

Redditch Kidney Treatment Centre

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Redditch Kidney Treatment Centre is operated by Diaverum UK Limited. The service has 20 dialysis stations. Facilities include four isolation rooms, three consulting rooms, and a meeting room.

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

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 5 April 2017, along with an unannounced visit to the unit on 11 April 2017.

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

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

Services we do not rate

We regulate dialysis services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There were effective systems in place to keep patients safe. This included appropriate management and reporting of incidents, effective cleaning schedules and maintenance programmes. All staff were aware of their roles and responsibilities in ensuring patient safety.
- Effective processes were in place for the provision of medicines. These were stored and administered in line with guidance and staff completed competencies annually to ensure they continued to administer medicines correctly.
- Patients' medical and nursing records were secure. All staff had access to all relevant records ensuring that patients' care was as planned and not delayed.

Summary of findings

- Staff worked collaboratively with the local NHS trust to monitor and assess patients regularly. Patients and their GPs were provided with a minimum of monthly written updates on their condition and treatment plans.
- Staffing levels were maintained in line with national guidance to ensure patient safety. Nursing staff had direct access to a consultant who was responsible for patient care. In emergencies, patients were referred directly to the local NHS trust and the emergency services called to complete the transfer.
- Staff were aware of their roles and responsibilities to maintain the service in the event of a major incident. Patients were able to continue their treatment at alternative centres.
- All policies and procedures were based on national guidance and compliance was monitored through an effective audit programme. Key performance indicators for October to December 2016 showed that the service performed better than all other Diaverum dialysis centres nationally.
- Patients' pain and nutrition were assessed regularly and patients were referred to appropriate specialists for additional support as necessary.
- There was a comprehensive training and induction programme in place to ensure staff competency. Training compliance was 100%.
- There were processes in place to ensure effective multidisciplinary team working, with specialist support provided by the local NHS trust.
- There were effective processes in place for gaining patient consent for treatment.

- Patients were treated with respect and compassion. Patients reported that staff worked above expectations going the extra mile to ensure their satisfaction.
- Staff were familiar with and worked towards the organisational vision of providing the best possible care for renal patients.
- There were effective processes in place to monitor risks associated with the service and individual patients. Quality assurance meetings occurred regularly and included the local NHS trust and specialists.
- There was evidence of strong national and local leadership, with accessible and responsive managers.
- All staff and patients were positive about the service.
- The service had implemented placements for student nurses.

However:

- The resuscitation trolley was not sealed to assist with the identification of tampering, which was not in line with local policy.
- There was no guidance on the escalation processes for when the medicine fridge temperatures were outside normal range.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Edward Baker

Deputy Chief Inspector of Hospitals

Central Region

Summary of findings

Our judgements about each of the main services

Service

Dialysis Services

Rating Summary of each main service

- There were effective systems in place to keep patients safe. Staffing levels were maintained in line with national guidance to ensure patient safety. Nursing staff had direct access to a consultant who was responsible for patient care. Effective processes were in place for the provision of medicines.
- Key performance indicators for October to December 2016 showed that the service performed better than all other Diaverum UK Limited dialysis centres nationally.
- There was evidence of strong national and local leadership, with accessible and responsive managers. All staff and patients were positive about the service.

Summary of findings

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Redditch Kidney Treatment Centre

Services we looked at

Dialysis Services

Summary of this inspection

Background to Redditch Kidney Treatment Centre

Redditch Kidney Treatment Centre is operated by Diaverum UK Limited. The service opened in March 2016 and provides haemodialysis to patients from the local area of Redditch, Worcestershire. This was in response to a request from the local NHS trust to provide a dialysis unit within a specified area.

The manager was registered with the CQC in February 2017.

The service is registered for the regulated activity of diagnosis and treatment of disease.

The service has not been previously inspected.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Justine Eardley, and another CQC inspector. The inspection team was overseen by Phil Terry, Inspection Manager.

Information about Redditch Kidney Treatment Centre

Redditch Kidney Treatment Centre is a 20 bedded unit that provides dialysis for patients with chronic renal failure. The unit was built in 2016 following the increased demand for dialysis in the Worcestershire area.

Diaverum UK Limited ('Diaverum') is contracted to complete dialysis for local patients under the care of nephrologists at the local NHS trust. All patients attending Redditch Kidney Treatment Centre ('the centre') receive care from a named consultant at the hospital, who remains responsible for the patient. Diaverum have close links with the trust to provide seamless care between the two services. To achieve this, the service has support from the local NHS trust to provide medical cover, satellite haemodialysis unit coordinator support, pharmacy support, and regular contact with a dietitian. This team attend the centre regularly and assess patients in preparation for monthly quality assurance meetings.

The centre is open between 6.30am and 6.30pm from Mondays to Saturdays. It provides treatment for patients aged 18 and over.

The centre is registered to provide the following regulated activity:

- Treatment of disease, disorder, or injury.

During the inspection, we spoke with 12 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with three patients and one relative. We reviewed five sets of patient records and associated documents.

Track record on safety from March 2016 to April 2017:

- No never events.
- No incidences of healthcare acquired MRSA.
- No incidences of healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- No incidences of healthcare acquired Clostridium difficile.
- No incidences of healthcare acquired E-Coli.
- One complaint.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We found the following areas of good practice:

- There were effective systems in place for recording and escalating incidents both internally and externally. There was a positive safety culture, which was inclusive of all staff.
- The centre and equipment used were visibly clean, with evidence of effective cleaning regimes and schedules in place. Audits were completed to ensure compliance with local policy and procedure. All staff were observed using effective precautions to maintain patient safety and reduce the risks of infection.
- All equipment was maintained according to the manufacturer's guidance. Equipment was standardised across the organisation with an adequate supply to cover maintenance or breakages.
- There were processes in place to ensure that medicines were ordered, stored, and used in line with guidance. Patients were able to access seasonal and ad hoc medicine through additional training of staff, which prevented additional visits to the patients' GP, or hospital.
- Patients' medical and nursing records were held securely, with direct access to all relevant records at each area where treatment was provided. Patients and their GPs were provided with a minimum of monthly written updates on their condition and treatment plans.
- Staff worked collaboratively with the local NHS trust to monitor and assess patients regularly. Staff completed regular risk assessments and patient reviews to ensure they were suitable to continue treatment at the satellite unit.
- Nursing staff were aware of their roles and responsibilities in the escalation of safeguarding concerns.
- Nursing staffing levels were maintained in line with national guidance to ensure patient safety.
- Medical advice was available during opening times, with direct access to the consultant or renal team at the local NHS trust.
- Staff were aware of their roles and responsibilities to maintain the service in the event of a major incident. Patients were able to continue their treatment at alternative centres.

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

Summary of this inspection

- The resuscitation trolley was not sealed as outlined in the local policy.
- There was no written process for the escalation of abnormal medicine fridge temperatures.

Are services effective?

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

We found the following areas of good practice:

- All policies and procedures were based on national guidance.
- Staff monitored key performance indicators and the unit performed better than all other Diavrum UK Limited centres for October to December 2016 audit.
- Patients' pain and nutrition were assessed regularly and patients referred to appropriate specialists for additional support as necessary.
- All staff completed a detailed competency pack on commencement of post. All staff were assessed annually.
- There were processes in place to ensure effective multidisciplinary team working, with specialist support provided by the local NHS trust.
- The centre was not open seven days per week, however, patients could access support through the local NHS trust if necessary.
- All staff had access to all relevant information for patient care and treatment.
- There were effective processes in place for gaining patient consent for treatment.

Are services caring?

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

We found the following areas of good practice:

- Patients were treated with respect and compassion.
- Nursing staff gave patients adequate time to ask questions and provided written information regarding patients' conditions, treatment plans and support networks.
- Nursing staff provided patients with information and contact details of support networks, which included the Kidney Patients' Association and social care.

Are services responsive?

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

We found the following areas of good practice:

Summary of this inspection

- The centre had been built to provide local dialysis patients with a treatment centre nearer to their home. Patients were assessed for suitability to attend the centre and had the opportunity to visit before finalising the placement.
- Patients were provided with appropriate information leaflets to enhance their understanding of treatment and its impact on their lives.
- The centre was fully equipped to provide patients with mobility, hearing, or visual impairment a safe treatment area.
- Patients' initial treatments were commenced at the local NHS trust and once stabilised patients were transferred to a local area. This process varied according to the patient's response to treatment. There were no waiting lists for treatment at Redditch.
- The centre had received one complaint in the past year. There were processes in place to ensure that patients could offer feedback.

Are services well-led?

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

We found the following areas of good practice:

- Staff were familiar with and worked towards the organisational vision of providing the best possible care for renal patients.
- The centre had effective systems in place to monitor risk and quality, using a dashboard to evidence performance and identify trends or areas for development.
- There was evidence of strong national and local leadership, with accessible and responsive managers.
- We were told by the staff that local leadership performed above and beyond expectations.
- All staff and patients were positive about the service.
- The centre had implemented placements for student nurses.

Detailed findings from this inspection

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- The centre had an effective system in place for recording, investigating and monitoring incidents. Staff were fully aware of their roles and responsibilities in the recording of incidents, both internally and externally.
- Staff were given the option to report incidents that occurred during patients' dialysis sessions at the end of the treatment. This was done by the flagging of an incident icon on the patient electronic records, which were completed immediately after treatment. Any non-patient related incidents could be recorded via staffs' home screen on the computers. We saw that there were sufficient computers to enable all staff to write notes simultaneously.
- The centre manager, director of nursing and chief executive were automatically alerted to incidents electronically. We were told that the director of nursing received a copy of all clinical incidents reported. The chief executive was automatically alerted to non-clinical incidents, such as problems with IT systems and power supplies. All alerts were discussed by the senior team to identify the level of investigation required and the actions to be taken, for example, a local or serious incident investigation.
- All incidents and any learning arising from them were shared across the team at team meetings and at the staff handovers. We saw minutes from meetings, which evidenced feedback to staff regarding local incidents and the actions to be taken. We saw that staff meetings included lessons learnt and details of investigations following incidents.
- Staff told us the majority of incidents reported related to patients' reactions to the dialysis session, for example, a period of hypotension. These were noted to be common side effects of treatment, but were recorded as incidents to alert staff to any issues with treatments.
- We were given examples of open discussions with patients relating to incidents or changes to plans. For example, we saw that one patient discussing changes to their dialysis regime and nursing staff informed the patient of the reasons why and how this would affect the patient. Nursing staff told us that as patients attended the centre frequently, they had an open relationship, so always discussed anything that may affect patient care and treatment.
- The centre reported one serious incident and no clinical incidents from March 2016 to March 2017. The serious incident related to a patient who had high blood glucose levels who became unwell during the dialysis session. Staff provided emergency resuscitation as necessary. This incident did not fall into the national category of serious incidents, however, the director of nursing and centre manager agreed that an additional investigation and learning was required from this incident to prevent future similar incidents.
- Data provided by the centre showed that there were three deaths of patients that had been receiving treatment from the service from March 2016 to March 2017. Two were unexpected deaths and related to emergency admissions to the local NHS trust with other clinical conditions.
- There were no never events reported from March 2016 to March 2017. A never event is a serious patient safety incident 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 harm or death but neither need have happened for an incident to be a never event.

Dialysis Services

- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. There was a Diaverum Policy relating to duty of candour, which outlined actions to be taken when something went wrong. All staff had completed training in duty of candour and the steps to follow when something goes wrong. Staff were aware of the thresholds for when duty of candour was triggered.
- We saw that staff were open with patients and we were assured that staff would inform patients if something went wrong, offer an apology and involve them in preventing reoccurrence.

Mandatory training

- Diaverum had an effective mandatory training programme, which was split into quarterly groups. This meant that all staff had to complete the specific training within a three month period. In addition to mandatory training, staff completed a number of competencies at their commencement to post. This included competence in recognising and managing situations such as a patient becoming unwell during dialysis, disconnection from dialysis machine and observations of infections.
- Training was divided into several categories. Mandatory training included subjects such as consent, infection control, fire safety, governance and basic life support. These subjects were completed either in face-to-face training or via an electronic learning programme and were completed annually.
- Practical training included clinical skills such as medicines' optimisation, care of fistulas and dialysis catheters and aseptic non-touch technique. Practical skills were competency based and completed as one off topics with the offer for annual updates from the practice development nurse.
- Equipment and facilities training consisted of all machinery such as hoists, dialysis chairs, resuscitation trolley, glucometers and the centrifuge. These topics were completed as one-off training. Fire, health and safety training included fire evacuation, which was practiced annually.

- We were told that staff were allocated specific roles and responsibilities with regards to equipment used. For example, some staff had been trained as 'super users' for the IT system, and other had been trained as trainers for the electrocardiogram machine (or ECG).
- The centre manager kept an electronic record of training compliance including additional training and external courses. We saw that there was 100% compliance with all mandatory training.
- Training was provided predominantly by the practice development nurse who attended the centre regularly. Alternatively, manufacturers or specialists provided specific training. For example, we were told that manual handling training was provided by an external company who attended the centre on a specific day completing several training sessions so all staff could attend.
- Staff members who were unable to attend face-to-face training on the specific day planned attended nearby centres on alternative dates when their training was planned or had an individual session with the practice development nurse.

Safeguarding

- There were systems, processes and practices in place to keep patients safe from avoidable harm. Staff were aware of their roles and responsibilities for escalating safeguarding concerns.
- Nursing staff told us they had not had to report or escalate many safeguarding concerns but were aware of the escalation process. We were told about a recent referral relating to staff concerns regarding a patient and their home environment. The referral was under investigation at the time of inspection.
- All safeguarding concerns were reported through the local NHS trust safeguarding team who contacted the centre with any feedback from investigations.
- The Diaverum director of nursing was the service lead for children's and adult safeguarding. Locally, the centre manager had been the only person to raise concerns.
- The centre did not treat patients under the age of 18 years, and did not therefore complete safeguarding children training in accordance with national guidance.
- All staff had completed safeguarding adults' level 2 training, were aware of the main types of abuse, and knew how to access the centre's policy for safeguarding patients.

Cleanliness, infection control and hygiene

Dialysis Services

- Nursing staff completed several audits relating to cleanliness and infection control including dialysis connection processes, sharps' disposal, hand hygiene and maintenance of dialysis fluid pathway. Audits were completed weekly and collected data sent to a central office for analysis and recorded on the service dashboard. Records from November 2016 showed 100% compliance with all audits with the exception of contamination of dialysis stations (80%), clinical environment (91%) and water treatment (95%). The target for compliance was 100%. We saw that the centre manager had included the results and actions to be taken by staff to improve compliance in an action plan and in team meeting minutes. Actions included additional training and reassessment for individuals found not to be compliant.
- Infection control practices were monitored by Diaverum through a dashboard of compliance against key performance indicators. Diaverum data showed that Redditch treatment centre had scored better than any of the other centres for in audits based on the data collected between October to December 2016.
- Four side rooms were available for patients identified as being at risk or those with potential infectious conditions. Due to the possibility of blood borne illness, patients were required to be segregated on their return. For example, patient visiting from or returning from a holiday to high-risk area such as India. The centre had strict guidance on the segregation and monitoring of patients for three months following return from high-risk areas. This was in line with national guidance.
- We saw that patients identified as at risk were allocated the same equipment and rooms for each session to prevent risks of cross infection. Rooms were observable from the main nurse's station and main unit.
- Water used for dialysis needs to be specially treated to prevent risks to patients. There was a large water treatment room, which was monitored remotely by the manufacturer. This enabled them to identify any issues with supply, effectiveness of treatment or leaks. In addition to the remote monitoring, staff had telephone access to the manufacturers for emergencies.
- On a daily basis, nursing staff monitored the water supply. We saw that some staff had been trained to be "super users" and completed routine work such as changing filters and monthly water sampling. In the event that a result showed an anomaly, staff would contact the manufacturer for an urgent review. Nursing staff told us that this had never happened.
- We saw that staff used personal protective equipment appropriately. This included face visors to protect staff from blood sprays.
- We saw staff washing their hands appropriately to maintain patient safety. This included before and after any patient contact. Hand hygiene training had been completed by 100% of staff.
- Staff used appropriate aseptic techniques to attach patients to their dialysis machines. This was completed through either the insertion of large bore needles into an arteriovenous fistula/ graft or central line. Arteriovenous fistulas (AVFs) are an abnormal connection or passageway between an artery and a vein created through vascular surgery specifically for dialysis. Grafts (AVGs) are artificial veins inserted for dialysis, and central lines are larger cannulas that are inserted for long periods for dialysis. All staff had completed aseptic non-touch technique training.
- Virology, MRSA and MSSA (Methicillin Sensitive Staphylococcus Aureus) infection screening was completed by nursing staff quarterly for all patients. The overall target for incidence of infections was zero. Quarterly and monthly blood screening was being completed during our inspection. We saw that blood samples and swabs were being taken for analysis of all patients. We saw staff explain to patients the reasons for additional blood samples.
- From March 2016 to March 2017, the centre reported no cases of healthcare acquired infections such as Clostridium Difficile, MRSA or MSSA. There was one reported case of other bacteraemia, which related to a patient who lived in a nursing home, who frequently attended the centre with no dressing covering the dialysis catheter. The centre took actions to minimise risks of cross infection.
- The centre had an effective partnership with the local NHS trust, which enabled patients to be seen and for staff to discuss care with specialists as necessary. This included the trust's infection control team, who were available to advise on treatments as necessary.
- Staff followed the local NHS trust sepsis guidelines, with any patients thought to be unwell being referred directly to the local NHS trust for an urgent medical review.

Dialysis Services

Cleanliness of premises

- Effective infection control procedures were in place. The centre was visibly clean on inspection. We were told that cleaning was subcontracted to an external provider. The contractors had regular meetings with the centre manager to ensure satisfaction with service.
- We saw that cleaning schedules were maintained, with evidence of regular cleaning documented.

Environment and equipment

- The environment and equipment met patients' needs. The centre provided 20 dialysis stations, including four isolation rooms. The dialysis stations were separated into bays of four; each area had a small nurse's station attached. Each bay had a minimum of two sinks for hand washing.
- During our inspection we saw that one sink was not functioning. On discussion with the centre manager, we were told that the sink tap had been broken when a patient had leant on the sink. The part was on order and awaiting delivery. We were told that prior to the sink being used; the maintenance team would complete a water assessment to ensure that the taps were free from contaminants. The lack of sink did not affect patient care and hand washing was completed at nearby alternative sinks.
- Each dialysis station had a reclining chair, dialysis machine, nurse call bell, table, and television with remote control. All equipment was numbered to ensure it remained in the same location.
- We saw that there was adequate equipment to enable regular servicing and maintain full service. All dialysis machines were under manufacturer's warranty and maintained according to guidance. The manufacturers attended the centre at regular intervals to complete routine servicing. All equipment checked was logged electronically with a record sent to the centre manager detailing works completed.
- During inspection, we saw that dialysis machine alarms were responded to within a few seconds. Alarms would sound for a variety of reasons, including sensitivity to patient's movement, blood flow changes and any leaks in the filters. Health care assistants were able to silence alarms and told us that if the same machine alarmed for a second time, the nurse would be called. We were told that some patients also silenced their own alarms following training. Some patients actively participated in

their dialysis, and were taught how to insert their own needles, set up their dialysis machine or attach themselves to the dialysis machine. Patients' ability to perform these tasks were recorded in their nursing notes.

- Staff were aware of the escalation process for the reporting of faulty equipment. The centre had two spare dialysis machines, which were cleaned daily to ensure they would be fit to use in an emergency. In addition, we were told that all Diaverum centres used the same type of equipment; therefore, another centre could provide equipment in an emergency. This had not happened since the centre opened in March 2016.
- All staff were trained on the equipment in use. Either Diaverum or external providers completed this as necessary. The organisation used the same type of equipment in all clinical areas, so staff transferring between units would be familiar with equipment. We saw that equipment-training records showed 100% compliance for all staff.
- All single use equipment was labelled accordingly, and disposed of after use.
- The resuscitation trolley was checked daily by staff and was found to be safe to use. We saw that the resuscitation trolley was not sealed in line with local policy. This meant that equipment could be tampered with. Nursing staff told us that the trolley should be sealed, however they currently had no seals to use. The centre manager was aware of this and was in the process of providing a supply of seals. As the trolley was in the main treatment area, there was minimal risk that it could be tampered with.
- In addition to the resuscitation trolley, staff had access to two emergency grab bags, which contained a selection of equipment that could be carried to a location in the event of an emergency.
- Water testing was completed weekly to ensure that water used during dialysis was free from contaminants. This was in line with guidance on the monitoring the quality of treated water and dialysis fluid. We saw the record log that recorded the testing and the results. Staff were aware of the processes for obtaining samples, and actions to take if results showed some contaminants. There had been no reported incidents of contamination.

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- Waste was managed appropriately with the segregation of clinical and non-clinical waste. Bins were not overfilled and were emptied regularly. We were told that filled bin bags were stored in secure units awaiting collection.
- The stock room appeared clean and tidy with shelving for all equipment. Fluids were stored on pallets off the floor. Stock was provided weekly and staff told us there were adequate supplies to ensure that the service could continue if a weekly stock delivery was delayed.
- We saw that the ambient temperature of the treatment room was recorded daily, and there had been no incidents where the temperature had been outside the recommended temperatures.
- The centre had three consulting rooms and a meeting room, which could be used for patient assessments, private conversations and treatments. The centre complied with all 'Renal care Health Building Note 07 01: Satellite dialysis unit (2013)' requirements, including appropriate waiting areas, storage, dialysis station size and access to facilities such as toilets.

Medicine Management

- The centre had processes in place for the safe management of medicines. Patients attending would receive prescribed medicines as necessary for their dialysis or continuing treatment only. Ongoing oral medicines were taken by the patient at home and not administered by nursing staff.
- Either the local NHS trust consultant or the satellite haemodialysis unit coordinator wrote medicine prescriptions.
- Medicines were stored in a large treatment room, which was secured with a keypad access door.
- There were a small number of medicines routinely used for dialysis, such as anti-coagulation and intravenous fluids. The centre also had a small stock of regular medicines such as EPO (erythropoietin – a subcutaneous injection required by renal patients to help with red blood cell production) and oral tablets for bone density. Controlled drugs (requiring extra security of storage and administration) were not used or available on site.
- Nursing staff completed monthly medicine stock level audits when the amount of and expiry dates were checked.
- Medicines were provided through two resources. Stock medicines came directly from Diaverum and other

medicines, such as antibiotics, were supplied from the local NHS trust. Ordering of medicines occurred on a monthly basis, when stock levels were assessed.

Delivery was completed by either a medicine company courier or the local NHS trust's non-patient transport system. Upon arrival at the centre, the registered nurse would check the medicine against the order form to confirm it is correct. A stock form was then completed, signed and faxed to the supplier to confirm delivery.

- The centre did not have a dedicated renal pharmacist. The satellite haemodialysis unit coordinator or their renal consultant prescribed all patients' medicines. We were told that medicines were reviewed at each quality assurance meeting for each patient. We saw that prescription charts were clearly written, showed no gaps or omissions and were reviewed regularly.
- Medicines that were temperature sensitive were monitored closely. We saw that the fridge temperatures were recorded daily, and had been maintained within the recommended parameters. However, the record sheet did not have an escalation process outlined. We spoke with staff who told us that changes in temperature would be escalated to the nurse in charge who would discuss the medicines with the pharmacist to determine if they could be used.
- We were told that on occasions where a patient required additional medicines, staff would contact the consultant or satellite haemodialysis unit coordinator directly. They would prescribe the necessary medicine, scan the prescription to the centre to enable medicine to be administered and post the hard copy of the prescription to the centre for confirmation. An example was given of a patient attending the centre with a suspected local infection of their dialysis catheter, where antibiotics could be prescribed and commenced within a short period of time and without an additional journey for the patient to the hospital.
- Staff were assessed annually for their competence in administration of medicine, as part of their mandatory training. The practice development nurse completed this. Compliance at the time of inspection was 100%.

Records

- Patients' records were held both electronically and in paper format. Diaverum electronic records were called the IRMS (International Renal Information Management System) and this system recorded information downloaded directly from the dialysis machines and

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data recorded by nursing staff. This database was compatible with the local NHS trust and information was shared directly, which enabled all patient information to be shared with the renal registry.

- We saw that the electronic records detailed dialysis sessions by date and time. This meant that any changes in treatment, any problems occurring during the session and any treatment changes could be easily identified. Staff told us that if a patient required treatment at the local NHS trust for a period, they could continue to track their care, and provide the appropriate treatment on their return to the centre.
- The centre kept a small number of paper records, which included the most recent dialysis prescriptions, patient, next of kin and GP contact details, risk assessments, medicines charts and patient consent forms. Paper records were stored in colour-coded files according to their dialysis day and time. The files were kept in a secure storeroom when not in use. All seen were completed legibly and accurately.
- Paper and electronic records were available for all clinic appointments and quality assurance meetings. This meant that the multidisciplinary team had access to the most up to date patient records when reviewing their care and treatment.
- Staff completed data protection training as part of their induction and annually. Training compliance was 100%.
- Patients' records were audited monthly, with a review of the patients' records and dialysis prescriptions. Data showed that in November 2016, the score for compliance with documentation was 83%: an action plan was in place to remind staff to keep written notes free from contaminants.

Assessing and responding to patient risk

- Effective systems were in place to assess and manage risks of deterioration to patients. Nursing staff used comprehensive risk assessments to review patients on a regular basis. We saw that patient records showed a minimum of weekly risk assessments, which were repeated up to three times a week depending on the findings and the patient's condition. This enabled staff to identify any deterioration or changes in patients' physical condition.
- Nursing staff completed a full patient assessment based on the activities of daily living to identify the patient baseline condition on referral to the centre. The

assessment included past medical history, mobility assessment, skin integrity assessment and dialysis access assessment. This information was used to plan treatments and attendance at the centre.

- Patients had clinical observations recorded prior to commencing treatment. This included blood pressure, pulse rate and temperature. The nurse reviewed any variances prior to commencing dialysis, to ensure the patient was fit for the session. Where necessary the nursing staff consulted with the satellite haemodialysis unit coordinator or the consultant for clarification.
- Patients' blood pressures were recorded at regular intervals during their dialysis. Alarm settings were adapted to each patient, allowing any variance to the patients' normal readings to be highlighted to nursing staff.
- The practice development nurse had commenced staff training in the use of the national early warning score (NEWS) to monitor patients clinical observations, such as blood pressure and pulse. However, we were told that all staff were required to be trained prior to implementing the score into practice. A planned date for completion of this training and implementation of using NEWS was May 2017.
- Nursing staff recorded patients' observations and details of any incidents relating to dialysis in the electronic patient record at the beginning and end of dialysis' sessions. This process required nursing staff to input details manually prior to closing the patient record, ensuring that electronic information was not the only information recorded.
- Patients with conditions such as Hepatitis B or tuberculosis, or advanced neurological conditions such as advanced dementia were not managed at the centre. We were told that patients who required additional support received their treatment at the local NHS trust where the nurse to patient ratio was increased to ensure patient safety.
- Patients were required to confirm identity prior to treatment and medicines. This was completed by patient being asked to give their name and date of birth, which was checked against the patient record, the dialysis or medicine prescription or dialysis card. We saw that staff checked every patient as they commenced treatment.
- The unit had recently introduced the use of patient identification bracelet for the administration of blood transfusions. Patients were required to wear an ID

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bracelet for the duration of the treatment, following the confirmation of their name and date of birth. Two nurses checked this prior to the administration of the blood transfusion, in line with best practice.

- The centre had access to emergency antibiotics which were administered for suspected infections following discussion with the medical team. A framework was used to identify any patients with a potential infection; this included the review of any wounds and dialysis catheter exit sites for signs of infection prior to commencing treatment.
- Patients suspected of having sepsis or were unwell were transferred immediately to the local NHS trust for an emergency review by the medical team. Nursing staff told us that they would not commence dialysis if they suspected sepsis, and would only continue antibiotic treatment as part of an ongoing treatment plan.
- Patients who showed signs of deterioration were discussed at the multidisciplinary team (MDT) meeting and a decision made as to whether they should attend the local NHS trust for ongoing treatment. We were told that patients who showed signs of ill health or required additional support during their dialysis would be transferred to the local NHS trust where nursing ratios and additional support from the medical team was available if they became unwell.
- Nursing staff called the emergency services to assist with any patient who rapidly deteriorated during their dialysis session, for an urgent transfer to the local NHS trust. Staff told us that paramedic services were quick to respond.
- Nursing staff were able to give us examples of when patient had been transferred to the local NHS trust for a variety of clinical reasons. The most recent example was one patient who was dialysed through a dialysis catheter: on arrival to the unit, staff were unable to withdraw blood from the catheter, which meant that dialysis could not be completed. The patient was transferred directly to the local NHS trust hospital for a review of the catheter.
- Appropriate equipment was in place to respond to any patient having cardiac problems at the centre.
- The centre had strict guidance on the management of vascular access. During inspection, we saw that one patient had a vascular catheter in place whilst their arteriovenous fistula was maturing. Nursing staff were observed checking the fistula and recorded progress in the patient's notes.

- During inspection, we saw that dialysis machine alarms were responded to within a few seconds. Alarms would sound for a variety of reasons, including sensitivity to patient's movement, blood flow changes and any leaks in the filters. Health care assistants were able to silence alarms and told us that if the same machine alarmed for a second time, the nurse would be called. We were told that some patients also silenced their own alarms following training. Some patients actively participated in their dialysis, and were taught how to insert their own needles, set up their dialysis machine or attach themselves to the dialysis machine. Patients' ability to perform these tasks were recorded in their nursing notes.
- Additional support services could be accessed through the local NHS trust if necessary. Any patients experiencing any difficulties were referred to the local NHS trust for assessment or treatment as soon as possible. Out of hours, patients were told to contact either their GP or the local acute trust for dialysis related problems.
- Patients visiting the unit were required to be segregated from other patients in line with national guidance. Visiting patients were also recorded on the Diaverum patient information system.

Staffing

- During inspection, we saw that there were three nurses and two healthcare assistants on duty. Staffing levels met patients' needs at the time of the inspection. We saw that the nursing rota confirmed staffing numbers were consistent and maintained the appropriate ratio of four patients to one nurse.
- The centre manager who was supernumerary, working predominantly Monday to Friday, supported staff.
- The centre had a nominated nurse in charge, who was the centre manager, the deputy manager or a senior staff nurse. The nurse in charge was supernumerary to numbers during the week, with the nurse being included in numbers on Saturdays. The nurse in charge role was highlighted on the duty roster so staff were aware of the role prior to attending for duty. The role of the nurse in charge was to support staff, patients and ensure the safe running of the unit.
- All staff completed a daily walkabout, during which they would review each patient, their treatment and discuss any issues. We were told that the walkabout was inclusive of the patient and was their opportunity to

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discuss anything that concerned them. In addition to the daily walkabout, the centre completed a weekly handover. This was a brief meeting, which discussed any organisational or centre specific changes or news. These meetings were recorded and a file left at the nurse's station containing historical sheets. We saw that patients were spoken with throughout their treatments.

- Staff recognised the need for an effective handover between shifts and had introduced a daily walkabout in addition to the handover. This enabled patients to be reviewed by all staff on duty, and share any changes in treatment, condition or outcome of investigations and appointments. Staff had adopted the daily walkabout and weekly handover with enthusiasm.
- There were 7.29 whole time equivalent qualified dialysis nurses employed by the centre at the time of inspection, with no vacancies and no plans to extend staffing numbers. We were told that nursing staff would be recruited as necessary to meet additional demands of the service.
- Diaverum used an electronic head count to identify the number of staff required for each centre. Any deficit in numbers was escalated to the human resources department for advertisement. Once successful applicants had been employed, the practice development nurse was contacted and informed of the start date to ensure that training was in place.
- The centre did not use agency staff, and used bank staff to supplement staffing numbers when necessary. According to the service data, this happened infrequently with less than one percent of shifts covered with agency staff from March 2016 to March 2017. We were told that bank staff were usually from other Diaverum dialysis centres or staff employed specifically to attend centres when staffing levels were short. These staff members were trained by Diaverum and familiar with policies, procedures and equipment.
- All nurses had link roles for specific topics such as infection control or nutrition. The roles of the link nurse were to attend regional meetings and bring changes in practice, updates on information back to the centre staff. We were told that the Diaverum network enabled staff to meet regularly with other centres to capture ideas.
- The centre maintained close links with the local NHS trust through the satellite haemodialysis unit coordinator and consultant. During inspection, we observed that the satellite unit coordinator was in the

centre for the duration of the day and completed tasks for Redditch and other centres according to need. We were told that the lead attended a different centre each day, managing their workload remotely.

- Medical care was provided by the local NHS trust. The centre had a dedicated consultant who attended weekly. During this visit, the consultant completed a clinic seeing a planned list of patients and anyone identified by staff as requiring a review. Outside the normal weekly visit, the consultant was available for telephone advice, and contactable by email. We saw this in practice during inspection.
- Nursing staff could access the renal team at the local NHS trust for additional support or advice. For example, in the event of an emergency nursing staff contacted the on-call renal registrar at the referring local NHS trust. We saw that there was a protocol and escalation pathway in place for this process.
- The consultant completed a monthly review of patients to monitor and track their condition. This was completed as part of the routine visit to the centre and enabled patients to be seen when they attended for their dialysis, preventing an additional appointment.
- Out of working hours, patients referred any care problems to their GP, who remained responsible for their care and treatment. Any emergency specific to their dialysis was referred to the local NHS trust.

Major Incident awareness and training

- The centre had effective adverse event policies and procedures in place for the loss of heating, power supply failure, staffing shortages, water supply failure and IT failure. Each procedure detailed relevant contact numbers; actions expected by staff of each grade and expected interactions with the local NHS trust referring services.
- The manager completed ad hoc emergency training for the nursing team using flash cards describing an emergency. We were told that the manager would place a flashcard detailing a patient's clinical condition in a dialysis station and call the emergency call bell. She would then work with staff to identify what actions they should take to resolve the situation.
- In addition to the flashcards, the manager had produced guides, detailing the roles and responsibilities for staff in emergencies. For example, we saw a poster detailing the actions of the nurse in charge and the healthcare assistants in the event of power failure.

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- The provider had an internal alerting system that automatically notified senior managers of the implementation of any adverse event pathway. This was completed via an email.
- In the event of IT failure, patients were able to continue with their treatment because the centre maintained a paper record of the patients' last dialysis sessions. This recorded the details of the filter used; pump speed and dialysis solutions used.
- Diaverum had a process in place that meant that when any adverse event was resolved, an investigation into the cause would be completed. If the recovery procedure was found to be inadequate, an improvement plan would be implemented. Outcomes of the investigation and any learning were shared with staff through a debriefing session.
- The centre was registered as requiring essential utilities, which meant that in the event of a local electrical failure or loss of water the centre would be reconnected as a priority.
- Nursing staff told us that in the event of a power cut, patients would receive their treatment at one of the other nearby dialysis centres until power was restored. This would be coordinated through the satellite haemodialysis unit coordinator.
- The centre completed annual evacuation training. All staff had had fire safety training.

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

Evidence-based care and treatment

- All policies and procedures were developed in line with national guidance, standards and legislation. This included guidance from the Renal Association, National Service Framework for Renal Services and the National Institute for Health and Care Excellence (NICE).
- Patients were assessed using risk assessment tools based on national guidelines and standards. This included falls risk assessments, nutrition scores and skin integrity assessments.
- We saw that the IT system used enhanced the collection of data and ease of monitoring. This was largely due to the Diaverum system uploading data collected during dialysis to the local NHS trust database. Similarly, staff at the centre were able to access all records at the local NHS trust; reducing time spent chasing blood and test results. Nursing staff told us that this positively impacted the patients' treatment, resulting in fewer referrals to the local NHS trust for additional blood sampling, or treatment due to lack of results.
- Staff monitored and recorded patients' vascular access on a vascular access chart. Vascular access is the term used for access into a vein, for example, a dialysis catheter. Recordings detailed the type of access, appearance, and details of any concerns. Each category was given a score of nought for no issues and one for issue identified. Any patient scoring one or more were referred immediately to the local NHS trust for review and possible intervention. This was in line with the NICE Quality Statement (QS72) statement 8 (2015): 'Haemodialysis access-monitoring and maintaining vascular access'.
- Patients were predominantly dialysed through arteriovenous fistulas. We saw that some patients had less established fistulas and were told that more experienced staff were responsible for cannulating these patients. This was in line with the NICE Quality Statement (QS72) statement 4 (2015): 'Dialysis access and preparation'.
- The centre was not responsible for any patients who completed their dialysis at home. These patients were managed by the local NHS trust. However, we were told that on occasion the centre manager had attended patients at home when they had concerns regarding their treatment or clinical condition.
- The centre met the national recommendations outlined in the Renal Association Haemodialysis Guidelines (2011). For example, Guideline 1.3: 'Patients travel less than 30 minutes', Guideline 5.7: 'The monthly measurement of dose or adequacy of haemodialysis' and Guideline 6.2: 'Monthly monitoring of biochemical and haematological parameter (blood tests)'.
- The centre did not facilitate peritoneal dialysis (which is a type of dialysis that uses the peritoneum in a person's abdomen as the membrane through which fluid and dissolved substances are exchanged with the blood. It is used to remove excess fluid, correct electrolyte problems, and remove toxins in those with kidney failure).

Pain relief

- Patients' pain relief needs were assessed and managed appropriately. Patients did not routinely receive oral analgesia during their dialysis sessions; however, local

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analgesia was available for cannulating the patients' arteriovenous fistula or graft (AVF/G). Needling is the process of inserting wide bore dialysis needles into the AVF/G, which some patients find painful.

- Local analgesia was prescribed as a 'to be administered as necessary medicine', which enabled it to be used at each attendance to the centre.
- Any issues identified with pain were discussed initially with the nursing staff who escalated concerns to the consultant or satellite haemodialysis unit coordinator.
- On any occasion where analgesia was required, a prescription could be scanned to the centre as with other medicines, although the centre kept a stock of paracetamol only. If pain related to the patients' general condition, they were reviewed at the consultant as soon as possible. This was usually during their next visit to the centre. Patients who required an urgent review for pain management were referred to their GP or the local acute trust depending on the severity.

Nutrition and hydration

- Patients' hydration and nutritional needs were assessed and managed appropriately.
- Patients in renal failure require a strict diet and fluid restriction to maintain healthy lifestyle. We were told that patients were reviewed by the dietitian monthly, who assessed their past medical history and their treatment plans to advise patients on the best diet for them. For example, one patient told us that they had been a diabetic for 20 years, and following discussion with the dietitian, found out information they did not know before, which had resulted in an improved management of their blood sugars.
- We saw that patients were provided with written information and guidance relating to their diet and fluid management.
- Patients were weighed on arrival to the centre at each visit. This was to identify the additional fluid weight that needed to be removed during the dialysis session. This varied from patient to patient.
- Some patients were observed weighing themselves prior to dialysis, and inputting this into the dialysis machine. Nursing staff told us that all patients were encouraged to participate in their treatment to different levels.
- All patients were assessed using the Malnutrition Universal Assessment Tool (MUST) a minimum of

weekly. We saw that all records showed regular assessments up to three times weekly. Any patients identified as being at risk were referred to the dietitian for a review.

- Patients were offered refreshments whilst attending the centre. This was hot or cold drinks, and biscuits. Nursing staff told us that patients frequently brought their own refreshments to consume whilst having their treatment.
- We were told that the centre was visited by a mobile sandwich van twice a day. Staff were able to provide menus to patients and telephone any orders for delivery.

Patient outcomes

- There was an audit calendar in place which detailed audits that should be completed daily (patient admissions), weekly (such as, empty dialysis slots, patient treatment numbers, and hand hygiene) and monthly (Hepatitis vaccination data, dialysis record audits and prescription delivery). The audit calendar included the report process and the online address where all records were analysed. This information was fed into the organisational database to produce a dashboard of compliance. We saw that the centre met all key performance indicators.
- The centre did not directly contribute data to the UK Renal Registry, as the centre's data was uploaded to the national database from the local NHS trust.
- Records from November 2016 showed 100% compliance with all audits with the exception of decontamination of water treatment (95%), clinical environment (91%), food provision during dialysis and decontamination of dialysis stations (80%). Each area for improvement was included on an action plan, detailing actions to be taken to improve, date due and date completed, and any details of actions completed. We saw that individual staff were challenged with audit results and training provided to ensure compliance. The staff handover was also used to remind staff about correct processes for decontamination of dialysis stations.
- Diaverum set targets relating to optimising patient conditions and experience, which included the weekly treatment times being equal to or greater than 720 minutes for 90% of patients, and patients' haemoglobin being maintained between 10 and 12g/dl in 65% patients. Redditch Kidney Treatment Centre performed better than all other Diaverum locations in the October to December 2016 audit.

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- Staff monitored patients' dialysis access (dialysis catheter, arteriovenous graft or fistula) monthly. Staff reviewed the targets for optimising vascular access, which was set by Diaverum, following a review of the referring local NHS trust and the national standards.

Competent staff

- As the centre opened in March 2016, the centre manager had arranged for additional training and supervision for staff to ensure that they were competent to manage patient care safely. This had included regular teaching sessions from the practice development nurse, mentoring of staff by the ward manager and additional training from external sources as necessary.
- All new staff were supported by the practice development nurse (PDN) and the centre manager to ensure the maintenance of standards and competence. The PDN attended the centre regularly to assist with mandatory and ad hoc training.
- On commencement of employment, staff were given a bespoke training plan depending on their level of experience and qualifications. This included an orientation programme, and competencies, which were based on the national standards framework.
- In addition to the in-person training provided, staff had access to the Diaverum training programmes for nurses, physicians and managers. These were completed via an online log in. Access to training was arranged by the practice development nurses following commencement of post.
- The duty roster was created to ensure that there was always a senior member of staff on duty therefore staff had constant access to a more experienced member of staff. Due to working in an isolated unit, not attached to a local NHS trust, staff were responsible for the management of any untoward incident or emergency. Staff were trained to manage situations like these by the manager.
- When necessary nursing staff received additional training in specialist areas to enhance patients experience. For example, one patient had an artificial feeding tube inserted into their stomach (percutaneous endoscopic gastrostomy- PEG). The patient had been identified as not managing the line and to prevent the GP arranging additional services at home, the centre offered to manage the care of the line when they attended for their dialysis. The manager liaised with the community nutritional specialist nurse, who attended the centre and trained staff in the correct management of line.
- Bank and new staff were inducted using a staff checklist which included the awareness of safety procedures (fire safety, resuscitation equipment), equipment training (dialysis monitor, infusion pumps glucometers) knowledge of governance policies, patients data requirements and uniform policy. We saw that the induction checklist was completed by staff at every attendance to the centre and signed by a substantive member of staff.
- 100% of staff had completed their annual appraisal. Annual appraisals identified any areas for development and an agreed timescale for completion. All staff completed competencies, which were measured against the National Health Service, Knowledge and Skills Framework. These were reviewed annually as part of the staff member's appraisal.
- We were told that the manager had an open door policy and was readily available if staff required supervision, training or assistance. We saw that staff and patients asked for advice, assistance or information when necessary. An example of this was, one nurse wanted further information and instructions regarding a patient's arteriovenous fistula. The manager assisted without hesitation, informed the nurse of what to do, how to do it, and demonstrated actions to be taken.
- There were systems in place to support staff who were not meeting the organisation's standards of care and competence in delivering safe patient care. This included additional support and training where necessary.
- All staff were assessed annually for medicines administration and understanding, manual handling and basic life support. Training compliance was 100% for all topics.
- Nursing staff were trained in dialysis by Diaverum and all staff had completed renal training programmes. In addition, over 50% staff had completed or were in the process of completing the national renal training course. Competence was monitored and recorded annually.
- The centre had clear guidance on the roles and responsibilities of the nurse in charge, staff mentors and senior team learning needs. All guidance included details of actions to be taken and the training required to complete the roles.

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- Nursing staff were required to re-register with the nursing and midwifery council (NMC) annually and revalidate every three years. We saw that there were systems in place to monitor staff when this was due for completion, and assist them with preparation for revalidation.
- Staff employed by Diaverum, were recruited through the central human resources department. Requirements for employment included the proof of nursing registration, basic life support training, manual handling training.

Multidisciplinary working

- The local NHS trust provided all specialist support for patients with the exception of nursing staff who were employed by Diaverum.
- The trust consultant, dietitian and satellite haemodialysis unit coordinator attended monthly multidisciplinary team meetings at the centre. These meetings were also attended by the centre manager and any available qualified nurses on duty. We saw that the meetings followed a set format where patients' current condition, their care plans, most recent blood results and medicines were discussed and recorded in the electronic patient record. Each patient review was recorded on a table, which was given to the patient and forwarded to their GP.
- Patients had access to a dietitian who reviewed each patient monthly, prior to the multidisciplinary team meetings (MDT). This enabled an informed discussion about planned care and treatment. Any changes to patients' diets were recorded on information leaflets, which were given to patients after each MDT meeting.
- Patients also had access to a social work advisor who assisted with any financial advice, benefits claims and helped inform patients of their entitlements. Nursing staff did not have regular feedback from the social work advisor unless information directly affected patients' care.

Access to information

- All information needed to deliver effective care and treatment was available to staff through either electronic or paper records. Paper records consisted of all patient risk assessments, consent forms and dialysis and medicine prescriptions. Electronic records including records from the local NHS trust and blood test results were accessible to all staff attending the centre.

- Staff working within the centre had honorary contracts with the local NHS trust, which allowed them to access the hospital's electronic patient records (EPR). This meant that staff had access to the latest information and patient treatment plans, blood and test results and multidisciplinary notes. Nursing staff told us that this had reduced the number of admissions to the local NHS trust as patients' blood and test results were available for review.
- Staff attending the centre from the local NHS trust were able to access their own desktops, which meant that information was readily available when visiting patients off site.
- These visiting staff could access their work desktops using the same passwords. This meant that all relevant information needed to complete patient assessments and treatments was accessible.
- Data collected during dialysis was automatically uploaded into the trust database, which meant that records were contemporaneous and accurate at the time of review. The compatible IT systems allowed all staff to access information about all patients.
- Nursing staff completed telephone referrals for additional support or specialists. This process was followed by a written letter or email to the relevant service to ensure details had been shared.
- Patients and their GPs received copies of their multidisciplinary notes on the day of the meeting. The final page detailed any changes to treatment or medicine, which needed to be implemented.
- The consultants, nursing team or dietitians would contact patients' GPs directly with any changes to treatment. We saw that following each multidisciplinary team meeting, a printout of current treatment and any planned changes was provided to the patient and to the GP. We were told that copies of this form were issued immediately to prevent any delays, and ensure that changes were in place before the next dialysis session. We were told that information to the GP was shared initially by telephone, and followed up with letters or secure emails.

Equality and human rights

- From 1st August 2016 onwards, all organisations that provide NHS care were legally required to follow the Accessible Information Standard. The standard aims

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ensure that people who have a disability, impairment, or sensory loss are provided with easy to read information and support to communicate effectively with health and social care providers.

- We were told that the centre did not provide care for patients with learning disabilities or those living with dementia and we were told that the majority of patients who required additional support received their treatment at the local NHS trust where staffing numbers were higher. Patients with complex needs were assessed by the local NHS trust prior to making a referral to the centre for treatment to ensure that they received their care and treatment in the most appropriate location.
- The Workforce Race Equality Standard (WRES) is a requirement for organisations that provide care to NHS patients. This is to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The centre was located in a culturally diverse area and staff employed by the service reflected this.

Consent, Mental Capacity Act and Deprivation of Liberty

- All staff were fully aware of their roles and responsibilities in relation to the requirements of consent. We saw that patients were asked for verbal consent at the start of each dialysis session and for any treatments or care during their attendance at the centre.
- We saw that each patient completed consent forms for the completion of treatment and for dialysis. This consent form was filed in the patient's paper records and updated annually.
- Staff were aware of mental capacity assessments, and how they would escalate any concerns to promote safe care and treatment. We were told that patients who were suspected not to have capacity to consent to treatment were discussed with the consultant. The patients would be reviewed as a matter of urgency and a mental capacity assessment completed. In these cases, the consultant would speak with the patient's family, who were asked to consent on the patient's behalf following a best interest decision. Staff referred to implied consent, with patients attending the centre in their own free will for treatment.
- Patients who expressed that they did not want to continue with treatment were referred urgently to the consultant. We were told that a meeting was arranged

to identify if there were any specific reasons that affected the patient's choice and where necessary try to resolve them. Patients who continued to withdraw from treatment were supported to understand the outcome and arrange help for the palliative stages of their illness.

- Nursing staff told us that patients who had variable capacity, such as those living with a dementia were treated at the local NHS trust where the patient nurse ratio allowed patients to be supported.
- Staff were aware of deprivation of liberty safeguards, but had not experienced any situations where a referral needed to be made.

Are dialysis services caring?

Compassionate care

- Staff understood patients' personal, cultural, social and religious needs. We saw that these were taken into account when planning treatment. For example, patient's dialysis sessions were planned around their work, social events, hobbies and patients grouped into those with similar interests.
- Patients told us that staff were kind, caring and provided excellent care and treatment.
- Patients told us that staff were always friendly and welcoming.
- We saw that staff spent time talking to patients throughout their treatments and their waiting time before and after. We saw that the administrator also spent time talking to patients and told us that this was one of the best things about the job, and that during interview for the position, it was made clear that the centre required someone who would interact with the patients.
- We saw that all interactions were respectful and considerate. Staff spoke politely to patients and were supportive. For example, one patient was experiencing problems with the flow of the dialysis machine and the nurse reassured the patient that treatment would still be effective and that they would continue to monitor the situation during the session, increasing the flow as able.
- We saw that staff were responsive to all patients' needs, including calls for help, alarms on dialysis machines and any non-verbal signs of distress. All staff were compassionate and attentive.

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- Patient's dignity was maintained using screens that could be placed around the dialysis station.
- Nursing staff maintained patients comfort using additional pillows, pressure relieving aids and if necessary a hospital bed. We saw that many patients brought their own blankets and comforters.
- We were told that staff had not witnessed any disrespectful behaviour but would escalate any concerns directly with the manager. Nursing staff told us that due to patients attending the centre regularly for long periods of time, they had formulated effective nurse patient relationships.
- Nursing staff told us that the centre completed biannual patient surveys, which were based on "I want great care" (a national systems for collecting patient feedback), capturing how many patients would recommend the service to friends and family.
- We saw that the patient's satisfaction audit was displayed in reception. The poster detailed the overall satisfaction score and details of comments and any actions taken. Patient satisfaction for 'I want great care' feedback was 93%. This was the second highest score within all Diaverum dialysis centres.

Understanding and involvement of patients and those close to them

- We saw that staff spoke openly about the treatments provided, the blood results and dialysis treatment plans. Many of the patients were observed speaking to staff about their latest blood results and what these meant and staff responded appropriately.
- Nursing staff told us that as they saw their patients frequently they were familiar with their moods and were able to identify when patients were having a bad day or were feeling unwell. This enabled them to spend additional time with the patients as necessary to support them with their treatment or assist with any concerns they may have.
- On referral to the centre, patients were encouraged to visit the centre for an initial assessment and a look around. On arrival, staff gave patients information packs about the centre, which detailed what to expect from the service and information on haemodialysis. Patients and their relatives were encouraged to spend time with the staff and other patients to ensure that they were satisfied with the centre before agreeing to start treatment at the unit.
- Patients new to dialysis were given additional time and support by staff prior to commencing treatment. Information leaflets were used by staff to inform patients of side effects and common risks and benefits of treatment, and were discussed throughout the patients visit to the centre.
- Patients and their relatives were encouraged to participate in their treatment. Staff encouraged patients to take responsibility for parts of their treatment, such as weighing themselves prior to dialysis, inputting data to the dialysis matching, preparing needles and connecting dialysis lines. Nursing staff told us that patients liked to have some control over treatment.
- Patients we spoke with were aware of the links between other clinical conditions and their renal failure. For example, one patient openly spoke about the management of their diabetes and the impact this had on their renal diet and treatment.
- We saw that patients were fully informed of their blood results at each dialysis session. Patients spoke with the nurses about the impact of their blood results and whether any changes would be made to their treatment. We saw that any changes to treatments were written and given to patients to ensure they were informed of the reasons why things had changed.
- All patients were reviewed a minimum of monthly by the consultant and dietitian which enabled discussions of any concerns, medicines, treatment changes, and plans for different dialysis. Following each meeting, patients were given a printed summary of the discussion and any planned changes to treatment. We saw that nursing staff spoke with patients about the discussions and answered any queries relating to the changes.
- All patients spoke positively about the staff and treatment at the centre. One patient told us that they had received treatment at other centres before joining Redditch, and had found that staff went above and beyond what was expected or received at other centres.
- Patients whose first language was not English were supported with decision making and understanding their condition by the use of translators and information leaflets.
- Patients were provided with the details of any blood results or test results during their visit to the unit. We saw patients openly discussing blood results, what they meant they were informed of any changes to treatment.

Emotional support

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- Patients were supported by the nursing staff to access support and additional services as necessary. This was made possible by staff completing organisational training provided by counsellors and social workers in the identification of patients' emotional needs.
- Patients told us that staff encouraged patients and their relatives to ask questions and provided them with information leaflets or advice on how to find information if necessary.
- Staff were aware of the impact that dialysis had on a patient's wellbeing, and staff supported patients to maintain as normal life as possible. Staff encouraged patients to continue to go on holiday, and participate in the management of their treatment.
- Staff gave patients support and time to discuss their treatment and care. We saw that all nursing staff spoke to patients at length about their most recent blood results and the impact that these had on their care.
- We saw that the centre provide details of support networks for patients and their loved ones. This included organisations such as the Kidney Patients' Association who complete social events, and support networks for patients and their loved ones.
- Nursing staff were observed giving patients time to talk about any concerns. The manager had an open door policy and during inspection, several patients entered the office to discuss the blood results or treatment. The manager always responded positively and gave the patient time to discuss their concerns.
- Patients had access to a renal social worker who was able to offer financial advice and support. This was usually following a request by the patient for assistance.

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

Service planning and delivery to meet the needs of individual people

- Diaverum was contracted to complete a programme of work by the local NHS trust. The trust and local clinical commissioning group had defined the scope and specifications of the service. Diaverum reported

progress in delivering the service against the defined specifications at monthly contract review meetings and through the collection of key performance indicators and quality outcomes.

- The operational manager told us that Diaverum was asked to build a dialysis centre within a specific catchment area to meet the demand of the local population. Patients in the Redditch area were travelling to the local NHS trust or other dialysis centres a minimum of three times per week. This journey time was between 30 and 40 minutes each way. As demand locally had increased, the local NHS trust entered into negotiations with the organisation to provide a service. Diaverum identified a location and built the treatment centre to meet the standards set out in the Renal Care Health Building Note 07 01(2013): 'Satellite dialysis unit requirements'.
- Patients who required dialysis in the Redditch area were assessed by the local NHS trust staff for suitability to dialysis in a satellite unit, and then referred to the centre. The centre had capacity to expand in the number of patients attending and the times of session available if necessary.
- Patients told us that they were kept informed of the plans to build the treatment centre and all chose to attend that centre due to the convenience of the location. Some patients told us they walked or drove to the centre and the journey had decreased from 40 minutes to less than 10 minutes.
- The centre consisted of three main areas on one level. The reception area and clinic rooms, dialysis stations and services corridor. Each area was secure with electronic pass access. Patients arriving in the reception were required to be buzzed in through a secure door from a large patient car park. This area had a camera to enable staff to identify callers upon arrival. The service corridor contained all treatment storage, water room, staff room, changing facilities, maintenance room and dirty utility room.
- The satellite haemodialysis unit coordinator arranged transport for patients through the local NHS trust. Patients and staff told us that they had regular drivers who were punctual and problems only arose if the regular driver was off work. Patients reported they usually waited a short period for transport to arrive.

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- Diaverum completed monthly contract meetings with the local NHS trust where they discussed performance, any new plans and developments. These were attended by the operational leads and managers from both Diaverum and the local NHS trust.
- The centre did not offer a seven-day service and was open from 6.30am to 6.30pm Monday to Saturday. The centre had capacity to increase the numbers of patients attending for dialysis during these hours, so was not planning to extend opening times to evening or night sessions at the time of inspection.

Meeting people's individual needs

- The centre provided disabled access, wheelchair accessible toilets inside and outside the clinical area and a selection of mobility aids. We saw that hoists were available for patients who could not transfer and wheelchairs were used to assist patients to and from their transport. There was a hearing loop available to assist patients who were hard of hearing.
- Nursing staff told us that patients could attend bathrooms during their dialysis sessions if they requested, however this was uncommon.
- We spoke with the satellite haemodialysis unit coordinator who explained that following a multidisciplinary team review, patients were referred to the centre according to their stability and their home address. Efforts were made to ensure that when possible patients did not travel long distances for treatment.
- Patients had access to a personal television and Wi-Fi during their dialysis sessions. This meant that patients did not get bored during their visit. One patient worked remotely as a personal assistant, and had arranged to work during the dialysis session, and we saw that other patients brought books to occupy their time.
- Nursing staff had attempted to group patients according to their interests, recognising that patients spent a long time with the same people during treatment. For example, staff had allocated patients to day and time slots depending on their interests and hobbies. We saw that four patients had been grouped together who had informed staff of a particular interest in football. This was particularly important as patients sat in the same place for each session.
- The centre currently had additional capacity to enable any patient who was delayed or unable to receive treatment on the specified day to attend the centre on an alternative time although staff reported that, this happened infrequently. Alternative appointments were arranged by the manager following a review of the available sessions and staffing numbers.
- Diaverum offered a holiday dialysis programme, which was managed locally by the manager. Nursing staff were aware of the process for receiving patients on holiday and told us that there was a robust process in place to ensure their safety. This included treatment in a side room and regular bloods. One patient told us that they went on holiday regularly and the arrangements for this was easy, with him contacting the dialysis centre directly to discuss possible dates. Following confirmation of dates, staff completed referral forms and relevant bloods to enable staff at the receiving centre had all relevant information.
- The centre had systems in place to provide dialysis for patients outside the usual catchment area, for example patients on holiday. There were currently up to two beds available for this. The system was based on the Department of Health: 'Good Practice Guidelines for Renal Dialysis/ Transplantation Units (2012)', which outlined the necessary screening, referral process and transport arrangements for patients care. When patients were referred to the centre, the consultant and MDT would review the shared information to identify whether the attendance could be accommodated.
- Patients were encouraged to participate in their treatment, and we saw multiple patients preparing equipment on their arrival to the unit.
- Diaverum provided patients with an online education programme. This included information on chronic kidney disease, treatment types, vascular access, advice on nutrition and hydration, how to analyse blood results, medicines, and how haemodialysis can affect patients' lives. The training is access through a log in provided by the dialysis centre.
- During inspection, we were told that Diaverum were in the process of launching a dialysis application for mobile telephones, which had been trialled at the centre. The application followed a similar brief to the training package, and allows patients to explore their blood results, monitor and track their weight and mood.
- Nursing staff also used information leaflets in a variety of languages to help patients understand treatments prior to consenting for treatment. We were told that

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patients whose first language was not English were not routinely dialysed at the centre, however a translator could be provided if necessary to ensure consent was understood.

- The Kidney Patients Association provided support networks for patients and their relatives, completing social gatherings, fund raising events and support sessions.
- Nursing staff referred patients to their GPs if they identified any social needs, such as additional care packages.
- The centre did not have a multi-faith room.
- Staff told us that patients did have access to a large meeting room that could be used for counselling and reflection as necessary.
- Nursing staff had been trained in vaccinations to enable patients to receive their seasonal flu vaccine at the centre, rather than attend their GP on an additional occasion.

Access and flow

- Patients were assessed for their appropriateness to attend the centre by the local NHS trust. Patients with acute kidney disease were treated at the local NHS trust and only chronic, long-term dialysis patients were referred to the centre for treatment. The referral to the centre was completed by the satellite haemodialysis unit coordinator, who contacted the manager informing them of the patient.
- When a patient was identified as being suitable to attend the centre, a referral was completed and an assessment visit arranged. Patients attended the unit to have a look around and meet staff. This gave staff the opportunity to complete the initial risk assessments and collect patient details and consent. Once the patient had agreed to attend the centre, the local NHS trust arranged transport if necessary and ensured medical notes were available.
- If the centre had no capacity, patients were placed on a waiting list, until a slot became free. On these occasions, patients would receive treatment in an alternative unit on a temporary basis. At the time of inspection, there were no patients on the waiting list for treatment.
- The centre reported no cancelled dialysis sessions from March 2016 to March 2017.

- Patients attending the centre had always received their initial dialysis at the local NHS trust. This was to ensure that patients were stable during their treatment before being treated in a satellite unit, therefore reducing the risk of any untoward incidents.
- The majority of patients attended the centre for treatment on a morning or afternoon on set days, for example every Tuesday, Thursday and Saturday morning. Patients we spoke with told us that they had some choice in when they attended, with one patient swapping from a morning to an afternoon appointment when it became available.
- As the centre was not working to capacity, we were told that there was some flexibility in the treatment sessions and timings as long as there was adequate staffing numbers to meet the needs. We saw that different machines were in use for morning and afternoon sessions, which meant that there were no or limited delays between patients arriving at the centre and start time of treatment. During inspection, we did not see any patients waiting in reception.
- Patients attended the centre for either a morning or afternoon appointment, which meant that discharge home was always at a reasonable time.
- All appointments with the consultant or dietitian were scheduled for the same day as patient's dialysis sessions to prevent multiple attendances at the centre.
- The centre reported that nine patients were transferred for dialysis at alternative sites from March 2016 to March 2017. Five patients were relocated to a site nearer to their home, and four transferred to the referring local NHS trust for enhanced care, as a result of a change in their clinical condition.
- Patient transport was coordinated by an area manager and involved the ambulance service and private patient transport systems. There were clearly defined guidelines for the transportation of patients, which included patients not waiting for more than 30 minutes for transport and journeys should be less than 30 minutes. Staff reported that there were occasions where treatment was delayed as a result of transport issues; however, we did not see this during inspection. Patients told us that transport was usually on time.

Learning from complaints and concerns

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- We saw that there was a clear process in place for the management of complaints: all staff were able to tell us what they would do for formal and informal complaints made.
- Data showed that there was one informal complaint received by the centre from March 2016 to March 2017. This related to patient transport and was managed jointly by the centre manager, satellite haemodialysis unit coordinator and the transport provider.
- The complaints policy refers to a five step process in response to complaints, which involves the receipt of, recording of, processing, responding and reporting on complaints within six weeks. The policy gives clear guidance on the identification of who should investigate and respond to a complaint and actions to take concerning categorisation and classification of seriousness.
- On referral to the centre, patients and their relatives were given a copy of the patient booklet, which contains details of the complaints procedure. Detailing how a complaint could be made, the process for investigation and the timescale.
- We saw a poster displayed in reception providing patients and relatives information on how to raise concerns and make a complaint. There were also feedback boxes available, to enable patients to make comments or suggestions anonymously.
- The manager held regular open door sessions where patients could escalate any concerns directly. This was in addition to the daily contact by the ward manager to ensure patient satisfaction.
- The director of nursing and operational manager from Diaverum were present during the inspection, and it was clear from their interactions and knowledge of staff that they had regular contact with staff.
- Nursing staff confirmed that the senior management team were approachable, always responded positively to any contact and always spoke with patients when they visited the centre.
- We saw that locally senior nursing staff held or were working towards specialist renal nurse qualifications, held teaching certificates and had completed management courses.
- Locally, the manager showed strong leadership and professionalism. All staff told us that they were an excellent role model for the nursing team and worked above and beyond expectations.
- All staff reported that the manager was approachable and responsive to any needs, whether that was for assistance with clinical practice or personal support.
- All staff felt valued and told us that they enjoyed working at the centre. One nurse told us that they had been advised not to work in the centre when qualifying as a nurse in 2016. However, stated that it had been the “best decision” as staff had been very supportive, had time for teaching and had encouraged personal development.
- Throughout the inspection, we saw that staff assisted each other with tasks and responded quickly to service needs. For example, we saw that nursing staff shared patient activity across the unit and not isolated to their designated patients. We saw that nursing staff helped each other when working with two co-located patients completing treatment simultaneously.
- Diaverum used a talent matrix to identify staff who would benefit from additional training in order to complete new roles.
- All staff were aware of the need to be open and honest with patients, describing situations when treatments and care had been discussed at length with patients.
- We saw that staff had effective working relationships with staff from the local NHS trust. Medical staff and specialists confirmed that the working relationships were positive and inclusive.

Are dialysis services well-led?

Leadership and culture of service

- Leaders had the appropriate skills and knowledge to manage the service. Locally the centre manager was supported by a deputy manager, nursing staff, health care assistants and an administrator.
- Diaverum UK Limited (‘Diaverum’) had an organisational structure, which included a managing director, supported by a director of nursing and operational manager, in addition to financial, commercial and operational clinical divisions. Staff were divided into three regions nationally, and each area had a practice development nurse and a manager/ matron.

Vision and strategy for this core service

- Diaverum’s vision was to be the “first choice in renal care” with a mission to improve the quality of life for renal patients. They had a care concept that was based

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on the approach to improving patients' lives, by providing the best treatment, and patient choice. Locally the team were aware of the vision and spoke openly about providing patients with the best care possible.

- There was an effective strategy for the delivering of quality care, with policies, guidance and procedures based on national guidelines. Staff understood this strategy.
- Performance was monitored through an organisational dashboard. Staff were aware that they had been rated as the best performing treatment centre for October to December 2016, with the manager telling us that the team had accomplished this together.

Governance, risk management and quality measurement

- Quality assurance was monitored by Diaverum centrally though regular audits. Staff guidance and procedures were based on national guidance and considered when completing staff training and workforce planning.
- The consultant nephrologist from the local NHS trust was the governance lead for the centre feeding information back to the local NHS trust and monitoring progress against guidance and the contract.
- There were monthly quality assurance meetings, which were attended by the consultant, satellite haemodialysis unit coordinator, Diaverum operational manager (when possible), manager, dietitian and any other available staff. These meetings followed a set agenda and discussed hospitalisations, deaths, water treatment, staffing and patient blood sampling. Audit data and compliance against training was also discussed at these meetings. We saw that minutes from these meetings were detailed and shared with all staff.
- Data collected by the centre was inputted into the renal registry by the local NHS trust. This information was validated.
- The centre had an overarching risk register, which was broken into clinical risks, operational risks, human resources and financial risks. A local risk register detailed all risks associated with the building and the services provided. We saw that mitigating actions had been taken to reduce the occurrence of or severity of risk. The risk register was escalated to the organisation and updated regularly by the centre manager. An example of the risks identified related to the movement of dialysis machines and storage of heavy equipment.

The mitigating action taken to address risks included the completion of manual handling training, removal of clutter to ensure walkways were free and provision of shelving and equipment trolleys for storing and movement of heavy equipment.

- In addition to the overarching risk register, the centre manager also maintained a patient risk register, which were updated monthly or as clinical conditions changed. We saw that this risk register detailed patient specific risks, such as the placement of a long-term dialysis catheter due to clinical conditions and patient regularly removed protective dressing from access site.
- We saw evidence that staff worked effectively with stakeholders. There was clear understanding of each role and professional interaction to meet patients' needs. We saw open discussions between centre staff and staff employed by the local NHS trust. Information was shared and all staff were encouraged to participate in discussions.
- All staff followed a robust induction programme, which consisted of online training and competencies assessed by the practice development nurse. We saw that roles and responsibilities were clearly defined for all tasks. This included posters for staff on what to do in an emergency, and training according to role.
- The centre managers met regularly as a support network for teaching and sharing learning. In addition, Diaverum provided two, two-day meetings annually for managers where training was provided in topics suggested by staff working in the dialysis centres.
- Locally, area managers and matrons had monthly one to one meetings with the manager to discuss progress against targets and any development plans or changes to practice.
- Area meetings were held every six weeks. These included all staff within the area and were used to continue development, ideas and provide training support and service planning. We saw minutes of these meetings were shared with staff working within the centre.
- The senior management team meet their national colleagues regularly and had the opportunity to travel to different centres to share ideas for progressing the services offered by the company.

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- Information from the Diaverum board was shared directly with staff working at the centre through emails, and verbal feedback at team meetings. We saw that the organisation leads were visible and included staff in any plans for development or change.

Public and staff engagement

- Diaverum completed biannual patient surveys, based on “I want great care”. An external provider managed this. Results showed that 93% patients were satisfied with the service and would recommend to a friend.
- The local NHS trust also completed a patient survey, where patients were asked to respond anonymously to a survey by post. These results were shared with the team locally at team meetings.
- Prior to the centre opening, patients were invited to attend an opening day when they could look around the centre and meet the staff working there. Patients and staff reported that this had been well attended and enabled patients to familiarise themselves with staff and the location prior to starting their treatment.
- There was an active user group at the centre with patients attending meetings and organised events. The centre had links with the Kidney Patient Association and the National Kidney Foundation who provided information leaflets and advertised support groups and events.
- Patient feedback had been included in the design of the centre. For example, patients had commented that they did not want to see nurses behind a nurse station and the centre had placed a nurse’s desk in each bay to ensure that nursing staff were visible and accessible at all times. Another change had been on the access to manager, whose office could be accessed from the reception and the treatment area, which meant that patients could see the manager without entering into the treatment area.
- Diaverum completed annual staff surveys however as the unit had been open for one year, the annual survey had not been completed at Redditch.
- Staff told us they enjoyed working at the centre and felt that the team and patients were an extension to their family.
- Staff gave us examples of local activities such as fund raising and days out. The team had recently offered patients a manicure or hand treatments for small donations to the kidney patients association.

- Staff completed a stress concerns assessment, which was a checklist of questions that staff should score one to five. A higher score related to the possibility of work related stress and staff were required to speak with their manager and complete a stress risk assessment. This was followed by an appointment with the occupational health team.
- The centre reported minimal sickness for December 2016 to February 2017 with 0.7% reported.
- Patient satisfaction audits were completed biannually using an external company to complete a survey. Patients, their friends and families were able to complete an anonymous questionnaire to identify any areas for improvement. Following completion, the centre compiled an action plan to address any areas where improvement was required. For example, nurse stations were placed in patient bays to promote access and improve visibility of staff.

Innovation, improvement and sustainability

- Locally the manager completed a “train for ten” programme. This involved staff on duty attending a ten minute training session on any dialysis related topic.
- Diaverum had identified that student nurses were not routinely allocated to dialysis centres as part of their training. With this in mind, they worked collaboratively with the University of Worcester to identify students that could attend the unit for training. The centre was expecting the first student at the centre in April 2017 and was the first dialysis unit to offer this option.
- An effective student nurse pack had been produced which detailed an action plan for students to complete whilst on placement. This covered academic study of the kidney, and its functions along with practical skills such as preparing a dialysis machine and care of an arteriovenous fistula.
- The centre used a talent matrix, which was used to identify staff that were performing well and had potential for senior posts. This gave examples of how to spot talent using the staff members’ current role and performance. For example, if a staff member was proactive in dealing with issues, met objectives and responded to challenges were considered a solid performer, whilst someone who proactively managed issues, acted as a role model and highlighted improvement exceeded objectives.

Outstanding practice and areas for improvement

Outstanding practice

- The centre manager completed ad-hoc training for all staff. This consisted of flash card detailing specific scenarios, which were placed on a patient's chair. The manager would alert staff to the scenario by using the patient call bell, and then observe staff complete the appropriate actions to manage the situation.
- The manager had highlighted roles and responsibilities for individual staff in the event of an emergency. We saw that there were action cards on the door to the electricity and gas supply cupboard, which detailed who was responsible for escalating any concerns with the supply, the number to contact and what remaining staff should do to ensure safety. We were told that as the centre was new, it was important to ensure that all staff knew what to do if something happened.
- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Diaverum was in the process of launching a patient telephone application, which monitored their blood results, weight and mood. Patients were able to arrange the app to ask them daily how they felt, and allowed patients to track how their treatment was progressing.
- To promote holistic patient care, staff were trained in additional skills to prevent the patients being transferred to other locations for additional care and treatment. For example, staff were trained in the management of a feeding tube, which meant that the patient did not have to attend an additional clinic appointment as well as their dialysis sessions.
- Patients were encouraged to participate in their own dialysis, and were trained to complete specific aspects of their dialysis if they wished. This included anything from weighing themselves, preparing their own dialysis machine or needling their own arteriovenous fistula.
- Identity bracelets were in use for patients receiving blood transfusions.
- Patients' medical and nursing records were available for all meetings and assessments, which meant that the most up to date information was considered when reviewing care and treatment.
- All staff were annually assessed by the practice development nurse to ensure that they maintained competence and followed national and local guidance.
- The centre had arranged for student nurses to be placed at the centre during their training. This highlighted renal nursing and dialysis as an option for a working environment to student nurses when considering substantive posts.
- The centre used a talent matrix to assist with the identification of staff skills and potential for senior posts.
- Patients had access to an on line application which provided information about their disease, treatment and assisted with monitoring their condition on a daily basis.

Areas for improvement

Action the provider **SHOULD** take to improve

- To review systems for checking that the resuscitation trolley is sealed as outlined in the local policy.
- To consider implementing a process for the escalation of abnormal medicine fridge temperatures.