Information technology systems were used to improve patient care. Blood results were reported electronically and this allowed for benchmarking against other Diaverum satellite dialysis centres to take place.
- Information collected was used to improve services. The centre collected information from both patient and staff engagement surveys to make changes to the service that they provided.
- Limited information was included in meeting minutes to staff at the centre. We could not be assured that all information to keep staff informed about their work place was effectively shared such as incident, complaint and audit data.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

- The service sought the views of patients and their families in various formats including suggestion boxes, formal feedback questionnaires and through speaking to patients during their therapy. The referring trust held renal patients focus groups that patients could attend with information being shared. Great Bridge Kidney Centre did not offer their own focus groups after patient feedback was that they did not feel a further one was needed.
- The centre carried out a patient satisfaction survey twice per year based on the NHS Friends and Family test in order to identify areas for improvement. We saw that leaders had acted on feedback from the patient satisfaction survey and had changed the survey so that it could be completed on electronic tablets which Diaverum provided making it easier and quicker to perform. Further improvements made to services following engagement activities included purchasing new blinds and pillows, installing a water cooler and changing the type of biscuits available to patients.
- Leaders from the service engaged with staff regularly through both informal and formal routes such as one to ones, staff meetings, appraisals and through the annual staff engagement survey 'My Opinion Counts'. The latest staff survey was conducted in December 2018, the centre scored higher than the internal Diaverum average for all questions but one which related to knowing the strategy of the company. On the whole staff reported that they liked to go to work and were motivated to use their strengths at work.

- The service held positive relationships with external partners. All staff at the centre reported positive relationships with staff from the referring trust and felt able to contact them when needed to improve the patients experience. The centre also engaged with advocates from the kidney patient association and literature on this service was available.

Learning, continuous improvement and innovation

The service did not always have documented evidence that staff had learnt from when things went well and when they went wrong. However, the service was committed to promoting training, research and innovation.

- The provider employed a practice development nurse who supported learning and training across Diaverum sites in the Midlands area.
- Clinic managers were involved in a peer review process to encourage learning and improvements. Clinic managers visited other Diaverum clinics to perform unannounced audits and inspections to ensure each centre was consistently adhering to standards.
- The centre was promoting and participating green nephrology a scheme supported by the centre for sustainable healthcare, at the time of inspection 70% of waste produced at the centre was recycled.
- Learning from incidents and complaints was not always communicated to staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that it has sufficient equipment to deliver safe care and treatment (in this case weighing scales) and sufficient plans in place so that breakdown of equipment does not affect service delivery.
- The service must ensure that it has robust policies in place setting out specific staff responsibilities in completing incident investigations and timeframes in which they should be recorded.
- The service must ensure that investigations into serious incidents are robustly and consistently performed with learning shared with all staff.
- The service must ensure that the risk register accurately reflects the current risks at the location.
- The service must ensure that statutory notifications are completed and sent to the Care Quality Commission as set out in the regulations.

Action the provider SHOULD take to improve

- The service should ensure that information and leaflets for patients whose first language is not English is readily available.
- The service should ensure that its safeguarding policy clearly defines the level of safeguarding training required to be completed by staff members.
- The service should ensure that all staff members are recruited through a thorough recruitment process with all necessary documentation being obtained.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs. The centre only had access to one set of weighing scales. In the event of a malfunction we were told staff would estimate patients' weights.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e)

This section is primarily information for the provider

Requirement notices

The service did not have a robust process in place to effectively investigate incidents. Lessons learned and findings from investigations were not always shared with staff. The policies surrounding the investigation of incidents were not clear on roles, responsibilities or time frames for investigations.

The risk register did not reflect all of the current risks to the service.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services Managers did not complete statutory notifications to ensure that the Care Quality Commission was notified of the deaths of people who used services so that where needed further follow up action could be taken.