B. Braun Avitum UK Limited

Gloucester Royal Hospital Renal Units

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location improved. We rated it as requires improvement because:

- The environment on ward 7B remained poor and damaged or malfunctioning equipment needed urgent repair.
- Updated safeguarding processes needed further development. There remained a lack of assurance that staff knowledge and understanding protected patients from harm.
- A minority of staff demonstrated impatience and a lack of kindness towards patients when working under pressure and patient surveys indicated a need for improved communication from staff.
- There were gaps in the provision of care for patients who could not communicate well in English and those living with mental health needs.
- Detachment between the provider and staff was marked and the senior team did not recognise or acknowledge the scope of challenges staff faced.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills. The service managed safety incidents well and learned lessons from them.
- The provider had implemented significant improvements in infection prevention and control, the safety of the environment and in safeguarding. Improvements needed time to provide assurance of effectiveness and reduced risk.
- Staff provided emotional support to patients and their loved ones.
- Staff provided good care and treatment and gave patients enough to eat and drink.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to suit patients' needs.
- The service engaged well with patients to plan and manage services. Staff were clear about their roles and accountabilities.
- Staff coordinated a wide range of service adaptations to meet individual need, including to help people adhere to religious beliefs and cultural needs.
- Most staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.

The provider had improved governance and risk management systems through an extensive programme of work, which needed further time and development to fully embed into the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis services	Requires Improvement 	We rated this service as requires improvement reflecting the need for sustained improvement in safe and well led. We rated effective, caring, and responsive as good. Please see the main summary.

Summary of findings

Contents

Summary of this inspection

Background to Gloucester Royal Hospital Renal Units

Gloucester Royal Hospital Renal Units is operated by B. Braun Avitum UK Limited. The service provides haemodialysis to NHS patients over the age of 18 under a contract with Gloucestershire Hospitals NHS Foundation Trust. The service operates 50 dialysis stations across 3 units on the site of Gloucestershire Royal Hospital. Cotswold unit is the main clinic, and the service also operates Severn unit, both of which are located on the hospital grounds. The service also provides care from a dialysis bay and side room on ward 7B of the main hospital.

Cotswold and Severn units operate from 7am to 6.30pm on Tuesdays, Thursdays, and Saturdays, and from 7am to 12am on Mondays, Wednesdays, and Fridays. The unit on ward 7B operates from 7.30am to 7pm 6 days a week, from Monday to Saturday for planned care. The service provides 24/7 on-call dialysis for emergency cases.

The provider registered this location in 2012. A registered manager is in post and the service is registered to carry out the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder, or injury

We last inspected the service in August and September 2022. As a result of a focused inspection, which included the safe and well led domains only, we served 2 Warning Notices under Section 29 of the Health and Social Care Act 2008. We notified the provider that they failed to comply with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to comply with Regulation 12(2)(d)(h)(i), Safe care and treatment, and with Regulation 17(1)(2)(b), Good governance. We told the provider they must make improvements in 7 specific areas and said they should make improvements in a further 3 areas.

We carried out this inspection in order to rate each domain and to assess the service's progress in addressing the previous areas for improvement. We found the service had improved, or begun to improve, all the areas relating to breaches of regulation. While this reflected better care overall, there remained a need for more embedded and sustained improvement.

How we carried out this inspection

We carried out an unannounced, comprehensive inspection of the service on 5 and 6 April 2023. Our inspection team consisted of a lead inspector and a specialist advisor with clinical experience in renal services. We included all 3 units located on the site of the Gloucester Royal Hospital in our inspection.

As part of our inspection, we spoke with staff from the host NHS trust to understand how systems and governance worked in partnership between the 2 organisations. The trust and hospital's staff do not form part of our report or judgement, but we refer to them because they are responsible for the care and treatment of the overall renal pathway, of which dialysis services are delivered as a component part by B. Braun Avitum UK Limited. We refer to the provider as "B. Braun" throughout our report. The NHS trust is responsible for the premises and infrastructure from which dialysis services are delivered.

During our inspection we spoke with 12 patients and relatives to gain an understanding of their experiences.

Summary of this inspection

After our inspection we carried out a remote interview with 2 members of the provider's national team and asked the service to send us additional evidence of working standards and practices.

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

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure adequate provisions are in place to support communication with patients who cannot communicate in English. Regulation 9
- The service should ensure that staff provide a kind and compassionate service to patients, including when communication is challenging. Regulation 10
- The service should ensure that patients unable to provide signed consent due to a language barrier are effectively and consistently supported. Regulation 11
- The service should continue to progress improvements in safeguarding processes, particularly in relation to staff knowledge. Regulation 13
- The service should ensure Legionella prevention measures are applied consistently to all sinks, including in the areas used by staff and patients on ward 7B. Regulation 15
- The service should ensure equipment is maintained safely and is fit for use. Regulation 15
- The service should ensure patient records are contemporaneous and up to date. Regulation 17
- The service should ensure staff in the ward 7B unit have effective support for managing patient flow and bed capacity. Regulation 17
- The service should ensure the risk register accurately and affectively reflects current risks to the service. Regulation 17
- The service should ensure complaint investigations document how staff are responsive to the needs of patients and those who look after them in order to demonstrate appropriate standards of care. Regulation 16
- The provider should ensure staff working on ward 7B have sufficient senior level support to coordinate patient admissions with the NHS hospital's bed management team. Regulation 17
- The service should maintain the display of the most recent inspection ratings in the appropriate place. Regulation 20A

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Dialysis services

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

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

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

Staff received and kept up to date with their mandatory training. The service maintained records of training compliance for each individual member of staff. However, as records did not include the expected or actual month of completion, it was not possible to calculate an accurate overview of completion as a percentage. The provider required staff to take responsibility for their training and to ensure it was up to date and the training link nurse supported the team accordingly.

Mandatory training was comprehensive and met the clinical needs of patients and staff. It included up to 69 modules depending on the individual's specific role and location of work. For example, staff who provided care on the ward 7B unit undertook more advanced training that reflected the needs of acutely unwell patients. The provider supplemented mandatory training with ad-hoc specialised training, such as managing patients with a phobia of needles and those who chose not to follow guidance to keep themselves safe.

Staff joined NHS colleagues on ward 7B team training days to help supplement their mandatory training. This reflected the higher level of acuity of patients in this unit and ensured dialysis staff could work effectively with other teams involved in complex care.

A practice development nurse (PDN) worked across the provider's clinics. They supported staff to complete mandatory training and helped them access national vocational qualifications.

The NHS trust, which operated the hospital site on which this service was located, provided a range of mandatory training to dialysis staff. This included simulated resuscitation and life support training as well as training in providing care to patients with mental health needs. Training was a mix of practical and remote e-learning. Staff undertook practical training in fluid assessment, anaphylaxis, and vascular access and were trained in basic life support. Senior nurses were trained in immediate life support.

Requires Improvement

Dialysis services

Safeguarding

Staff understood how to protect patients from abuse although there were inconsistencies in the provider's drive to improve communication and knowledge. Staff had training on how to recognise and report abuse and they knew how to apply it.

At our last inspection we found inconsistencies in staff knowledge and understanding of safeguarding policy and escalation processes, and we told the provider they must make improvements in this area. At this inspection we found some evidence of improvement. The provider had reissued the safeguarding policy and provided a printed guide for each member of staff. They worked with the NHS trust to ensure areas of joint responsibility were more clearly understood by staff.

Team meeting minutes indicated the provider had communicated expected improvements to staff, such as publishing an emergency contact list. While this reflected improved practice, there was a need for more embedded, sustained work. For example, the provider noted they had introduced safeguarding displays at nurse stations, issued staff with safeguarding information booklets, and updated contact lists for staff in each unit. However, there was no information on display at the nurse stations on Severn unit or the 7B unit and 2 members of staff could not locate contact information for safeguarding teams internally or in the NHS trust.

The provider told us the safeguarding policy and contact information were accessible by all staff on the intranet although this was not common knowledge amongst all staff.

Staff had not recognised and documented potential safeguarding risks for a patient who had several vulnerabilities, including the potential that a relative controlled their ability to communicate with the service. While staff had requested police carry out a wellbeing check, the patient's records had gaps in risk assessments. The inability to obtain support from a translator due to a lack of capacity in the contracted third-party provider meant the patient's medical review was delayed. We asked the registered manager to carry out a review of the patient after our inspection to gain assurance there was no unmet need. They arranged for an in-person translator to attend the patient's next appointment and reviewed care with a multidisciplinary team. While this reflected a good outcome, there was not a system in place to ensure staff had recognised such risks without prompting or intervention.

Staff provided care to patients as part of a wider multidisciplinary renal treatment pathway controlled mostly by the NHS trust. This meant any member of staff involved in the care of a patient could report a safeguarding concern. We spoke with 5 members of hospital staff about this, reflecting different roles and departments. In each case they demonstrated understanding of how safeguarding arrangements worked for patients under the care of B. Braun. For example, a member of trust staff told us how they alerted a patient's social worker to a potential risk and liaised with dialysis staff to meet the patient and coordinate action to ensure the patient was safe.

Most staff we spoke with were unaware of any safeguarding incidents or learning from such instances either in this location or across the provider's network. However, some staff demonstrated how they acted on safeguarding concerns to keep patients safe from potential harm. For example, 1 individual explained how the team coordinated support for a patient who lived in an adult social care facility when they had concerns about their standard of hygiene and wellbeing.

The service reported 1 formal safeguarding incident between January 2023 and April 2023. The incident demonstrated significant delays in local social care services and staff acted with NHS colleagues to protect the patient from harm whilst waiting for community assistance.

Requires Improvement

Dialysis services

The service provided care to patients living with complex mental health needs, including dementia. While staff undertook training to provide safe levels of care, there were limited resources and guidance in place to help staff understand and act on the increased risk of safeguarding.

Staff completed safeguarding training for adults and children to level 3. The service did not provide treatment to children and young people and staff maintained up to date training as good practice in case young people accompanied patients.

The clinic provided short-term dialysis for patients on holiday in the region under an NHS England scheme. The provider's patient coordinator ensured patients' home NHS trust provided contact details for their duty safeguarding service, which local dialysis staff could use in the event of a concern.

The NHS hospital's safeguarding policy and process was supplementary to B. Braun's and staff were expected to use both in the event of an urgent need.

Cleanliness, infection control and hygiene

The service had improved standards to control infection risk. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises within their remit visibly clean.

The NHS trust provided estates and facilities services under a contractual obligation. Some aspects of routine cleaning and infection control, such as overnight deep cleans, were also the responsibility of the trust. Clinical areas on Cotswold and Severn units were clean and had suitable furnishings which were clean and well-maintained. Surfaces were free from dust and staff cleaned regularly.

Cleaning arrangements in the dialysis unit on ward 7B were different and were primarily the responsibility of the trust, with oversight from B. Braun staff. Infection prevention and control (IPC) standards in this unit needed improvement. For example, the flooring in the room used for isolating infectious patients was heavily stained, which meant it was difficult to assess cleanliness. Cleaning of this room was the responsibility of NHS staff, and the B. Braun team advised them as to the level of cleaning needed between patients. During our inspection we observed a hospital member of staff clean the room poorly, with limited effectiveness, and using a method that did not meet the requirements of the dialysis service. While the housekeeping team worked for the NHS trust, B. Braun was responsible for ensuring the room was safe and fit for purpose. Staff told us they would check and assess the standard of cleaning between patients in this room but there was no documented evidence of this, which meant they had limited assurance of standards of practice.

In all units, each dialysis space had antibacterial hand gel for patients and staff, who used it frequently and correctly.

Staff audited unit cleanliness monthly as part of a wider health and safety audit. Audit results between January 2023 and April 2023 demonstrated 94% compliance with expected standards. Where expected standards were not met, staff used action plans to implement changes and improvements. For example, audits identified inconsistencies in cleaning standards by NHS staff in the dialysis unit and side room on ward 7B. To address the issue, staff asked for a secondary clean and reported their concerns to the cleaning team.

Cotswold and Severn units were undergoing significant refurbishment and improvement and the audit results reflected this, such as floor and wall repairs that were underway. The unit had undergone a range of improvements at the time of our inspection and staff expected future audits would reflect higher levels of compliance as a result.

Staff cared for patients who tested positive for COVID-19 in side-rooms to reduce the risk of cross-infection. They used enhanced IPC and personal protective equipment (PPE) measures to ensure each patient received their prescribed dialysis safely. However, there was no system in place to ensure all staff understood the exact location of patients. For example, during our inspection, 2 patients who had COVID-19 were cared for in side-rooms on Cotswold unit. We asked 3 members of staff which side rooms the patients were located in and received 3 different answers. There was no signage on the side rooms to indicate a COVID positive patient was present although staff kept additional PPE outside of 1 of the rooms to indicate an increased risk.

Cleaning records in Cotswold and Severn units were up to date and reflected consistent frequencies of cleaning. Staff cleaned equipment after each dialysis cycle. They sterilised unused equipment every 48 hours and labelled each item to show when it was last cleaned.

Staff screened patients every 3 months for Methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-sensitive Staphylococcus aureus (MSSA). Such infections were a potential risk for central catheter exit sites and regular checks helped to avoid outbreaks in the service. Infections were rare and containment policies were in place to reduce the risk of outbreaks. The service had a good track record in relation to managing central venous catheters. In the previous 6 months the service reported 3 bacteraemia incidents and 7 central venous catheter exit site infections.

Senior staff carried out hand hygiene and aseptic non-touch technique (ANTT) practice in each unit using a sampling approach. They tracked staff audited over a 12-month period to ensure they included a good mix of roles. Between January 2023 and April 2023 audits demonstrated consistently good practice, with an average of 95% compliance with expected standards.

The PDN took a proactive role in coaching and developing staff with good hand hygiene and ANTT practice. They audited staff and carried out spot checks, offering best practice advice. Staff demonstrated consistently good standards of both during our inspection. Staff completed annual ANTT training in addition to support from the PDN.

Environment and equipment

The maintenance of facilities, premises and equipment within the provider's remit was undergoing significant improvement. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. They were proactive in assisting patients who needed assistance but did not use their call bell to attract attention. For example, staff observed patients struggling to reposition themselves or trying to reach something they wanted and provided assistance accordingly.

The service had secured a significant refurbishment programme on Cotswold and Severn units, including new flooring, repairs to windows and roofs, and replacement of broken fire safety infrastructure. This meant the units were compliant with national standards, including the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09 in relation to clinical environment design and HBN 00/10 in relation to infection control in the clinical environment.

Staff disposed of clinical waste safely and in line with DHSC Health Technical Memorandum (HTM) 07/01 (2013) in relation to the safe management and disposal of healthcare waste. The most recent results from February 2023 reflected 89% compliance. The provider had a national programme of waste streaming in place designed to reduce unnecessary disposal and improve recycling.

Requires Improvement

Dialysis services

Staff managed chemicals in line with the Control of Substances Hazardous to Health Regulations 2002 (COSHH), including in safe storage and use in patient areas. This was an improvement since our last inspection and reflected compliance with national standards.

The service was mostly compliant with DHSC HTM 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste. Staff labelled sharps bins in line with required standards and stored and used them safely. Staff in the dialysis unit on ward 7B did not routinely close the sliding apertures on sharps bins, which presented a safety risk and was not in line with expected standards.

Provider staff carried out regular water flushing of taps as a strategy to reduce the risk of Legionella build-up. At this inspection there were significant improvements in the environment in Cotswold and Severn units. For example, handwashing sinks that did not comply with the HBN were being removed and other taps were fitted with safety filters that staff monitored and replaced regularly. This reduced the risk of Legionella outbreaks.

This approach reflected good practice and meant the service was compliant with DHSC HTM 04/01 in relation to the management of safe water in healthcare premises. However, there was a need for improvements in the management of this process in the unit on ward 7B. For example, staff used a storage room that formed part of the water treatment plant. This room had a handwashing sink that was rarely used but was not included in the regular flushing regime. Although a sign was displayed to note the water supply was switched off unless the sink was needed, this was not the case. We spoke with staff about this who recognised the risk of Legionella build-up but could not identify why the sink was excluded from water safety measures.

Staff documented a range of checks on water safety, including daily temperature and pressure checks. An external laboratory monitored microbiology safety including monthly total viability count (TVC). TVC is a test to check the number of microorganisms, such as bacteria, in a water sample.

The estates and facilities were provided by, and remained the responsibility of, the NHS trust. While improvements had been made to Cotswold and Severn units, and staff managed the dialysis unit on ward 7B more safely, the fabric of the environment in this area was poor. The service had a private side room used for providing dialysis to patients who needed to be isolated. This room was in a poor state of repair with damaged flooring and walls and was not compliant with HBN 00/10 in relation to flooring in healthcare settings. Floor tiles were missing or damaged, which presented a risk of bacteria building up and impacting patient health and potential for infection. The condition of the room was the responsibility of the NHS trust, and it was not clear they were aware of the urgent need for repair and improvement.

Staff had decluttered clinical areas as far as possible, which reduced fire risk and improved overall safety. The dialysis unit on ward 7B had very limited storage space available as it was located in a small section of a larger NHS hospital ward. To address storage issues and associated hazards, staff implemented a new system whereby COSHH materials and other consumables were delivered from 1 of the larger units every day. This meant staff could manage stock and space more safely.

An external organisation managed the water treatment systems under a contract with the provider in Cotswold and Severn units. On ward 7B, the contractual arrangement was convoluted and delayed essential maintenance. Staff used business continuity plans to minimise disruption to patients in the event of water systems failure.

Patients underwent dialysis treatment using either a hospital bed or a dialysis chair depending on their individual needs. Beds, chairs, mattresses, and cushions were in a good state of repair and staff used a repair and maintenance process to address damage.

Each unit was equipped with emergency equipment including an automatic external defibrillator (AED), oxygen, and breathing support equipment. In the event of a clinical emergency, the trust provided cover from the on-call resuscitation team. The dialysis team had access to ward emergency resuscitation equipment as part of a service level agreement.

Staff maintained a sepsis box on each unit. These included an approved screening tool, fluids, and a blood culture collection set. The service displayed up to date guidance on correct use of the equipment such as from Resuscitation Council UK in relation to cardiopulmonary resuscitation.

Staff working in the dialysis unit on ward 7B used NHS resuscitation equipment that belonged to the host NHS ward in the event of an emergency. Staff worked with NHS colleagues to coordinate care in the event of a cardiac arrest. We spoke with ward staff who were aware of this arrangement and said it worked well.

The reverse osmosis unit, part of the water treatment equipment, in the dialysis unit on ward 7B needed urgent maintenance. A member of staff had carried out makeshift repairs on the unit to avoid closing the dialysis unit. However, this involved using medical consumables in place of authorised manufacturer repairs and the unit was leaking, presenting a health and safety risk. We spoke with the registered manager about this. While they were aware of the problem, they said delays were caused by the maintenance contract with the trust.

The registered manager carried out 2 practical fire drills per year on Severn and Cotswold units and used staff action to identify opportunities for learning and improved training.

Assessing and responding to patient risk

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

At our last inspection we told the provider it must implement improved systems for sepsis management. The provider had improved communication and engagement with staff regarding the sepsis policy. All staff we spoke with, including agency staff, demonstrated a good understanding of the risks, symptoms, and appropriate response to sepsis, including the location of emergency equipment and escalation process. During our inspection the dialysis team on ward 7B effectively managed a patient admitted from the ED who they suspected was septic. They coordinated urgent care with the NHS renal team and arranged for the patient to be admitted.

Staff responded promptly to any sudden deterioration in a patient's health. Incident reports indicated staff acted quickly when patients' needs changed. A renal doctor was on call in the hospital from 9am to 5pm daily in the event a patient deteriorated. The patient deterioration policy included thresholds for safe treatment. For example, if staff could not stabilise a patient in the unit, they arranged for a transfer to the emergency department (ED), which was located on site.

Staff in the dialysis unit on ward 7B often provided care for patients who were acutely unwell, including those transferred from the ED and at risk of clinical deterioration. There was not a consistent system of clinical management to monitor these patients. For example, during our inspection 2 patients had deteriorated whilst in the hospital and required coordinated care between different teams. However, staff did not use an appropriate tool such as the national early warning scores (NEWS2) system. While staff told us patients remained under the substantive care of consultants elsewhere in the NHS trust, whilst undergoing dialysis B. Braun was responsible for them and an inconsistent, uncoordinated system reduced the assurance of safe risk management. We asked the provider to supply evidence they audited the use of NEWS2, or an equivalent, but there were unable to produce this.

Requires Improvement

Dialysis services

Patients treated in the dialysis unit on ward 7B were often waiting for inpatient admission to the hospital. While B. Braun staffed the dialysis service, NHS hospital staff were responsible for care and treatment before and after dialysis. During our inspection we saw patients often arrived from the ED without fully completed medical information, vital signs, or test results. For example, on 1 day of our inspection, ED staff transferred a patient with suspected sepsis to the dialysis unit without confirming their results or initiating a monitoring tool. This created significant extra workload for the dialysis team, who had to maintain care for patients already in the unit in addition to managing other urgent admissions.

Staff carried out a monthly falls risk assessment, and a manual handling risk assessment for patients every 6 months, or more often if their health condition changed. The assessments ensured staff provided appropriate support to patients when moving between transport, wheelchairs, and dialysis chairs. The service reported 8 falls in the previous 15 months, which was a fraction of total patients seen and reflected good standards of practice and risk management. In each case staff reviewed the circumstances of the fall and identified opportunities for learning or changes in care.

Staff training reflected a focus on safety and managing risk. For example, all staff undertook annual prevention of falls and prevention of venous needle dislodgement training.

Staff completed an individual risk assessment with each patient on arrival. This included a general check of how they were feeling, a check for swollen ankles, feet, and legs, and a check for breathlessness. This reflected good practice and meant staff could modify treatment based on each patient's needs.

Staff carried out a formal handover of patients before the start of each shift to plan the service and discuss any issues, incidents, or pressures. Once treatment commenced, the whole team carried out a walkaround of the service to identify any issues.

The service provided patients with guidance on managing post-treatment symptoms or problems, such as who to contact for out of hours help. Where patients had complex needs, staff prepared a care plan with the NHS hospital renal team to manage the risk of out of hours hospital admission.

The waiting area in Severn unit was unstaffed. The team managed this risk appropriately, through secured access to the unit and posters that explained to patients how to attract attention or contact staff if they needed help.

The provider used a liability waiver system to continue to provide care to patients when they declined to follow medical guidance or advice. For example, if patients did not want staff to measure their vital signs before and after dialysis, they signed the waiver form to denote they understood associated risks.

Staff briefed patients on fire evacuation processes when they first began dialysis. As patients undergoing dialysis had a fistula inserted, leaving the building quickly in an emergency would be slowed if staff needed to remove each patient's medical equipment. The briefing included a demonstration of how each patient could safely clamp and disconnect their dialysis lines to evacuate safely. Staff had prepared large, visual displays in each unit demonstrating the correct procedure to use, including photographs. In an emergency, this would enable staff to assist the most vulnerable patients who could not evacuate by themselves.

The service offered holiday dialysis for patients away from home as part of national NHS England standards. A dedicated holiday coordinator worked with patients' home medical teams and completed additional risk assessments to ensure staff could provide safe care. In some cases, the host hospital accepted holiday dialysis patients on behalf of the service. The coordinator liaised with trust colleagues to ensure this was a safe process.

Staff followed the provider's policy to manage and prevent blood borne viruses (BBV), such as Hepatitis B, by using a system of pre-dialysis screening, immunisation, and testing. The service worked with the NHS trust to ensure the process worked effectively. Where the service accepted patients for holiday dialysis, staff followed national guidance on BBV and haematology screening, which required confirmed test results dated no more than 8 weeks prior to the start of dialysis.

Staffing

Staff had the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The registered manager regularly reviewed and adjusted staffing levels and skill mix, and gave agency staff an induction.

The service had enough nursing and support staff to keep patients safe. As care was pre-planned, staffing levels and skill mix were set in advance and remained consistent. On Cotswold and Severn units, a clinical manager and deputy manager led a team of senior dialysis nurses, registered nurses, dialysis assistants, dialysis support workers, and healthcare assistants (HCAs). The numbers of each role varied between the units depending on capacity. A deputy manager, who was also a senior dialysis nurse, and a nurse led the dialysis unit on ward 7B. After our inspection the provider told us staff used different titles depending on with whom their employment had first commenced since B.Braun had taken over the service from another organisation. This meant some staff wore name badges that inaccurately depicted their job title and role.

Each unit except Cotswold maintained a 1:4 nurse to patient ratio, which met national standards. Cotswold unit maintained a nurse-to-patient ration of 1:3.5.

Supernumerary senior nurses worked between Cotswold and Severn units to provide support during busy periods.

The registered manager made sure agency staff had a comprehensive induction and understood the service, which enabled them to provide safe care.

The service reported a 16% turnover rate between April 2022 and March 2023.

The service had variable sickness rates, with absence ranging from 1% to 16% between October 2022 and March 2023.

Staff were highly trained and specialists in their field. Renal nurses completed an intensive 6 to 8-week clinical training programme followed by intravenous medication administration competencies and specialist equipment training before they could deliver care.

HCAs and dialysis assistants undertook specialised dialysis and renal care training to ensure their skills met patient need. This included a 3-stage programme of renal care followed by equipment and practical training. Training was competency based and staff had to demonstrate their skills before they could provide care themselves as part of the team. Training for dialysis assistants included technical elements such as central venous catheter management and a 6-month clinical package.

The service did not employ doctors. The host NHS trust had a duty renal consultant available from 9am to 5pm on each day clinics were open. Outside of these hours an on call consultant provided on-demand support to nursing staff in the units. Other renal doctors provided support on a planned basis. Each patient had a named NHS consultant. Each consultant carried out a monthly ward round of their assigned patients whilst they were receiving dialysis.

Requires Improvement

Dialysis services

An on-call team provided out of hours emergency dialysis in the ward 7B unit on demand.

Records

Staff kept detailed records of patients' care and treatment.

Patient notes were comprehensive, and all staff could access them easily. The service kept contemporaneous records as part of long-term treatment. These included each patient's latest haemodialysis prescription, blood borne virus test results, and COVID-19 status. While the sample of notes we checked were generally good, there was a need for staff to complete notes in a timelier manner and with more attention to detail, particularly when the patient had known vulnerabilities. For example, we found a number of risks that appeared unmitigated from our review of a patient's notes. We spoke with several members of staff about this who demonstrated a good understanding of the patient. This meant risks were managed to some extent but staff without prior knowledge of the patient would not be aware of their situation from the documented information.

When patients transferred between teams, there were no delays in staff accessing their records, such as when patients received dialysis temporarily while on holiday.

Records were stored securely and encrypted by the NHS trust's medical records team. The service archived records in hard copy and digitally and used service level access agreements with the referring trust about storage and access.

Staff audited standards of documentation monthly using a comprehensive tool that included clinical, demographic, and other care details.

Staff recorded blood results and the NHS trust pathology department uploaded them to the renal database. It was the trust's responsibility to submit the results to the renal registry.

Two parallel records systems were in place in the units. The NHS trust was responsible for prescribing documentation, including dialysis flow sheets prepared in advance of treatment, and erythropoietin (EPO) and iron injection charts. EPO is a medicine used to treat anaemia, which is common in patients who need dialysis treatment. The provider was responsible for all other care and treatment records.

Staff used an electronic patient records system shared with the NHS hospital to monitor and track care and treatment. Staff in the dialysis unit on ward 7B used this system to monitor the needs of patients transferred from the ED, such as blood results and initial monitoring.

The registered manager audited a sample of 1 folder for each named nurse per quarter. The most recent indicated compliance between 80% and 100% for named nurse documentation and patient treatment care plan information.

Medicines

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

Requires Improvement

Dialysis services

At our last inspection we told the service it must improve storage arrangements for medicines, including ensuring they are always stored at the safe temperature established by manufacturers. Staff had acted on this, and medicines were stored securely in areas with controlled temperatures. Audits between January 2023 and April 2023 demonstrated consistent standards of temperature management and safety. Staff documented daily temperature checks and had an up-to-date escalation plan in the event temperatures exceeded safe limits.

Staff followed systems and processes to manage and administer medicines safely. Each patient's renal consultant prescribed anti-clotting medicines and staff administered these locally. They maintained a good standard of documentation, including tracking of stock and batch numbers.

Staff completed medicines records accurately and kept them up to date.

Renal consultants based in the NHS trust prepared haemodialysis prescriptions in advance of treatment. The service did not have prescribing staff. If nurses identified a need for a medicine, they contacted the duty renal consultant in the NHS hospital, who would review the patient and issue a prescription. This included for urgent need, such as an emergency medicine for low blood pressure.

Incidents

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. The service used an electronic incident reporting system shared with the NHS host trust.

The provider shared incident reports and learning from their other sites, including those outside of England and under a different jurisdiction, with the whole team. This helped staff adopt learning from colleagues across the provider's network, including near misses. For example, a patient in another service had suffered a grazed arm due to leaning against an armrest whilst being assisted to transfer. As a result, staff took more time to consider potential risks and ensure patients who were frail or unsteady had more cushioning.

The provider used an internal reporting system to track adverse events. This supplemented the NHS trust's electronic incident reporting system, to which the service had access, and was called APO (adverse patient outcomes). In the previous 12 months the service reported between 15 and 60 APOs per 1000 dialysis cycles. APOs included 33 pre-defined common incidents, such as difficulty cannulating or a patient fall. The most reported categories were missed dialysis and treatment time shortened by over 10 minutes. This data reflected care on Cotswold and Severn units; the provider did not supply us with monitoring data for the unit on ward 7B.

As a result of incidents, the registered manager had implemented improved risk management processes for patients living with dementia or a learning disability. For example, they introduced quarterly risk assessments for venous needle dislodgement. This followed instances in which patients had pulled out needles unless cared for on a one-to-one basis.

Requires Improvement

Dialysis services

Incident reports that involved medical emergencies indicated a well-coordinated response between the unit staff and NHS hospital teams. For example, where a patient experienced a fall in the Cotswold unit, a registrar arranged a head computed tomography (CT) scan and emergency department treatment. This contrasted with incidents that involved patients with a mental health need, in which coordinated NHS hospital response was lacking.

The registered manager monitored national patient safety alerts and implemented policy, practice updates, and new risk assessments in response. The NHS trust also monitored this information and supported the local team as part of a joint process of safe practice

Is the service effective?

Good

We have not previously rated effective.

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

All patients were under the long-term care of an NHS trust, whose consultants planned and monitored their dialysis regime. B. Braun staff followed policies and protocols based on guidance from the National Institute of Health and Care Excellence (NICE) and the Renal Association.

Staff worked to NHS trust policy in relation to measuring and monitoring of areas such as the ultrafiltration rates of haemodialysis patients. They used a continuing care pathway to track a range of clinical measures of health including periodic bone disease reviews, diabetic monitoring, and compliance with prescribed treatments.

Staff assessed vascular access and used medical photography to monitor access conditions over time, in line with NICE quality guidance.

Most policies and operating procedures were standardised across the provider. Managers tailored individual policies to each clinic, such as the local business continuity plan.

The provider carried out an annual audit of the service using national quality standards. The registered manager and provider senior team used the audit to assess compliance and standards with expected practice.

Nutrition and hydration

Staff gave patients food and drink when needed. Patients could access specialist dietary advice and support.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. They checked patient allergies and dietary needs and documented these in records. Posters were on display in key areas of each unit to remind patients to discuss specific needs with staff.

Healthcare assistants provided patients with sandwiches, snacks, and drinks during each dialysis session. These were supplied by the NHS trust and staff maintained an up-to-date log of patient requests, dietary needs, and allergies and checked these with each patient during the food service.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition and worked with dieticians from the NHS trust to plan and coordinate care.

NHS dieticians reviewed patients monthly and dialysis staff liaised with them as part of the multidisciplinary process.

Pain relief

Staff monitored patients to see if they were in pain and supported them to relieve pain.

Staff asked patients about pain before treatment and referred to NHS colleagues for support in the event a patient's pain was uncontrolled.

Staff did not administer pain relief and patients knew to bring their own medicines with them to self-administer. The provider communicated this with patients in advance of starting treatment.

Patient outcomes

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

Staff used a rolling programme of non-clinical audits to monitor the service and check improvements. The programme was flexible, and staff increased frequency where they identified risks. Staff shared the results of audits with referring trust and consultants. This included water sampling results and blood monitoring results to establish the effectiveness of dialysis by monitoring urea reduction ration (URR). URR is a measure of how effectively dialysis is working.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. The referring NHS trust benchmarked standards of care against the UK Renal Registry and Renal Association standards and worked with the provider to ensure the results were as expected. Alongside this process, the provider's integrated governance committee benchmarked each dialysis clinic against specific service requirements.

Dialysis patients underwent long term care, and each had a named consultant with the NHS trust. They reviewed patient outcomes monthly and the provider's nursing team prepared data and adapted care based on feedback. Staff reported treatment variances to the on-call consultant and reported these using the provider's electronic records system.

NHS dieticians took a lead role in managing patients' nutritional needs as part of multidisciplinary working to work towards good health and treatment outcomes. They monitored patients' bloods monthly and implemented nutritional support alongside dialysis staff as a joint approach to care.

Staff used the Charlson Comorbidity Index to monitor patients living with comorbidities and were at significant risk of poor health. Between 5% and 7% of patients typically scored at the "severe" level of the scale and staff used this information to adapt care accordingly.

The service monitored treatment compliance in line with national standards. In the previous 6 months an average of 84% of patients met or exceeded the national benchmark target of 12 hours of dialysis per week and 92% met the target of 3 or more dialysis sessions per week. The registered manager tracked reasons for not achieving targeted treatment and worked with NHS consultants to address this where it was within their control.

The service benchmarked patient blood results in line with the Renal Association clinical practice guidelines and the NHS trust liaised with the Renal Registry to determine regional achievements.

Staff reviewed patient care monthly and discussed opportunities for change, such as conservative disease management, with each patient individually.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The service gave all new staff a full induction tailored to their role before they started work. This was a 6-week programmed that included specialist haemodialysis care, use of the clinical frailty scale, depression in chronic disease, and a vascular access training package. Practical training included life support, blood transfusion, manual handling, and use of intravenous pumps.

The provider supported staff to develop through yearly, constructive appraisals and regular supervisions of their work.

The practice development nurse (PDN) supported the learning and development needs of staff. The PDN worked nationally for the provider and spent 1 day per week with the Gloucester team, working across all 3 units. The provider did not give staff protected time for teaching and learning outside of mandatory training and so the PDN worked opportunistically with staff and provided real time mentoring and coaching.

All staff had the opportunity to ask the PDN for 1-to-1 support on specific topics and this had led to sessions of competency training on the use of new dialysis machines.

The registered manager led monthly unit meetings. Minutes and actions from meetings were available for all staff to help them keep up to date.

Staff adopted specialist link roles such as in infection control, dementia, and diabetes. Link roles meant staff accessed more advanced training and joined team meetings with colleagues in the NHS trust. This enabled them to take a lead in specific areas and support colleagues with better practice.

Dialysis nurses had the opportunity to complete the national renal course and 7 staff had been certified as mental health first aiders. Other opportunities included shared care training, mentoring, and dealing with stress. The provider offered agency staff additional training for their specific role.

Multidisciplinary working

Requires Improvement

Dialysis services

The dialysis team worked with other healthcare professionals to benefit patients.

Dialysis care was multidisciplinary by nature and staff worked as part of a specialist cross-organisational care team. They worked within service level agreements and contracts with the NHS trust. The registered manager joined monthly contract meetings with the trust that were multidisciplinary in nature and focused on providing coordinated care.

Dialysis nurses joined monthly multidisciplinary team meetings with NHS colleagues, including a consultant and a dietician, with attendance from other specialties based on patient need.

Staff delivered care prescribed and monitored by the NHS trust, which retained overall responsibility for care planning and pathways. Dialysis staff had telephone access to each patient's consultant nephrologist in the event they needed a clinical discussion during the day. Out of hours staff had access to the on-call consultant.

The service held details of each patient's GP and nurses were equipped to make community referrals if additional care or assessment was needed.

Staff liaised with GPs, hospices, and community teams to ensure patients with palliative or end of life care needs received coordinated, individualised care. Staff used a treatment escalation plan and do not resuscitate (DNAR) forms shared with other service providers to ensure all staff were aware of patients' wishes. The unit manager worked with consultants in such cases to ensure they had a full understanding of need.

Staff had adopted the national shared care approach to treatment, which incorporated the multidisciplinary team of the provider and the NHS trust along with best practice standards from 3 national specialist organisations.

Staff used a 90-day multidisciplinary clinical pathway, on a continuous cycle, that incorporated health assessments from different specialties in the NHS trust. This included cardiology, dietetics, and social worker support provided through primary care. While these services were not provided by this provider, staff worked closely with colleagues in other organisations to coordinate effective care.

The multidisciplinary team monitored the needs of dialysis patients admitted to the hospital through the emergency department. This meant the dialysis team could coordinate treatment whilst others involved in care arranged to provide specific care.

The dialysis unit on ward 7B provided care for out of area patients. For example, the NHS trust's Cheltenham site had no dialysis provision and so patients were sometimes transferred to the unit in urgent circumstances. We observed a good standard of handover by staff during our inspection, including comprehensive checks of the patient's medical condition and needs.

The team in the dialysis unit on ward 7B initiated short notice and urgent multidisciplinary working and referrals when patients were admitted with acute medical needs. For example, they worked with renal doctors and the hospital's laboratory to process blood cultures to help plan care for patients whose health was deteriorating.

While the multidisciplinary system worked to some extent, a number of areas that impacted patient care were outside of the control of staff. For example, staff said if a patient's named consultant was unavailable, it was sometimes difficult to obtain senior medical support. They described a recent instance in which the duty consultant refused to see a patient who was deteriorating. Staff said, "It was very stressful for the patient and shouldn't have happened. It could've been sorted straightaway, but we had to push and push."

Requires Improvement

Dialysis services

Seven-day services

Key services were available to support timely patient care.

The service was open 6 days a week from Monday to Saturday. Care was scheduled in advance and staff introduced late night sessions in response to patient preferences. The hospital's renal and diagnostics teams were available daytimes and staff had an on-call point of contact in case of clinical need during late night clinics.

Cotswold and Severn units were open 6 days per week from 7am. On 3 days the units were open until 6.30pm and on 3 days they were open until midnight. The unit on ward 7B opened from 9am to 7pm 6 days a week, from Monday to Saturday. An on-call team provided 24-hour urgent care.

Patients were the substantive responsibility of the NHS trust, which was responsible for 7-day services outside of dialysis sessions.

Health promotion

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

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

The service maintained links with regional organisations that provided support to patients, such as peer support services from the National Kidney Foundation. Staff displayed up to date information on the groups in key areas and provided patients with support to access them.

Staff provided each patient with an education programme at the beginning of their treatment. This helped patients to navigate the demands of dialysis treatment alongside their other health needs and challenges. This was a continuous programme in which staff provided patients with individual support on managing their health as their treatment progressed.

Staff gauged patient knowledge on wider health issues and wellbeing in an annual survey. Despite the wide range of information available in the unit for patients, and the ongoing guidance available from staff, only 85% of patients said they felt they had enough information on kidney disease. Slightly more indicated they felt information on diet and nutrition was more forthcoming. The registered manager reminded patients to take time to access the printed information available in each unit to improve their knowledge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Dialysis was a component part of a wider long-term care and treatment plan and the decision to initiate dialysis was made between the patient and an NHS doctor. At the point of beginning treatment with this service, staff discussed each patient's care plan with them and obtained signed consent to proceed. While this process reflected good practice, there was a lack of assurance about the consent process for patients who did not speak English. For example, in the records of

a new patient to the service, staff noted their admissions form had been completed using an online language translation tool. They commented that the patient had not consented to their treatment plan because they did not speak English. We asked the provider to send us evidence of the process staff used to provide care to patients who could not provide consent to care but we did not receive a response.

Staff completed deprivation of liberty safeguards (DoLS), Mental Capacity Act, and dementia awareness training during induction and then at 3 yearly intervals.

The patient's named consultant or specialist registrar carried out a capacity assessment on admission and used this to plan ongoing care and treatment. Dialysis staff asked consultants for updated assessments if they felt a patient could not fully understand their planned treatment.

Each patient had a named nurse who carried out monthly care reviews. If they found a patient could no longer consent to care, or struggled to understand the information given to them, they contact the patient's consultant to identify a solution.

Is the service caring?

Good

We have not previously rated caring.

We rated it as good.

Compassionate care

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

Most staff were discreet and responsive when caring for patients and adapted care to the open-plan environment of the dialysis units. Most staff took time to interact with patients and those close to them in a respectful and considerate way.

During most of our observations staff treated patients with compassion and kindness. They took time to speak with patients and understood their needs. However, on occasion some members of staff were impatient with patients. For example, a patient on Severn unit told staff they were too warm and asked for the windows to be opened. A member of staff curtly replied, "The window is already open," and did not try to assist the patient further. On Cotswold unit 2 members of staff openly discussed a patient who had disclosed an issue with their medication while standing next to them. This did not respect the patient's privacy or dignity.

During most of our observations staff ensured patient's privacy and dignity. For example, they used mobile screens or curtains to provide patients with a more private area for dialysis.

Staff in the dialysis unit on ward 7B acted quickly to provide compassionate care and meet the needs of patients with deteriorating conditions. For example, they secured a special mattress topper for a patient in acute distress who had been transferred from the emergency department (ED). This helped the patient to undergo treatment more comfortably and calmed their anxiety.

Patients told us they felt supported and well looked after. A long-term dialysis patient said, “I’ve been coming here for years, I know everyone and it’s more like a social club than a hospital, it’s always nice.” Many patients were on waiting lists for organ transplants and said staff were caring and compassionate in their approach. For example, 1 patient told us, “The care here is excellent. The nurses are very kind despite always being rushed off their feet.”

In the most recent annual survey, 88% of patients were satisfied with the approachability of staff. This was an average and reflected 92% satisfaction on Cotswold unit and 85% on Severn unit.

The service often received unsolicited written notes from patients who wished to express their gratitude to the team. Recent comments included, “The care you and your team showed was second to none”, and “Thank you for all the support you gave me, you are one in a million.”

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. In the unit on ward 7B, we observed staff support patients and their loved ones who were distressed and helped them maintain their privacy and dignity. Patients in this unit were often acutely unwell and had been transferred from other parts of the hospital with little information or understanding about their planned care or treatment. In each case we saw staff explain why they had been transferred to the unit and what would happen next, reassuring them that they were in a safe place. For example, 1 patient had been transferred from the emergency department (ED) without being told where they were moving to or why. The ED had not informed the patient’s relatives, who were very worried trying to find the patient in the hospital. Dialysis staff expertly diffused the situation, liaised with hospital colleagues to better understand the plan for the patient, and spent time with their relatives providing emotional support.

Staff in the unit on ward 7B provided caring and compassionate support to a patient who complained of being very hungry after they spent 24 hours in the hospital’s ED department. They reassured the patient and sourced food for them whilst they underwent dialysis.

Staff understood the emotional and social impact that a person’s care, treatment, or condition had on their wellbeing and on those close to them. They got to know patients and understood their holistic needs by building a rapport with each of them. While this was true of most staff-patient interactions, there were periods during our inspection where some staff were impatient and fractious under considerable pressure. For example, a patient with limited ability to communicate in English pressed a button on the dialysis machine during treatment. A member of staff sharply admonished them and said, “I’ve told you not to touch the buttons.” They did not attempt to find out why the patient had interfered with the equipment, such as if they needed help. We spoke with the registered manager about this who said they had addressed the issue with the member of staff.

Patients spoke highly of the support offered by staff. A recent patient wrote to the team and noted, “I am very appreciative of the cheerful and friendly nature of all, which helps considerably during what could be a daunting experience.”

Staff welcomed carers or family members to accompany patients during dialysis although rigidly adhered to a separation of responsibilities. For example, staff did not usually provide support or direct engagement with carers. The provider said levels of engagement with carers were based on local safety requirements.

Requires Improvement

Dialysis services

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. They talked with patients in a way they could understand. For example, when a known patient was admitted to the hospital, staff had a clear understanding of their home circumstances and supported their relatives, who were confused and upset, to better understand the treatment decision.

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

Staff supported patients to make decisions about their care. They used the national shared care approach to support patients to become 'expert users' in dialysis, such as by understanding the purpose of clinical equipment and recognising when something was going wrong.

Staff encouraged patients to make decisions about their own care using all the information available to them, including where their choices presented a risk of harm. For example, patients at risk of a fall did not always wish to follow staff guidance in wearing appropriate footwear. Staff used a waiver document to document discussions with patients about risk and patients signed this to note they understood the potential implications of their decisions.

Staff routinely involved patients in managing their own health and treatment, including recognising, and addressing risks. For example, they prepared visual aids and posters about the signs of sepsis and how to manage bleeding and displayed these in patient areas. When patients first joined the service, staff included this information during a dialysis education session. The service monitored the number of patients who wished to be included in their own care. At the time of our inspection this included 52 patients and staff worked with each individual to identify the potential for safe home dialysis in the future.

Staff supported patients to spend their dialysis time however they wished. If patients liked to sleep, staff facilitated a quiet space free from disturbances. We observed they helped patients use digital devices to access Wi-Fi to watch TV or to browse the internet.

The practice development nurse met with patients to gauge their understanding of fistulas and venous dislodgement. They prioritised patients living with dementia and with mental health needs, which reflected the level of risk to each patient.

Patients reported generally good levels of involvement from staff in the annual feedback survey. For example, in 2022 88% of patients felt staff spent enough time with them and felt they were involved in their care. In the same survey, 85% of patients said they were satisfied with communication with the service.

Is the service responsive?

Good

We have not previously rated responsive.

We rated it as good.

Requires Improvement

Dialysis services

Service delivery to meet the needs of people.

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

The team planned and organised services to meet the changing needs of patients. For example, clinics opened extended hours 3 days each week to enable patients to schedule dialysis around other commitments. The service worked with the NHS trust and community services to ensure patients received care and treatment in line with their circumstances. Many patients were on a transplant list and staff were prepared to interrupt or adapt services at short notice when an organ became available.

Staff worked with NHS colleagues to minimise the risk or frequency of hospital admission for patients with complex needs. All members of the multidisciplinary team received an alert when a known dialysis patient was admitted to the hospital, and they coordinated any additional care or treatment needed.

Treatment took place in open-plan clinical areas. Staff used privacy curtains on request and planned the use of private rooms in advance based on individual need.

While mental health care was not part of the service's contractual remit or clinical service, staff provided care for patients living with complex mental health needs, including dementia, and conditions such as schizophrenia. Staff demonstrated good knowledge of how to meet people's individual needs, including liaising with residential care home teams to plan visits and working with carers and relatives. However, access to mental health support was very limited. The provider did not employ mental health specialists and relied on the NHS trust or other organisations to provide staff such as registered mental health nurses or psychologists. We spoke with an NHS consultant about this who described mental health services as a "grey area" and said dialysis staff often had to spend time searching for help.

Staff contacted patients who did not attend planned dialysis. They liaised with each patient's NHS renal consultant if they could not be contacted, which initiated a communication process to identify any additional needs the patient might have. Where patients had known risks or vulnerabilities, staff contacted police to arrange a home welfare check, which provided assurance of safety.

Staff provided patients with the national shared care handbook as a strategy to encourage independence and self-management. For example, the shared care scheme helped patients to manage dialysis while on holiday and aimed to provide suitable patients with the skills and expertise to understand their health and treatment. Where clinically appropriate, staff used the scheme to develop patient knowledge to the extent they could safely dialyse at home.

The provider had a well-established equality and diversity policy, and staff undertook training to help them apply the policy to all areas of practice. This ensured the service operated within the requirements of the Equality Act 2010 and provided staff with tools and resources to support them, such as cultural awareness information and empowerment to tailor communication to individual needs.

Staff worked with other healthcare providers, including NHS trusts, nationally and internationally to coordinate dialysis care for patients visiting the area on holiday. The service followed national guidance to ensure the process was safe and spoke with patients early in the process to ensure their needs could be met. If the unit was full to capacity on the requested dates, staff identified alternative services in the region. This system worked well and several patients who had received holiday dialysis wrote to the team after their visit to thank them for convenient and effective care.

Dialysis services

Staff used a social care review protocol as part of the dialysis continuing care pathway to document and track any concerns or needs about welfare and needs at home. The NHS team most often led on this process and B. Braun staff alerted them if patient needs changed.

Meeting people's individual needs

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

Staff provided care in line with the principles of shared care. This enabled them to plan and meet patient needs whilst encouraging individuals to take greater responsibility in understanding their condition and treatment. The provider used an established policy to guide staff and ensure they understood the scope of the national shared care programme. Staff provided patients with a list of aspects of treatment they could complete themselves and worked with them to identify the most appropriate choices. For example, patients could choose up to 15 elements of care to carry out themselves, such as measuring blood pressure and pulse and preparing aspects of the dialysis machine and consumables.

At our last inspection we found the waiting area in Cotswold unit was poorly managed and chaotic, with a direct impact on patient wellbeing. Staff had acted on this and changed the layout and management of patients in this area, which was now calm and conducive to waiting for treatment.

Staff adapted care for patients living with mental health problems, learning disabilities and dementia, as far as possible to ensure patient needs were met. While staff described such efforts to us, other evidence suggested more needed to be done to support them to deliver care to patients with complex needs. For example, in a recent incident report staff had noted a patient living with dementia who had difficulty following instructions had been "uncooperative" with care instructions. While learning indicated staff took practical steps to keep patients safe, there was no indication of learning from a communication perspective in the context of dementia.

Staff could not always get help from interpreters or signers when needed. In some cases, staff communicated with patients, including during initial consent and medical history processes, using automated online translation services. While this enabled staff to communicate to some extent, it did not provide assurance of accuracy in medical terminology. The service used a live telephone-based interpretation service, the same as the NHS trust, on demand. However, this was unreliable, and staff could not always obtain timely support.

Staff supported patients to navigate the national NHS 'dialysis away from base' policy to ensure they planned dialysis in advance when travelling, such as when they were on holiday.

All clinical areas had fully step-free access and accessible toilets. Staff worked with patients to accommodate carers and escorts, such as family members, where this was necessary to meet their needs.

Staff followed NHS England policy in supporting patients to access dialysis away from home when travelling on holiday. This included making applications on the patient's behalf to NHS dialysis units nationally and to private clinics outside of the UK for international travel. The provider had systems to support patients to access dialysis whilst on complex travel itineraries, such as cruises and non-European travel.

Staff worked with patients to establish advanced directives about their care in the event their condition deteriorated or became palliative. This was in line with the provider's policy and meant staff understood the aspects of care, treatment, and quality of life most important to each patient.

Staff contacted the NHS trust's learning disability nurse specialist for support in communication and delivering adapted care. All staff completed e-learning on understanding learning disabilities and senior nurses completed specialist behaviour management training.

Access and flow

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

Staff scheduled dialysis sessions in advance on a rolling, long-term basis. They worked with patients to accommodate requests for changes in dialysis times.

Staff used contingency plans to avoid cancelled dialysis sessions, such as in the event of a water failure.

Staff in the dialysis unit on ward 7B maintained a live record of each patient in the admission system so that dialysis staff and the wider multidisciplinary team could track them and proactively respond to care needs. For example, the team tracked medical patients who were admitted to surgical wards as outliers and made sure ward teams were aware of specific needs.

The team described considerable difficulties in securing inpatient beds for patients after their dialysis. We saw patients who were the responsibility of the NHS hospital routinely accommodated in busy corridors due to a lack of capacity and dialysis staff said this meant patients often waited for extended periods in the dialysis unit. A member of staff said, "The lack of capacity in the hospital means we are often forced to provide care for patients with very complex needs outside of our training and skillset. It's not fair on the patient and it's not safe, but no one seems to take charge of the situation."

During our inspection, NHS hospital staff made the decision to admit patients to the dialysis unit on 7B without consultation with the dialysis team. Staff said this was common practice and meant they often provided care to patients outside of the service's purpose or remit.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Patients, relatives, and carers knew how to complain or raise concerns. The service displayed information on the complaints procedure in patient areas and in printed information given to patients when they began treatment. The remit of the NHS hospital Patient Advice and Liaison Team (PALS) included the dialysis service and could accept complaints on the provider's behalf.

Formal complaints were rare and in 2022 the service received 1 written instance, which was initially received by PALS. The provider's national complaints department maintained oversight of complaints and provided a final response with information from the local team. While the service responded and closed the case within the provider's policy timeline,

the response was not compassionate or understanding and instead blamed the complainant for seeking inappropriate support from staff when they were too busy to provide this. The provider did not identify or document any learning from the complaint and there was no evidence the service worked with PALS colleagues to improve standards of practice.

Staff understood the policy on complaints and knew how to handle them. A senior nurse was present whenever the service was open and resolved minor issues at the time, avoiding the need for a formal complaint.

Is the service well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders understood the priorities and issues the service faced.

The registered manager was the overall service manager and held significant experience in renal services and working with the host NHS trust. A team of deputy managers and senior dialysis nurses led shifts in each unit.

While this provided stability in the service on a day-to-day basis, there was limited other senior presence in unit on ward 7B. For example, staff coordinated urgent admissions and referrals, liaised with the hospital bed manager themselves whilst also providing routine care. There were gaps in communication amongst senior staff about the operation and pressures on this unit and staff were not assured the provider considered its risks or operational needs.

Most staff spoke positively about their relationship with the manager and said they felt supported and looked after.

Senior provider staff regularly visited the units. This included managers from operations, quality, and training. Staff said such visits were regular occurrences and provided an additional leadership presence.

There were limited opportunities for staff progression and development. Staff highlighted this in forums and surveys and the senior team was in discussion to create new team leader roles. The provider offered a 'passport to leadership' course and a specialist 'women in leadership' programme for interested staff.

Vision and Strategy

The provider had a vision for what it wanted to achieve. The vision was focused on promoting better health aligned to local plans within the wider health economy.

The provider had an overarching vision that centred on protecting and improving global health. This was underpinned by a mission statement focused on driving standards in system-wide healthcare. Transparency, trust, and recognition were core elements of the provider's values and were prominently displayed in Cotswold and Severn units.

The service fell within the remit of the provider's 10-year strategy, which was at its midway point. Staff had variable buy-in to the vision and strategy and none of the nursing or support staff we asked knew about it in detail although the provider included it regularly in staff communications. Staff said they had not been involved in its development. The provider did not have assurance the vision and strategy were applied to staff at care delivery level. The senior team said they would not expect staff to have knowledge and engagement with the vision and strategy and that these operated at the provider's overall international level.

The provider had established a new diversity and inclusion strategy for the next decade and invited staff to specialist online webinars to develop their understanding and skills.

The provider had been involved regionally in the development of transplant management systems and early access for haemodialysis patients although a change in leadership in the NHS trust meant the service was subsequently excluded. This resulted in the removal of considerable expertise from regional development and there was no indication from the provider that they could influence or promote changes.

Culture

Most staff felt respected, supported, and valued by the registered manager and were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

The registered manager and provider colleagues we spoke with recognised the dedication of staff in maintaining the service and staff told us they felt valued and respected locally. However, there was a clear feeling of detachment from the provider. Most staff could not articulate how B. Braun, at a corporate or national level, influenced or supported local care and understanding of wider work was low. Staff did not have a good understanding of some basic provider-level national policies and contacts.

Most staff felt positively about working for the provider, which was reflected in decades-long service by some individuals. A new member of staff said their first few months had been good. They described the service as, "Very friendly, welcoming, great staff."

The registered manager told us they felt positively about the provider's recognition of staff at its current level and believed a reliance on local partnerships between staff mitigated a lack of provider involvement due to the location of the head office some distance away. This was at odds with the workload of staff, although there were plans in place to increase some staffing levels in line with upcoming contractual changes.

The provider had a clear focus on promoting equality and diversity in the workforce and corporate communications and exercises reflected this. The provider noted diversity as a key element of its business strategy.

The provider facilitated a bi-monthly employee forum nationally across all locations and 2 representatives from the Gloucester location attended each meeting. While this reflected an intent to engage with staff, there was limited evidence it contributed to a positive working culture. Minutes indicated a lack of communication with staff regarding development opportunities and focused on enforcement of the provider's annual leave restrictions and sickness leave policy.

The overarching negativity of the forum minutes was reflected in our discussions with staff. Some individuals we spoke with felt overwhelmed with work and said recognition was lacking, which reflected a gap between the provider, the registered manager, and some staff, particularly in the unit on ward 7B. There were differences in understanding of how staff could secure urgent maintenance repairs for essential equipment and the unit was isolated from the larger stand-alone units.

Staff adapted care and work arrangements to meet cultural and religious needs. The service offered shifts to meet staff religious beliefs, including adaptations during special periods such as Ramadan. The provider sourced adapted uniforms for staff to help them adhere to religious needs whilst meeting infection control standards. Staff provided gender-specific care on request by patients and implemented adjusted dialysis teams, such as for patients living with dementia who found early mornings more difficult to manage.

Governance

The provider was improving governance processes. Staff were clear about their roles and accountabilities and had regular opportunities to meet.

At our last inspection we found significant gaps in the effectiveness of governance processes, particularly in the management of relationships with the NHS trust. The registered manager had worked with the provider to improve relationships and processes, which resulted in a programme of refurbishment and improved responsiveness from the trust's third-party contractors.

The clinical governance system was joined with the NHS trust's framework, which was led by a matron in the medicine division. The registered manager joined divisional meetings although short staffing in the NHS trust meant there was limited documentation of outcomes and actions. The registered manager presented bi-monthly service data to the NHS trust as part of ongoing governance contract monitoring. Data from the previous 4 months reflected a comprehensive system of monitoring patient care and treatment information that provided assurance of meeting governance and care standards.

At our last inspection we found staff used a covert audio device in the private side room on ward 7B that transmitted conversations and other audio to staff. The service could not provide assurance of consent or confidentiality and we told the provider they must address this. At this inspection staff told us they had implemented a new use and consent policy for the system. As the room was not in use at the time of our inspection, we could not observe it in practice although staff demonstrated good knowledge of the process.

The registered manager met every other month with the provider's senior team and colleagues from the NHS trust as part of the overarching governance framework. This included a review of treatment and care measurements and other markers of care standards, such as care plan recency and starting dialysis within planned times.

The registered manager led local governance for the 3 units alongside comparable processes in the NHS trust. This included regular meetings with colleagues in the trust's renal service and more broadly with the trust's medical service managers. The provider coordinated national governance structures for all renal services and the registered manager contributed to this.

The governance structure included bi-monthly contract review meetings with the trust, 6 monthly internal clinical governance meetings, and monthly meetings with NHS consultants. The registered manager joined monthly renal operations meetings with the NHS hospital renal lead to maintain oversight of the whole treatment pathway.

A quality manager worked nationally across all units and led the implementation of policies and procedures. They monitored audit outcomes and worked with local teams to support improvement. They joined staff in clinical areas and supported delivery.

While the service displayed CQC registration details at the entrance to Severn and Cotswold units, this did not include the most recent inspection ratings. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we issued a requirement notice for the provider to address it.

Staff undertook annual code of confidentiality and code of conduct training.

Management of risk, issues, and performance

Systems in place to manage risk and performance were improving. Staff were not always able to address risks and issues.

The provider and registered manager were in the process of improving clinical governance and risk management systems. This needed time to be fully established and demonstrate long-term effectiveness. For example, the NHS trust was in the process of addressing significant risks to patient and staff safety caused by failing infrastructure. The provider needed to demonstrate such responsiveness would continue long term and ensure the estate, which was the responsibility of the NHS trust, did not fall into further avoidable disrepair.

The minutes of team meetings showed staff regularly discussed risks and safety management. For example, there was evidence the whole team had reviewed the provider's new sepsis policy and familiarised themselves with emergency equipment. The provider sent monthly clinical governance bulletins that included national trends and themes across services. This recently included a sharp increase in aggression and violence from patients and an increase in needlestick injuries amongst staff. The team discussed these issues to identify opportunities to avoid risk.

The service monitored needlestick injuries (NSI) as part of a national safety target set by the provider of 1 NSI per 15,000 treatments. In 2022 the service performed better than the target with an average of 1 NSI per 18,860 treatments. Early data for 2023 suggested continuing improvement in this area.

The provider had acted on a national increase in threats or abuse against staff by introducing a 'zero tolerance' programme, which included posters in patient areas and guidance for staff to follow in the event they were threatened.

Staff managed risk as part of patient engagement, which encouraged patients to understand risks around them and take a role in protecting themselves. For example, a key issue was reducing mobility and associated risk of falls. Staff worked with patients individually to assess and reduce falls risk and displayed "Call don't fall" posters that encouraged patients to ask for help when they needed it. This was in response to feedback from patients who said they did not want to disturb staff and so took risks when trying to mobilise.

A falls group worked at provider level to reduce falls instances. Between January 2022 and March 2023, Cotswold and Severn units accounted for 10 of the 26 falls reported nationally across the provider's 10 units. The group highlighted the waiting room after a dialysis cycle as the most common place and time of a fall and issued directives to staff reminding them to escort patients appropriately.

The NHS hospital had a 24/7 on-site security team and provided a service to the dialysis units on request.

Requires Improvement

Dialysis services

While the provider had improved maintenance and estates-related risks to some extent since our last inspection, governance processes and contractual arrangements meant patient and staff safety was not assured in some areas. For example, part of the water treatment equipment on ward 7B was damaged and leaking water into a storage room. Staff had carried out makeshift repairs themselves, using medical consumables to prop up equipment. While this prevented the unit from closing, there was an associated safety risk. Staff in this unit and the registered manager each had a different understanding of why the equipment had not been repaired and there was a lack of leadership and oversight by the provider to resolve this issue. There was no evidence of support for staff who feared the equipment would leak substantially, causing widespread damage to the flooring and ward underneath. The risk management system had failed to address this issue in a timely manner and the registered manager said this was a result of a convoluted procurement process with the NHS trust, who was responsible for the estate. The provider's lack of engagement and oversight of such issues meant local staff worked under considerable pressure with damaged equipment. After our inspection the registered manager told us repairs had been secured for late May 2023.

The service monitored performance based on patient sessions numbers, missed sessions, and compliance with the UK target of weekly dialysis time. Between January 2023 and April 2023, the service performed similarly to the UK target of 86% of patients achieving 12 hours or more of dialysis time per week, with an average of 84% across the units.

The service audited environmental and facilities standards in line with Department of Health and Social Care standards as part of overarching governance arrangements. Between January 2023 and April 2023, the service reported 93% compliance, with action in place for areas for improvement.

The registered manager incorporated quality management in monthly unit meetings. Meeting minutes reflected a focus on risk management and patient safety such as results of audits and ongoing estates improvement. While this reflected good practice, there was limited evidence the of assurance the dialysis unit on ward 7B was included in provider-level governance systems and monitoring.

The provider operations manager was responsible for the risk register, which was organised by individual unit. The registered manager escalated issues to this through the operations manager. At the time of our inspection there were 48 active risks across the 3 units. The operations manager updated the severity or frequency of risks to reflect the latest performance and incident data, such as by reducing the level of risk monitoring for supply chain interruptions. The risk register had no local ownership of risks and did not always reflect known risks in specific areas. For example, the risk register for the dialysis unit on ward 7B did not reflect the leaking water plant or instances of staff caring for patients with needs beyond their skills due to bed shortages in the hospital. In addition, some risks dated to 2016, 7 years previously, with a generic note for periodic updates through a separate risk assessment system. This meant the service did not have assurance the risk register was operating effectively or was fully up to date.

The service had a business continuity and contingency plan to reduce the risk of service interruption in the event of adverse events. This included emergency supplies of medical equipment and medicines stock and arrangements with manufacturers for the urgent supply of critical products at short notice.

Information Management

Information systems were integrated and secure.

Staff completed training in documentation, data protection, record keeping, and information governance.

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

Posters in waiting areas explained the relationship between the provider and NHS trust and detailed what this meant for information and data management. The information included a data processing statement and contact details for the provider's data protection officer.

Additional data sharing agreements were in place between the provider and the NHS team responsible for ward 7B. This included shared access to incident reporting and complaints records, which reflected good practice.

Engagement

Leaders and staff actively engaged with patients to plan and manage services. Engagement with staff was limited.

At our last inspection we found there was limited meaningful engagement between the provider and staff who worked in isolation from the wider organisation. There was limited drive for improved engagement with staff from the provider and areas highlighted in forums and the staff survey resulted in limited improvement. There was no evidence of work or intent from the senior team to address these areas.

The service ensured patients understood which providers were responsible for specific elements of their care. They displayed information on each provider along with their contact details and information about individual responsibilities, such as transport services and the NHS trust.

Staff engaged extensively with patients, which reflected the nature of the long-term, highly structured care provided. For example, visual displays around units reminded patients of the importance of adhering to their renal care plan. Staff prepared information reminding patients of the dangers of shortening planned dialysis time, in response to increasing trends for patients to do this. They calculated how much time would be lost over the course of a year to demonstrate the risks of shortening weekly dialysis even by small amounts.

The registered manager led an annual patient survey, which asked patients to rate and comment on a range of different elements of the service. The most recent survey related to 2022 and found an overall 85% satisfaction rate. The service did not survey patients who received care on ward 7B, which meant there was a gap in assurance of patient satisfaction in this area. The service shared results and the areas to be addressed with all patients, regardless of whether they had taken part, after analysing the results.

Patients consistently reported temperatures in the units as an area for improvement. This fluctuated sometimes due to maintenance works or issues and staff reminded patients to bring their own blankets or warm clothes if they were usually cold.

Staff described generally good relationships with the NHS trust and teams jointly responsible for patient care. However, some staff said it was difficult to secure support from renal doctors when patients deteriorated. In addition, staff described instances of NHS doctors refusing to carry out patient reviews unless this was for their own named patients. This presented a risk to patient safety and required staff to negotiate with the trust to secure patient support.

Learning, continuous improvement and innovation

Requires Improvement

Dialysis services

Staff were committed to continually learning and improving services.

In recognition of the increasing acuity and complex needs of patients, and the subsequent pressure on staff, 7 individuals had completed accredited training to become mental health ambassadors. This provided staff with a more in-depth understanding of mental health, how to manage it, and how to signpost people to support services.

A patient advocate worked with the provider in their other registered locations in a peer mentor role. The advocate was working with the senior team and the NHS trust to plan implementation of the role at this site. The advocate had a deep understanding of the ethos of care and the needs of patients who needed long-term dialysis, including social and emotional needs. They described a range of potential initiatives that would significantly improve the patient experience, particularly in communication and liaison with the clinical team.