Aston Kidney Treatment Centre

Quality Report

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

Aston Kidney Treatment Centre (the centre) is operated by Diaverum Facilities Management Limited. The service has 24 dialysis stations. Facilities include four isolation rooms, two consulting rooms, two meeting rooms and an office room.

Diaverum was awarded the contract as part of a partnership agreement with a local NHS trust to provide haemodialysis adults over 18 years living with chronic kidney failure.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 28 June 2017, along with an unannounced visit to the centre on 3 July 2017.

Summary of findings

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

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

We found the following issues that the service provider needs to improve:

- The process of incident reporting, investigation, and learning from incidents was poor with a lack of understanding of good governance processes.
- Staff did not have the required level of knowledge and understanding to meet the duty of candour requirements.
- We found several safety concerns with medicines management, which were not in line with safe medicine standards. This included issues with storage, prescription, administration and documentation of medicines.
- The centre could not evidence annual competency records including aseptic non-touch technique. Training records were not up-to-date.
- Overall, compliance with aseptic non-touch technique and hand hygiene was variable. We found that not all staff followed correct infection prevention and control policies.
- There were issues with access to the centre building including access to parking facilities.
- Staff at the centre were in the process of receiving mental capacity awareness training. The practice development nurse confirmed this training did not include deprivation of liberty safeguards.
- The manager did not recognise the risks we observed during the inspection or escalate them appropriately.
- Safeguarding knowledge and awareness was not sufficient to provide assurance that staff were aware of actions to take.
- The centre did not adequately support patients who did not speak fluent English. We were concerned patients would not be able to communicate if they felt unwell or give informed consent.
- Staff did not adequately maintain patient dignity.
- Most records we viewed did not contain suitable and adequate risk assessments to ensure the health and safety of patients receiving care or treatment.
- The centre was experiencing issues with some patients accessing dietitian support. This had not been identified as an issue by the centre,
- The centre was not labelling clinical waste bags in line with regulations.
- We saw staff breach information governance requirements and did not adequately protect patient information from non-authorised access.
- Effective processes were not in place for identifying, recording and managing risks. Concerns identified by the inspection team had not been identified on the risk register. We raised our concerns with the centre manager who did not respond appropriately to concerns raised at the announced visit.
- The overall leadership and governance of the centre needed strengthening.There was no evidence of a learning culture.The centre did not proactively seek patient safety and care quality improvements.

However, we also found the following areas of good practice:

- Staffing levels were maintained in line with national guidance to ensure patient safety. Nursing staff had direct access to a consultant who was responsible for patient care. In emergencies, patients were referred directly to the local NHS trust and the emergency services called to complete the transfer.
- Overall, the unit achieved effective outcomes for their patients.
- The centre delivered high flux dialysis to all patients and haemodiafiltration to 99% of patients. These are the most effective forms of treatment for kidney failure.
- Staff worked flexibly, working over their hours when needed for the interests of patients.
- Staff were caring and friendly. They knew their patients well and looked after them with compassion and understanding.

Summary of findings

- Overall, feedback from patients was consistently positive about the nursing staff delivering day-to-day care. The service had received three complaints in the 12 months preceding our inspection.
- There was effective multidisciplinary working between centre staff and the referring NHS trust.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices. Details are at the end of the report.

Full information about our regulatory response to the concerns we have described in this report will be added to a final version of this report that we will publish in due course.

Heidi Smoult
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis Services		We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Background to Aston Kidney Treatment Centre

Aston Kidney Treatment Centre is operated by Diaverum Facilities Management Limited. The centre opened in 2014. It is a private dialysis centre in Aston, Birmingham. The hospital primarily serves the communities of the surrounding areas. It also accepts patient referrals from outside this area.

The centre has had a registered manager (centre manager) in post since the centre opened but registered in September 2016.

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

- Treatment of disease, disorder or injury.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, and a specialist advisor with expertise in dialysis treatment. Tim Cooper, Head of Hospital Inspection, oversaw the inspection team.

Information about Aston Kidney Treatment Centre

Diaverum Facilities Management Limited ('Diaverum') is contracted to deliver dialysis treatment for local patients under the care of nephrologists from the commissioning NHS trust, University Hospital's Birmingham NHS Foundation Trust. All patients attending Aston Kidney Treatment Centre ('the centre') receive care from a named consultant at the hospital, who remains responsible for the patient.

Diaverum have close links with the trust to provide seamless care between the two services. To achieve this, the service is supported by the commissioning NHS trust to provide medical cover, satellite haemodialysis unit coordinator support, pharmacy and dietitian support. This team attend the centre regularly and assess patients in preparation for monthly quality assurance meetings.

The centre is open between 6.30am to 11.30pm on Monday, Wednesday and Friday, with three dialysis shifts on these days. On Tuesday, Thursday and Saturday the unit has two dialysis shifts, and the operational hours are 6.30am to 6.30pm.

The centre is registered to provide the following regulated activity:

- Treatment of disease, disorder, or injury.

During the inspection, we spoke with 22 staff including; registered nurses, health care assistants, non-clinical staff and senior managers. We spoke with 12 patients and two relatives. We also received 20 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 15 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registering with CQC.

Activity

- During 2016, there were 18,082 haemodialysis sessions. Of these, 100% were NHS-funded.
- The centre was treating 120 patients at the time of the inspection.
- There were 360 treatment sessions per week.
- The centre was running at 99.2% utilisation in the previous three months and 100% at the time of our inspection.However, there was some additional capacity available for twilight shifts on Tuesday, Thursday and Saturday.

Summary of this inspection

- There had not been any transfers out of the centre to another provider in the previous 12 months.

The centre employed one clinic manager, one deputy clinic manager, 17 registered nurses, six health care assistants and one receptionist.

The registered manager was responsible for the storage of medicines. Controlled drugs were not stored at the location. Diaverum Facilities Management Limited employed one practice development nurse to provide training and development to staff within the Midlands area.

Track record on safety (July 2016- June 2017)

- No never events
- No serious injuries
- There was one venous needle (online attachment) dislodgment in January 2017 reported.
- There were 283 'other' patient incidents reported. There was insufficient detail provided to know specifically what these incidents were.
- No healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- One incidence of healthcare acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of healthcare acquired Clostridium difficile (c.diff)
- No incidences of healthcare acquired E-Coli
- Three complaints

Services provided at the hospital under service level agreement:

- Clinical waste removal
- Cleaning
- Maintenance of machines
- Maintenance
- Supply and removal of oxygen cylinders
- Laundry

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We found the following issues that the service provider needs to improve:

- Staff did not understand patient harm in relation to clinical incidents. There were incident data discrepancies and we were not assured incidents were categorised correctly.
- Root cause analysis investigations were inadequate to identify a root cause and to drive improvement. Staff did not have the necessary training or support to carry out these investigations.
- There was no evidence of a learning culture.
- Staff did not understand the duty of candour requirements and no staff at the centre received training.
- Meeting records did not include sufficient detail to evidence discussions held.
- Staff training records showed high compliance rates however, for clinical competencies such as aseptic non-touch technique, the manager could not provide the evidence.
- Staff told us they did not receive protected time to complete training.
- Staff could not tell us who the safeguarding contacts were both internally and externally. The centre did not display safeguarding information for staff or patients. The manager did not assure us they provided adequate safeguarding support to staff.
- The centre did not follow procedure for visiting children on the unit. Staff could not describe action they would take if they had children's safeguarding concerns.
- There were insufficient measures to prevent the spread of infection including open doors of isolation rooms, poor hand hygiene and variable aseptic non-touch technique. There was insufficient action taken following our escalation of concerns.
- The centre did not label clinical waste in line with regulations.
- Staff did not use dialysis machine alarm guards appropriately to ensure patient safety.
- There were multiple issues with medicines management. This included issues with storage, prescribing, consent, administration and the documentation of medicines. During the inspection, we identified a medicine error.
- Care records and risk assessments did not ensure the safety of patients. We found several issues including missing, incomplete and inaccurate assessments.

Summary of this inspection

- We observed several information governance breaches during both visits to the centre.
- Staff did not always assess and respond to patient risk. This included the lack of language support to enable patients to communicate to staff.
- Staff were not confident in managing sepsis 65% of staff had not received sepsis training.

However, we found the following areas of good practice:

- Staff understood their role and responsibility for reporting clinical incidents and were aware of what required reporting.
- Staff worked flexibly to ensure safe staffing levels with the rota planned to ensure staffing standards were met.

Are services effective?

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

We found the following areas of good practice:

- The unit monitored key performance indicators monthly as recommended by the Renal Association.
- The unit was within the three top highest performing centres in 2016 and top four in quarter one of 2017.
- The unit provided haemodiafiltration treatment for 99% of patients, which is the most effective treatment for kidney failure.
- In the 12 months leading up to our inspection, 100% of patients received high flux dialysis, meaning better quality dialysis.
- From February to April 2017, we saw 97% of patients who attended three times a week were dialysed for the prescribed four hours treatment time. This is better than the minimum standard of 70%.
- All staff were up-to-date with their annual appraisal.
- The unit had an integrated IT system with the commissioning NHS trust meaning all healthcare professionals could coordinate care effectively and communicate with one another easily.
- Staff reported effective multi-disciplinary working with consultants and other NHS trust renal staff.

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

- The unit was below expected ranges for patient haemoglobin blood levels.
- Not all patients received the dietitian support they required. The NHS trust was experiencing dietitian staffing issues.

Summary of this inspection

- Centre staff were in the process of receiving mental capacity training but this did not include deprivation of liberty safeguards awareness.
- Staff training records were incomplete and not updated regularly. The centre could not evidence if staff were competent to carry out clinical skills such as aseptic non-touch technique. Our observations showed that overall, staff were not competent.
- The manager was not signed off as competent to be able to sign off other staff clinical competencies.
- The centre did not provide adequate language support for non-English speaking patients to ensure they gained informed consent.

Are services caring?

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

We found the following areas of good practice:

- Feedback from patients was consistently positive about the nursing staff delivering day-to-day care.
- Staff treated patients with care and compassion. Patients described nursing staff as kind, caring and hardworking.
- Patients had access to a renal social worker or renal psychologist through the referring NHS trust and, on a day-to-day basis supported emotionally by the nursing team.

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

- Staff did not protect patient dignity at all times.
- The centre did not provide all patients with the support they required to be fully involved in their care.

Are services responsive?

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

We found the following issues that the service provider needs to improve:

- The centre was not consistently meeting the 90% standard of treating patients within 30 minutes of their appointment time. The average was 81% the 12 months prior to the inspection.
- The centre shortened patient treatment times on 122 occasions during a six-month period due to transport delays and patients arriving late.
- The centre only provided written information in English despite serving a culturally and ethnically diverse community.

Summary of this inspection

- The centre did not use professional translation services for non-English speaking patients despite the NHS trust providing this service.
- The centre did not have a holiday coordinator. The provider website provided information for patients wishing to go on holiday.
- Parking and access to the building was not appropriate for the service. Although the centre had limited control, action taken was slow.
- The centre did not provide evidence of how they supported shared care patients.
- The provider did not have an active 'patient user group'.
- The centre was not meeting the 'accessible information standard' to provide necessary reasonable adjustments and support to patients requiring it.

However, we found the following areas of good practice:

- The centre reported no cancelled dialysis sessions between July 2016 and June 2017.
- Overall, patients knew how to complain and told us the manager listened and responded to their concerns.
- The centre received few formal complaints with two formal and one informal complaints received within the 12 months prior to the inspection.

Are services well-led?

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

We found the following issues that the service provider needs to improve:

- The registered manager lacked adequate knowledge and understanding of governance processes such as categorisation of incidents and duty of candour requirements.
- We were not assured there was an effective governance framework in place. Systems were not in place to effectively manage risk and safety. Identified risks were not on the risk register such as dietitian access issues and staffing clinical competencies.
- There was a lack of awareness and oversight of safety issues such as poor medicines management and infection prevention and control practices. Concerns identified by the inspection team had not been identified on the risk register nor did the clinic manager have an awareness of our findings. The centre did not proactively react following feedback to our concerns.

Summary of this inspection

- Monthly governance and team meetings did not have a strong focus on quality and improvement. There were missed opportunities to learn from incidents.
- The unit did not look outwards for ways to challenge standards or to improve. There was not a culture of learning or improvement.
- We were not assured audit processes were effective and incident and outcome data collected by the centre was robust.
- There was a clear statement of vision and values. However, concerns identified during this inspection suggested the vision and values were not driven by safety and quality.
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- We observed several information governance breaches.
- A Workforce Race Equality Standard (WRES) report was not produced for this service.

However, we found the following areas of good practice:

- We saw all staff were centred on caring for patients and supporting their colleagues.
- Staff described approachable and supportive management.
- The centre engaged with patients and staff to make improvements to the service.
- There was a focus on 'green' care to limit the impact upon the environment.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- The centre used an electronic incident reporting system for staff to report incidents. There was an alert system via text message to senior management if staff reported a serious incident. The centre manager was responsible for investigating clinical incidents.
- Staff were aware of their responsibility to report incidents and could describe what required reporting including what classed as a serious incident. Examples of incident categories reported included hypotension (low blood pressure), vascular access issues, medication errors, increased dialysis time, infections and emergency transfers.
- Nursing Staff told us and we saw that they reported when a patient decided to shorten their treatment time or if they did not attend their appointment. They would also inform the satellite coordinator and consultant.
- We saw the electronic incident reporting system and found that incidents were reported either as serious or non-serious. The manager told us that it was the judgement of the staff member reporting the incident as to whether it was classed as serious or not. Staff told us the system did not help them identify the level of patient harm.
- The providers system included senior staff review of the classification of harm and would amend if necessary once reviewed.
- We asked the manager whether this approach ran the risk of the incident reporting process not capturing near misses and actual patient harm but they could not explain the rationale for the process.
- We saw that the centre reported incidents as part monthly data submitted to the NHS trust. The data reported on the centre's internal system and the data submitted to the NHS trust did not match. The internal system did not categorise incidents based on level of patient harm but the centre was required to provide this information to the NHS trust.
- The data submitted to the NHS trust was broken down by the number of incidents causing patient harm, number of high-level incidents (moderate severity or above), number of venous needle (online attachment) dislodgments and patients 'other'.
- Data submitted to the NHS trust showed during July 2016 to June 2017:
  - There were no incidents causing patient harm reported.
  - There were no high-level incidents (moderate severity or above) reported.
  - There was one venous needle (online attachment) dislodgment in January 2017 reported.
  - There were 283 'other' patient incidents reported. There was insufficient detail provided on the document to know specifically what these incidents were.
  - Six patient falls reported.
  - One healthcare acquired infection (MSSA) reported.
  - There were no pressure ulcers reported.
  - Data was missing for January 2017 for the number of 'other' and high-level incidents.
- We compared data submitted to the NHS trust and data from the electronic reporting system and found data did not match for the number of incidents

reported, for example, the number of falls reported to the NHS trust was seven but the number on the electronic system was five for the period June 2016-May 2017.

- It was clear that staff including the manager did not understand patient harm in relation to clinical incidents. With the vascular needle dislodgements and MSSA infections incidents, the centre reported 'no patient harm'.
- We saw that incidents were an agenda item for the quality assurance monthly meeting with consultants. The incident was listed against the affected patient however; there was no detail about the discussions held or actions taken.
- The centre reported no never events July 2016 to June 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Staff told us they sometimes received feedback from handover and team meetings. We saw team meeting records for January to June 2017 and there was no evidence that incidents were discussed or learning from incidents. Meeting records did not demonstrate how the centre was improving care quality and safety.
- During our inspection, we discovered a medication error. We saw that the nurse involved reported the incident electronically immediately.
- The manager told us that they were unable to access all information that we asked to see during the inspection including serious incident investigation reports because their computer recently failed. The manager confirmed they had not submitted an incident form for the loss of data from their computer.
- One nurse told us how they had received training on how to tape needles securely known as 'chevron taping' after a venous needle dislodgement had occurred.
- Post-inspection we requested root cause analysis (RCA) documentation. We found that the quality of investigations was poor and reports lacked detail of the root cause of incidents. We saw that various staff members carried out the investigation and no evidence that senior management reviewed the reports.
- During 2016, there were five RCA's carried out for two blood leaks, a patient with low calcium, a MSSA exit site infection and a venous needle dislodgment. We found the MSSA infection was not included in the data submitted to the NHS trust.
- During 2017 up to the point of inspection, there were three RCA's for an arterial needle dislodgment, a venous needle dislodgment and an MSSA infection. We found that the arterial needle dislodgment was not included in the data submitted to the NHS trust.
- The centre did not correctly identify serious incidents and patient harm on the data submitted to the NHS trust and therefore the data collected by the centre was inaccurate. There was a discrepancy in the data reported and the incidents investigated.
- The manager told us that staff involved in the incidents would complete the root cause analysis process but no staff including themselves had not received training to do so. This meant there was a lack of consistency and impartiality to investigations.
- Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. The centre had a duty of candour policy for staff to follow.
- Out of nine staff members we asked, two members of staff could describe the concept of being transparent with patients. Other staff did not understand duty of candour and did not refer to their professional duty of being open and honest with patients when things go wrong. No staff had received duty of candour training.
- The manager was honest about their lack of understanding about duty of candour requirements and was unfamiliar with the duty of candour policy. They also told us they had not received duty of candour training.
- We asked to see duty of candour evidence for a patient death that occurred at the centre in 2017 but

the manager confirmed that duty of candour was not carried out as per the requirements. We was not provided with RCA documentation for this incident and we were told this was because of the manager's computer failure.

Mandatory training

- Mandatory training included an orientation programme, fire safety, manual handling, adult safeguarding level 2, basic life support, radicalisation awareness (Prevent), hand hygiene and data protection.
- Mandatory training was split and delivered within a designated quarter to ensure staff kept up-to-date.
- Training records provided post-inspection showed that at the time of inspection, 100% (23) of staff were up-to-date with prevent (radicalisation training), fire, basic life support, data protection, safeguarding adults training and all staff had received an orientation programme.
- Records showed that 22 out of 23 staff (96%) were up-to-date with hand hygiene training, 20 (87%) and were up-to-date with manual handling.
- Some modules were only required for registered nurses (16 in total) including a basic dialysis programme, anaphylaxis, central venous access device (CVAD) and aseptic non-touch technique training and records showed 100% of nurses were up-to-date with these modules. However, when we asked to see evidence of competency documents, the centre was not able to provide these.
- Registered nurses were required to complete annual online medicines management training and records showed 94% (15 out of 16) were up-to-date.
- All staff were required to complete training on the electronic record system and records showed that 100% had completed the module.
- Staff told us that they did not receive protected time to complete mandatory e-learning and usually came into work early or stayed later to complete modules. Following the inspection the provider said they made five days protected time for staff training, however staff were not aware of this.

Safeguarding

- Records showed that 100% of staff were up-to-date with safeguarding training.
- Staff told us they received adults safeguarding training but were unsure of the level. The 'mandatory education and training updates' procedure dated February 2016 did not specify what safeguarding training staff received or whether it included both adults and children. Staff told us they did not receive childrens safeguarding training.
- We asked the manager what level of safeguarding training staff received but they told us they were unsure. The practice development nurse told us all staff received level two adults safeguarding e-learning training every two years.
- Staff were able to describe what types of things would cause concern. They told us they would inform the nurse in charge or the manager of their concerns. They could not tell us who the safeguarding contacts were internally or externally to the centre. We did not see any displayed safeguarding details in the waiting area, toilets or staff room.
- The manager was the safeguarding lead at a local unit level but did not assure us that they could provide adequate support for staff if there were concerns.
- No patients under the age of 18 were treated at the centre. Staff told us children under the age of 14 were not allowed on the unit at all but were allowed over the age of 14 if supervised at all times. We saw on our announced visit that a child under the age of five accompanied a relative within the waiting area.
- Staff were not confident in explaining action they would take if there were safeguarding concerns with children visiting the centre.

Cleanliness, infection control and hygiene

- On the day of our announced visit, the centre was visibly clean and tidy however, on our unannounced visit, we observed rubbish such as consumable packaging on the floor in the main clinical area and the clean utility room.
- An external company provided daily cleaning every day the centre was open. The supervisor from the cleaning company visited the centre once a month to check the standard of cleaning.

- We saw staff disinfecting dialysis machines between each patient and at the end of each day. Staff used single use consumables such as bloodlines and appropriately disposed them after each treatment. Staff cleaned the chairs and beds in between patient use.
- The loop and all dialysis machines connected to the loop were heat disinfected overnight. The loop is the water supplied from the treatment plant room to all dialysis machines. Staff performed a manual disinfection of all machines once a week.
- There was a hand washbasin in the waiting area for patients to use before their treatment and a poster reminding patients to wash their fistula (vascular access as required to deliver dialysis treatment) arm.
- The centre's main treatment area had hand-sanitising gel on the entrance and exit. We did not see any staff using these when entering and leaving through the doors.
- Hand washbasins in the main unit were operated by non- touch sensors, with sufficient soap and paper towel supplies. Each washbasin had large posters displaying the World Health Organisation's 'five moments' of hand hygiene' guidelines.
- On the announced visit, we observed hand hygiene for all staff. We saw that hand hygiene was overall poor with only one nurse following the provider adopted policy of the WHO 'five moments' of hand washing. One staff member dismissed our challenge about the WHO 'five moments' and continued with poor technique.
- We fed back our observations of poor staff hand hygiene compliance after the announced inspection however; we did not see an improvement on the unannounced inspection despite our feedback and displays of hand washing procedures above all hand washbasins. On both visits, we only saw one staff member (out of eight) following the 'five moments' of hand washing policy.
- Hand hygiene was part of the quarterly hygiene and infection control audit.The centre's target for hand hygiene was 100%. The average compliance during 2016 for hand hygiene was 95% and for January to June 2017, compliance was 90%. The reason for non-compliance was staff wearing rings and therefore not bare below the elbow. During our inspection, we saw that several staff wore rings.
- The centre carried out a quarterly hygiene and infection control audit. We saw audit results for quarter one and two 2017 with an overall compliance rate of 96% for both. Audit results for 2016 showed an average score of 98%. Issues identified included rips in dialysis chairs and staff non-compliance with the uniform policy. The centre did not provide evidence of an action plan to replace damaged dialysis chairs.
- We saw staff using personal protective equipment (PPE) such as gloves, aprons and each staff member had their own face shields and we saw that there was adequate supply for staff to use. Nursing staff provided patients with facemasks and gloves as required before procedures.
- Infection is the highest risk complication of vascular access in dialysis patients. The Renal Association guidelines recommend aseptic non-touch technique (ANTT) should be mandatory at every use of central venous dialysis catheters to minimise the risk of infections. ANTT is the use of sterile techniques designed to prevent contamination from microorganisms and therefore correct
- We observed poor ANTT for four out of five nurses we observed on the announced visit and three nurses on the unannounced visit. We saw staff exposing the sterile field to the risk of contamination by touching non-sterile items such as machines without changing their gloves again and touching sterile items on the sterile field with non-sterile gloves.
- We were concerned that staff persisted to practice poor on the unannounced visit despite raising this concern on the announced visit. The quarterly hygiene and infection control audit did not assess staff compliance with aseptic non-touch technique and therefore this questions the effectiveness of the audit.
- We saw staff using trolleys for connection and disconnection that were visibly dusty and when wiping them post use, did not clean the whole trolley.
- There was no system in place to show equipment was clean and ready for use such as stickers or signs.

- We saw that patient toilets were visibly clean and cleaning records for June 2017 showed they were checked daily each morning.
- The centre appropriately separated clinical and domestic waste with designated storage for large waste bins and a designated exit door for waste collection. Staff appropriately segregated waste in clinical areas.
- The centre did not comply with the Department of Health's health technical memorandum 07-01: safe management of healthcare waste. Staff labelled clinical waste bags with a Diaverum tag but this did not identify the location of the centre and therefore individual bags could not be identifiable with the source of the waste. Clinical waste awaiting collection was stored in lockable skips in a secure compound outside the building.
- Staff labelled and stored sharps bins correctly.
- The centre screened all patients for MRSA every three months. The centre treated MRSA positive patients in isolation rooms. Additionally, the centre screened all patients every three months for all blood borne viruses, and treated those with hepatitis C.
- Patients with hepatitis C, diarrhoea, MRSA, HIV and any patients returning from a high-risk holiday area were treated in an isolation room. A dedicated nurse cared for these patients each shift to minimise the risk of cross infection.
- The centre discussed patients returning from holiday at monthly quality assurance meetings. Patients were treated in isolation for the required amount of time. We saw that the centre had dedicated machines for these patients.
- On our unannounced visit, we saw that isolation room doors were open during patient treatment.
- In the previous 12 months of the inspection, there were no healthcare associated infections at the centre. The manager told us that there had been a bacteraemia of MSSA recently confirmed at the time of our announced inspection. We saw one root cause analysis report of an exit site infection (MSSA) for June 2016, which did not appear in the data submitted to the NHS trust.
- Staff took water samples once a month from the loop and sent off for testing. We saw evidence of testing between January to June 2017, which showed the water was pure and safe to use. We saw records to show nursing staff carried out water testing each morning to check for any impurities and ensure the water was safe to use.
- Staff carried out daily water tests to monitor the presence of chlorine in the water in line with the UK Renal Association clinical practice guidelines. We saw records that confirmed this and no variances recorded between January and June 2017.
- When asked, the manager was unable to provide evidence of a legionella risk assessment for the centre and could not tell us if one was done. Post-inspection the provider sent us evidence that a legionella risk assessment was carried out in June 2016.

Environment and equipment

- The centre was located within a multi-occupancy commercial building and therefore access to the centre reception was through a main building entrance, secured with an intercom system. The intercom alerted staff at the reception desk and inside the main unit. There was no CCTV camera on the main entrance due to property owner restrictions but there was a camera in the centre reception area. We saw staff giving people access to the unit without establishing who they were during busy periods.
- Electronic fobs controlled access into the main treatment area from reception and into the corridor where the water treatment plant and storeroom were located. The clean utility room was locked with a keypad. This ensured only people with authorised access could enter these areas.
- The centre had a separate entrance/exit for staff, deliveries and disposal and collection of waste.
- The main treatment area was managed and staffed based on three bays and four side rooms, providing a total of 24 dialysis stations. Staff worked from five nurses' stations, which ensured every patient receiving treatment was visible to at least one member of staff at all times.
- Every treatment station had a nurse call button. When a patient pressed the call button, an audible alert

sounded and a light above the station was illuminated. This ensured all staff were aware of the call and clearly indicated which patient needed assistance.

- The centre had 30 dialysis machines. The machine storeroom contained three spare machines and three isolation machines. This meant patients' dialysis would not be interrupted or cancelled in the event of equipment failing. During our announced inspection, two machines were awaiting repair but a technician attended the same morning and repaired the machines promptly.
- Staff told us there was an effective machine technician service with an on-call system and staff could directly access them via mobile phone.
- The centre's dialysis machines were serviced annually on site by the manufacturer's technicians. All machines had been serviced in November and December 2016.
- We saw records that showed all dialysis chairs were serviced and electrical safety tested in November 2016. The provider sub- contracted electrical maintenance services and we saw the certificate to show all equipment was serviced and safe to use in April 2017. Gas safety testing was completed with no safety issues in April 2017.
- The Renal Association guidelines recommend that providers replace dialysis machines every seven to ten years or between 25,000 to 40,000 hours of use. We looked at five dialysis machines and saw that all were within these guidelines.
- On our announced visit, we noticed a leak around the central acid system and informed the manager who said they would monitor any further liquid on the floor but did not immediately report the potential leak. We escalated this to the area manager to report the problem in view of the risk of dialysis treatment suspension. Following the inspection the provider informed us they undertook monitoring of the leak and escalated it to maintenance.
- On our unannounced visit, we found the centre did not report the problem until two days after our feedback. Staff provided us with the maintenance report that showed no identified concerns.
- In the storeroom, new stock was organised and labelled clearly and stored off the floor on shelving or crates. All staff we spoke with told us that there were adequate supplies of equipment.
- A staff member told us there was only one member of staff who was trained to input stock on the electronic system and this meant they had to work on stock take days which occurred once a month.Following the inspection, the provider informed us that the manager was trained to input stock also.
- The centre had one emergency resuscitation trolley with basic life support equipment, including automated external defibrillator, suction machine, both in working order and manual ventilation devices. The trolley contained emergency resuscitation drugs that staff were not trained to use and staff confirmed that they had not used them before.The provider confirmed following the inspection that the NHS commissioner of the service required these drugs be present, in case one of the commissioning trusts doctors was on-site to assist in the event of an emergency. All consumables and medicines were in date. We saw records for March to June 2017 that confirmed staff checked the trolley daily, except Sundays when the centre is closed.
- The emergency trolley was positioned so that it could be accessed quickly in an emergency.
- We saw nurses completed checks of expiry dates of bloodlines, the dialyser and the haemodialysis solution and recorded the date on treatment records for each patient.
- The centre only had one set of weighing scales and did not have a backup in the event of failure. Staff told us they would use patients previous weight until the scale was repaired. Staff at the centre had not considered backup scales.
- There was sufficient space around dialysis chairs for access and privacy purposes as per Department of Health requirements.
- On the day of our announced visit, the manager was unable to provide us with evidence that the water treatment plant had been serviced within the past year. The manager emailed it to us the next day that showed it was up-to-date.

Medicine Management

- The centre did not use or store any controlled medicines. The manager had overall responsibility for the safe and secure handling and control of medicines.
- There were no nurse prescribers at the centre. The consultant and/or the satellite coordinator from the NHS trust reviewed the patients' prescription charts in the monthly quality assurance meetings.
- There were no arrangements for a pharmacist to visit the unit and the unit did not conduct pharmacy audits. Pharmacy support was available from the local NHS trust pharmacy for advice relating to dialysis drugs.
- We found several concerns with the management of medicines including storage, administration and documentation. We identified concerns on both the announced and unannounced visits and fed back our concerns to the manager.
- The lockable medicines cupboard and two refrigerators were stored within the clean utility room.
- The majority of medicines stored within the cupboard were within their expiry date however, we found
- We found 17 boxes of Sodium Chloride intravenous fluid bags not locked away and 14 boxes of Sodium Chloride ampoules also not locked away. We informed the manager and regional manager on the same day.
- On the unannounced visit, we found that medicines cupboards were locked and one refrigerator was locked but the other refrigerator was unlocked. All Sodium Chloride (bags and ampoules) were not locked away.
- We found issues with the monitoring and recording of refrigerators and room temperatures. We found that staff were incorrectly documenting room temperatures as refrigerator temperatures and they told us the form was confusing.
- For refrigerator one, records for May 2017 showed that the temperature went above the maximum of 8°C on three days (12.9°C). For June 2017, there were two days where staff recorded the maximum temperature as 9.7°C. There was no evidence of action taken and staff told us that they reset the thermometer and the nurse in charge was informed. There was no evidence of any further action taken such as reporting the refrigerator for a maintenance check.
- For refrigerator two, the maximum temperature was over 8°C on two days in June (both recorded as 8.7°C) and staff did not record the temperature for 13 April and 23 May 2017; these were days the centre was open.
- Post-inspection, the centre provided email evidence that the satellite co-ordinator checked with their pharmacist about the drugs stored in the refrigerators. The pharmacist at the commissioning NHS trust confirmed no action was necessary but that it should be noted that both products stored in the refrigerators should be considered as being used off-license because they have been stored outside of license recommendations (above recommended storage temperature range).
- Staff did not action high temperatures of the clean utility room (where medicines were stored) appropriately. Records showed for 10 days in April 2017, 10 days in May 2017 and every day in June 2017 (30 days), the maximum temperature of over 25°C for the medicines stored in this area was exceeded.
- On our unannounced visit, we checked the room temperatures and found for the two days in July, staff recorded the maximum room temperature as 30°C. The nurse in charge confirmed that the only action taken was a thermometer reset. We were concerned that the safe storage for medicines in the clean utility was compromised and fed this back to the nurse in charge.
- Storeroom temperature records showed that in June 2017, staff did not record temperatures for 3 and 7 June and on 14 days the temperature went above the 25°C maximum with 7 days recorded up to 28°C. On the day of our unannounced visit, staff recorded the maximum temperature as 28.4°C with no action.
- We were concerned that citric acid (20 bottles) was stored in this storeroom without a storage specific risk assessment. We saw citric acid, as a COSHH item was risk assessed however; the risk assessment did not included suitability for storage in the storeroom.

- Staff told us that Sodium Chloride boluses should be prescribed for all patients for use during dialysis treatment as required. We saw that three out of 11 medication administration records (MARs) did not have sodium chloride prescribed and so we could not be sure whether this meant it was given without a prescription or not. Eight had this prescribed but there was no evidence that staff administered it and so we were not assured that patients had received the medicines prescribed as part of their treatment.
- Not all nurses followed the provider medicines management policy or the Nursing and Midwifery Council (NMC) medicine management standards. We saw that nurses took out medicines in batches and did not check patient identities prior to medicine administration. This increases the potential for medicine errors and therefore patient harm.
- We saw one nurse giving an anti-coagulant injection and a Sodium Chloride bolus without checking the medicines with a second nurse or with the prescription prior to administration. We saw four nurses during our two visits not following safe medicines management processes.
- We saw nurses taking medicines out of the utility room in batches (for several patients within the bay) without medication charts and left at patient chair sides until administration. Two nurses did not check the drug at the point of administration or check patient identification as per NMC Standards for medicines management 2007.
- On the announced visit, we saw oral medications left by the dispensing nurse next to a patient but the nurse did not witness the patient taking it.
- One nurse checked a patient identity from the patient's daughter to administer medications because the patient did not speak English. The nurse did not address the patient during the discussion.
- We found the centre held Erythropoietin (to help red blood cell production) and Iron administration records in folders within the clean utility room. A nurse confirmed that staff gave the medicines and then signed the records later during the treatment session and therefore not at the point of administration. This also meant staff were not checking the medicines against the medication record.
- We saw one nurse following correct medicines administration processes by checking the medicines with another nurse against the prescription and checking patient identity prior to administration.
- During our unannounced inspection, we found one patient's medication in the cupboard of the clean utility. The consultant prescribed the patient on 3 June 2017 because of abnormal blood results. The nurse told us the patient was non-compliant with taking the medication but would accept the medication from the staff and was why it was stored at the centre.
- The named nurse told us they had discussed with the patient their non-compliance and escalated the patient to the consultant. We asked to see the care records of the same patient to show this but after the manager searched electronic records; they could not find supporting documentation.
- For the same patient, we noted that there was a missed dose of the same medicine (29 June 2017) on the patient's medication record and therefore a medication error. We asked the patient's named nurse for the reason who told us they believed they gave the dose but did not document it but could not be sure they gave the dose. We saw that the nurse submitted a clinical incident record the same day for the error.

Records

- The centre held patient records both electronically and in paper format. The electronic system recorded information downloaded directly from dialysis machines and data recorded by nursing staff. This database was integrated with the NHS trust systems, which enabled information to be jointly shared and accessible to staff at the point of care including consultant nephrologists.
- Staff kept paper records of attending patient's on a particular day at the chair side or at the nursing station. The centre stored patient records in locked cupboards behind the nursing station on days they were not attending. Archived records were stored in a locked room in an access fob controlled corridor.
- We saw nurses completing paper and electronic treatment records with recorded pre and post dialysis observations. We saw entries were signed and legible.

- During the inspection, we looked at 15 patient care folders. We found errors with all of these. The main concern we had was that risk assessments were not consistently completed. We found examples of risk assessments that staff had completed incorrectly and staff completing documentation audits had not identified errors. We raised this concern to the manager post-inspection including examples of patients incorrectly assessed and those with high-risk scores with no action taken.
- The centre carried out monthly audits of dialysis records and prescription delivery as part of contract monitoring by the NHS trust. We saw records to show the average compliance rate for dialysis records for January to June 2017 was 97%. The most common issues found were that care assessments had not been reviewed and completed and take home medications had not been checked each month. Audit results of prescription delivery showed an average compliance rate of 99% during January to June 2017.
- We observed several information governance breaches on both days of our inspection. We saw one patient's folder left open by staff at the nursing station and the electronic record on the computer was unaccompanied by a nurse and therefore visible for anyone passing to see. Staff left the morning session's patient folders piled on the nursing station during the afternoon session treatments. On several occasions, we walked past unaccompanied computers displaying patient information that the nurse left unlocked. This meant any unauthorised person might have been able to view the information.

Assessing and responding to patient risk

- Staff told us that only medically stable patients could receive dialysis at the centre. The commissioning NHS trust assessed patient suitability for satellite unit care. If a patient became acutely unwell at the centre, the centre transferred them to the acute NHS trust via ambulance. If a patient was deemed unsuitable for satellite care provision, their care would be provided at the commissioning NHS trust, to ensure patient safety.
- Staff recorded an assessment of patients' pre and post dialysis within paper care records. This included the start and finish time of treatment, a summary of the patient during treatment and a final evaluation of the patient following treatment. In addition, staff would enter the same information on the patient's electronic care records for both the location and the referring NHS trust.
- Observations of vital signs such as blood pressure and pulse were recorded before, during and after dialysis treatment. We saw staff checking on patients during their treatment. Patients weighed themselves at the start and end of treatment.
- Procedures were in place to assess all patients for blood borne virus (BBV) conditions for example, hepatitis B and C. The centre carried out routine screening of susceptible patients three-monthly for BBV and for those patients returning from holiday in 'high risk of infection' regions.
- Staff told us that they use patient photos inside their treatment folder to positively identify patients prior to their treatment however; we found three folders without photos inside. Staff confirmed there was not a formal process for identifying each patient before dialysis. Some staff did ask the patient to confirm their name and date of birth pre-dialysis but this was not consistent.
- Staff did not safely monitor or respond appropriately to dialysis machine alarms. On both the announced and unannounced visits, we saw patients cancelling the alarms and staff not checking to see if action was required. We saw examples where staff were near sounds of machine alarms and took several minutes to respond. This continued on our unannounced visit despite feedback following our announced visit.
- We asked staff how non-English patients would communicate if they felt unwell to them. They told us if it was a language that staff could speak (Urdu, Punjabi and Filipino) a staff member could communicate with them or a relative.
- On the unannounced visit, we saw that a Bengali speaking patient was unable to speak English and there was not an interpreter present or a relative. This patient attended the session alone and therefore could not communicate to staff if they felt unwell or wanted to ask questions.

- We saw that the centre had risk assessment documentation to assess patient risk of falls, manual handling, vascular access devices and for the development of pressure ulcers. We saw evidence that most records we viewed did not contain suitable and sufficient risk assessments to maintain the health and safety of patients receiving care or treatment.
- We saw that staff used a central venous catheter device (CVAD) risk assessment form to monitor the device. Documents provided post inspection demonstrated that when staff identified a score which indicated that escalation was required this was undertaken as per provider policy.
- We viewed five other central venous access device (CVAD) risk assessment forms of which two did not have documented evidence that staff appropriately escalated to the consultant as per provider policy. Staff were required to escalate scores of '1' or more to the consultant.
- Staff told us that there were 12 patients with femoral access catheters and that they did not have individualised care plans or specific risk-assessments for this type of vascular access.
- We reviewed two of the 12 care records of femoral access patients that showed there was no risk-assessment and a representative of the commissioning service, the registered manager and another member of operational staff confirmed this. The representative from the commissioning trust told us this was not an expectation of the centre. We viewed seven venous needle dislodgement (VND) assessments of patients with a fistula access device and six were incorrectly risk assessed and therefore action was not taken to mitigate risks.
- We viewed 11 patient pre-treatment assessment forms and found that all of them had at least one signature missing of the nurse completing the assessment. Of the 16 pre-treatment assessment form of one patient, seven did not have the nurse assessor signature.
- Staff told us all patients required skin assessment for pressure ulcer development three monthly. Out of the 15 patient records we viewed, one patient did not have a skin assessment, four had missing completion dates and one was incorrectly assessed and scored. Six out of the 14 forms we saw did not have any documented evidence of action taken when staffed assessed the score as high-risk. Six out of 14 had not been re-assessed three monthly as per provider policy and these included patients assessed as high-risk for developing pressure ulcers.
- There provider told us that they utilised the National Institute for Health and Care Excellence (NICE) guideline (NG51) for recognition, diagnosis, and early management of sepsis. The centre displayed the NICE pathway flowchart at the main nursing station; however, we found only one staff member who was confident in the action they would take if they suspected sepsis.
- The centre did not currently use a nationally recognised early warning scoring system such as NEWS to detect and monitor deterioration in the patient's condition. The practice development nurse had commenced staff training in the use NEWS however, not all staff were trained and therefore the score was not yet in place.
- On our unannounced visit, we saw that one patient looked particularly unwell. Their nurse said they had noted this and felt the patient did not seem their usual self. We asked both nurses allocated to that particular bay whether they would seek medical review for that patient. Neither nurses recognised the need to escalate the patient for medical review. We asked the nurse to take appropriate action for the patient.
- During our unannounced visit, we saw two examples of incorrect vascular access cannulation technique:
  - We saw one nurse unsafely aspirating the arterial line with a 5ml syringe of Sodium Chloride during cannulation. We saw air was present but the nurse continued to push the syringe and therefore there was a risk of air entering and potentially causing an air embolism, respiratory arrest and cardiac arrest. We told the nurse to stop due to the safety risks.
  - Also during the unannounced visit, we saw another nurse use a non-primed syringe, also known as 'dry needling'. This was against Diaverum policy for vascular access cannulation. The nurse told us they had forgotten to prime the syringe. The provider did have a policy for the best practice for staff to follow.

- The arrangement for emergency patient care for example, cardiac events, was directly via the local ambulance trust. Staff in the clinic had appropriate basic life support training and all necessary emergency equipment was available on site.

Staffing

- The centre had 16 whole time equivalent (WTE) dialysis nurses and six WTE healthcare assistants. The company calculated staffing numbers to accommodate for annual leave. There was an active advertisement for a full time dialysis assistant.
- The clinic manager worked five days per week and 100% of their time was supposed to be managerial time but this varied depending on shifts requiring cover. There was a deputy manager but this person was on maternity leave at the time of the inspection.
- The nurse-to-patient ratio at the centre was one nurse for every four patients, which is the ratio recommended by the British Renal Society's National Renal Workforce Planning Group 2002 staffing guidelines and is in the contract with the NHS trust. There was one healthcare assistant for every 10-12 patients.
- Records showed that during the 12 months prior to the inspection July 2016 – June 2017, there were no shifts that did not meet the one nurse to four patient ratio.
- The centre had not used any agency staff in the 12 months prior to the inspection. This meant the patients received care from nursing staff that were familiar with them and the centre. Staff told us they regularly filled gaps in the rota.
- The centre's sickness level was at 9% at the time of inspection. The centre's target for sickness was 3%. The sickness rate was based on two members of staff on long-term leave. The manager said that HR was supporting them with following the company sickness policy.
- The centre did not employ any medical staff. Consultant nephrologists from the commissioning NHS trust attended the centre twice a month to hold clinics and once a month for quality assurance meetings.
- Centre staff told us they could easily contact the consultant by email or call them if they had a general query. If the query was urgent they would telephone the renal team at the NHS trust for advice.

Major incident awareness and training

- The centre had contingency plans to deal with the most common situations affecting dialysis units, such as loss of power and water supply failure. Staff we spoke with were familiar with the actions they would take in the event of an incident occurring but did not refer to company policies.
- Staff told us that the centre did not practice fire evacuation drills.
- The centre did not have individualised patient evacuation assessment plans. Senior managers post-inspection told us and we saw that staff noted on the daily allocation sheet if patients require mobility support.
- In case of adverse weather, the centre would contact the NHS trust or the nearest alternative centres to relocate patients if needed.

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

Evidence-based care and treatment

- Overall, we saw that staff delivered dialysis therapy in line with clinical practice guidelines published by the UK Renal Association and accredited by the National Institute for Health and Care Excellence (NICE). However, we did observe two examples of poor practice with vascular access cannulation. Staff were required to read any new or updated company policies and sign to confirm they had read them.
- The centre provided haemodiafiltration to patients, which is considered best practice because it can lower the risk of developing complications associated with dialysis treatment and can provide better patient outcomes.

- All patients had monthly blood samples taken, which were analysed by the laboratory at the NHS trust. Staff reviewed patients' blood results each month at the quality assurance meeting and made changes to prescriptions and treatment as necessary.
- Staff assessed patients' weight, blood pressure, pulse and temperature pre and post treatment and we saw nurses completing these assessments during our visits.
- The UK Renal Association's clinical practice guideline on vascular access for haemodialysis recommends 80% of all long-term dialysis patients should receive dialysis treatment through 'definitive access' such as an AV fistula or graft. At the time of the inspection, the fistula prevalence rate at the centre was 73%.
- Arteriovenous fistula's (AV fistulas) are specially created blood vessels in the arm to aid transfer of a patient's blood to the dialysis machine and back to the body. An AV fistula is a surgically created (at the commissioning NHS trust) by connecting an artery to a vein, which makes the blood vessel larger and stronger. AV fistulas are regarded as the best form of vascular access for adults receiving haemodialysis. This is because they last longer and have less risk of complications than other types of vascular access.
- The centre monitored vascular access every treatment and reported to the commissioning NHS trust at monthly quality assurance meetings. Patients with CVC's were risk assessed and placed on a CVC risk register. We saw the risk register and actions associated with each individual patient.
- The centre displayed the NICE Sepsis guidelines (NG51 sepsis: recognition, diagnosis and early management) on the wall behind the nursing station and was adopted by all Diaverum centres. Staff we spoke to could not confidently explain how they would manage signs of sepsis. Information received following the inspection identified that 35% of staff had received training in sepsis management at the time of the inspection.
- Diaverum adopted an International Standards Organisation (ISO) accredited integrated management system (9001) which aimed to ensure all policies and procedures support best practice evidence and an environmental management system (14001) for managing the organisations impact upon the environment. This included an annual review requirement with a review date for both in 2017.

Pain relief

- Staff told us they discussed pain management with patients when they first start attended the centre for treatment. Some patients used a cream on their fistula arm, to help reduce the pain when needles were inserted. The patient obtained it through their GP and applied it themselves prior to leaving home for their appointment.

Nutrition and hydration

- Patients who have renal failure require a strict diet and fluid restriction to maintain a healthy lifestyle.
- The centre provided patients with at least one hot drink and biscuits and staff encouraged patients to bring in their own food.
- The commissioning NHS trust provided dietitian support for all patients. At the time of our inspection, patients on the twilight session told us that the dietitian was not always available to see them. We spoke with the satellite co-coordinator who told us they were currently recruiting to increase the dietitian team. We saw emails from the centre manager to the dietitian who explained they were experiencing problems seeing all twilight patients due to shortages. The dietitian was attending alternate weeks on the twilight session and prioritising nutritionally compromised patients. The dietitian said two new dietitians were starting in August 2017.

Patient outcomes

- The UK Renal Registry is part of the Renal AssociationThe commissioning NHS trust reported data to the registry for all dialysis patients and therefore the centre did not directly contribute data to the UK Renal Registry.
- The centre used a scoring system, based on patients' monthly blood tests to assess the effectiveness of their treatment in line with the Renal Association Standards. These included tests for haemoglobin (sign

of anaemia), albumin (sign of malnutrition or fluid management), renal clearance (how effective the dialysis treatment is), and phosphate/calcium balance (risk of developing bone disease).

- The results show how the centre performed in the achievement of quality standards based on UK Renal Association guidelines. We reviewed results of blood tests for three months from March to May 2017. These comprised of a number of standards, for example:
- The rate blood passes through the dialyser over time, related to the volume of water in the patient's body (expressed as 'eKt/V >= 1.2h'). On average around 93% of patients had effective dialysis based on this standard. This was significantly better than the 70% target.
- Urea reduction ratio (URR). The average URR for the patients at this unit from February 2017 to April 2017 was 97%. The Renal Association guidelines indicate a target of 65% and therefore the unit was performing better than the target. Patients with these levels of waste reduction through dialysis have better outcomes and improved survival rates.
- Other results that measure the performance of the treatment the unit provided included iron (haemoglobin/Hb) and potassium levels in the blood, against the Renal Association standards:
  - During March to May 2017, the average number of patients with the NICE recommended iron levels (100-120 g/l) was 63% against the 70% target.Anaemia (low iron levels in the blood) can be a complication of renal failure and dialysis associated with increased risks of mortality and cardiac complications.
  - From March to May 2017, an average of 12.5% of patients had high levels of potassium (greater than 6.0 mmol/l). If potassium levels are higher than 6mmols, it can cause acute cardiac problems. This means around 87.5% of patients had potassium levels within acceptable ranges.
- Diaverum compared the performance of all its centres throughout the country, and published results for staff and patients. The centre provided data that showed it was one of the top three performing centres throughout 2016, and was the fourth performing centre in quarter one of 2017.
- The centre provided haemodiafiltration (HDF) treatment for 99% of patients, which is the most effective treatment for kidney failure.
- In the 12 months leading up to our inspection, 100% of patients received high flux dialysis. High flux dialysis is a form of more effective clearance of waste products and fluid. High flux dialysis delays long-term complications of haemodialysis therapy.
- From March to May 2017, we saw 97.5% of patients who attended three times a week were dialysed for the prescribed four hours treatment time. This is above the minimum Renal Association standard of 70%.
- The centre monitored patients who 'did not attend' (DNA) and recorded the reasons for non- attendance. During July 2016 - June 2017, 99 patients did not attend their treatment with an average of eight patients per month and a rate of 7% of all patients. The centre submitted this data to the commissioning NHS trust and informed consultants. Patients told us staff called them if they did not attend.
- Other patient outcome data the centre collected and submitted included the number of patient deaths, planned hospitalisation and non-planned hospitalisation episodes.
  - During July 2016- June 2017, there were seven patient deaths.
  - During the same period, there were 12 planned hospitalisation and 91 unplanned hospitalisation episodes recorded with reasons.

Competent staff

- Records showed that at the time of inspection, 100% of staff at the centre had an appraisal within the past 12 months. Senior nurses completed appraisals as part of their own development.
- We saw records that showed 100% of staff were up-to-date for basic life support training.

- Three registered nurses including the manager had completed a university certified renal course with another nurse due to commence the course.
- Registered nurses had to complete yearly competencies for infection control, aseptic non-touch technique and medicines management. Staff we spoke with told us they had not been re-assessed for aseptic technique. The manager told us that staff completed intravenous medicines administration competencies once only.
- Records showed that 15 out of 16 registered nurses completed the annual e-learning training for medicines management.
- Records showed that all staff had received daily water monitoring, disinfection, microbiological and chemical testing training and six staff received machine water sampling training.
- We saw five staff training paper records including the managers and found they were not up-to-date as per provider policy. The practice development nurse said they held annual competencies electronically but could not provide the evidence to show staff were up-to-date for aseptic non-touch technique.
- On the day of our unannounced visit, the practice development nurse told us their aim that day was to assess aseptic non-touch technique competency, and had done so for two nurses.
- The manager told us they had not been signed off for their own competencies and therefore could not sign-off other staff as competent and had raised this previously with their line manager.
- The practice development nurse told us the centre had fallen behind with monitoring the completion of competencies and they were in the process of reviewing and delivering required training.
- 35% of staff at the centre had received sepsis training prior to our inspection June 2017. This meant that 65% of staff involved in direct care for patients still required.
- The centre adopted a named nurse approach for continuity for patients and for each treatment bay, there was a team leader. The manager told us they allocated nurses based upon skill mix and to develop staff experience.
- For new staff commencing employment at the centre, nurses underwent an eight-week induction programme where they were not counted as part of the staffing numbers to orientate to the centre.

Multidisciplinary working

- There were two renal consultant's allocated to the centre and had overall responsibility for patient care. They visited the centre twice monthly to carry out clinical review of all their patients.
- The consultant nephrologist, the satellite co-ordinator, the dietitian and the centre staff attended the monthly quality assurance meeting.
- The consultant and dietitian sent written updates to GP's of any changes to the patients' treatment. Patients confirmed the centre did this in a timely manner.
- The nursing staff from the NHS trust would inform the staff at the centre by telephone and email of any patients discharged from hospital who needed their dialysis sessions to recommence at the centre.

Access to information

- Staff told us they had the necessary information they needed to look after patients.
- Electronic records including blood results from the commissioning NHS trust were accessible to staff on the unit. The electronic systems were integrated and in real time. This meant that staff could access records at the point of care.
- Staff told us and we saw that the patient treatment database sent information to the NHS trust.

Consent, Mental Capacity Act and Deprivation of Liberty

- It was provider policy to gain written consent at the beginning of treatment and annually. We saw four patient folders that did not have completed consent

forms within the past year. Post-inspection, senior managers provided evidence they had been completed but were not present in the patient folders at the time of inspection.

- We saw two signed consent forms of patients who did not speak English and whom did not speak a language of any staff. Staff confirmed the centre did not use translation services and therefore the centre was unable to evidence sufficient support was put in place to enable these patients to give informed consent.
- Some staff told us they had not received training in mental capacity awareness.The practice development nurse (PDN) confirmed they were in the process of delivering mental capacity training to all staff with 65% of staff trained at the time. Deprivation of liberty safeguards awareness was not included in this training. The PDN told us the aim was to include this in the future.
- Staff we spoke with told us they had not needed to assess a patient's capacity, but they would seek support from another colleague. If a patient refused consent, they would explain the risks, complete an incident form and inform the consultant.
- There were no patients at the time of our inspection deemed to lack capacity to consent and the satellite co-ordinator manager confirmed this.

Are dialysis services caring?

Compassionate care

- Patients we spoke with told us the staff were happy, friendly, caring and hardworking, ensuring they take the time to talk and get to know them. One patient told us the staff were 'first class'. Another patient told us the staff go out of their way to make them feel comfortable.
- We saw staff regularly checked how their patients were feeling during and after disconnection from the dialysis machine.
- We received 20 comment cards filled in prior to our announced inspection from patients or their relatives. All comment cards described kind, caring and hardworking staff and overall, respondents were happy with their care. Five comment cards mentioned staff shortages (three comments), parking issues (two comments), delays in patient transport (two comments), and dialysis chairs looking dirty and generally uncomfortable (two comments).
- We saw staff engaging in friendly conversations with patients and addressing them by their preferred name. We could see that nurses and patients knew each other well. One comment card response described having 'excellent relationships with the regular staff in their bay'.
- Patients told us they felt welcomed and respected. We saw the receptionist greeting patients and talking with them while they waited for their appointment.
- We saw thank you cards from patients displayed behind the nursing station, thanking staff for their kind and committed care.
- One patient relative wrote on a comment card 'the staff at the centre are very hard working and despite short staffing on many occasions, they never fail to treat patients with love and care. I trust the staff completely'. Another comment card said care was 'beyond expectations'.
- We saw staff providing extra support to patients with restricted mobility.
- One nurse told us they always used privacy screens for female patients with central venous catheters however, we did not see any nurses asking patients or using screens when treating patients with central venous catheters.
- One patient told us that their consultant said that they needed to see their GP about their diabetes because their renal care was unrelated.

Understanding and involvement of patients and those close to them

- The centre invited patients and their relatives/carers to visit the centre before starting treatment. This was organised by the specialist nurse at the commissioning NHS trust. We were told this was to encourage patients to see what the centre looked like and receive the necessary information to feel involved in their care.

- Patients we spoke with told us they received an explanation of their blood results each month from their nurse or the dietitian.
- One patient told us he had received a handbook, and found it useful to help them understand their condition and how the centre works.
- We saw from admission paperwork, staff asked patients if they wanted to participate in their dialysis treatment.
- One comment card said that 'the nurses are very informative and clearly explain processes and treatment'.
- We observed nursing staff informing patients of their blood pressure and blood glucose readings as they took them and nurses involving the patient in deciding how much fluid to remove.
- One patient told us they were not given sufficient information in a format they could understand to feel involved in their care.
- On our unannounced visit, we found one patient who did not speak English and did not have an interpreter present or a relative and therefore could not ask staff any questions about their care. The patient population of the centre was diverse and therefore we found that the service was not caring towards patient needs for non-English speaking patients.

Emotional support

- The centre had access to a renal social worker and counsellor to provide additional support to those patients who needed it.
- We saw that relatives were allowed to stay with patients to provide emotional support if required.
- The centre displayed information about the British Kidney Association and their contact details in the patient waiting area.

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

Service planning and delivery to meet the needs of local people

- The centre was contracted by the commissioning NHS trust to provide haemodialysis services for its patients. The NHS trust defined service specifications for care delivery. The centre reported its progress in delivering the service against the defined specifications at monthly quality assurance meetings and through the collection of key performance indicator and quality outcomes.
- The building met most of the Department of Health building requirements (Satellite dialysis units: planning and design HBN 07-01). The centre was level access and had separate access for waste disposal and delivery of goods. There was plenty of natural light in the main unit, as well as additional lighting. Sink basins were placed in line with requirements. There was adequate space to permit emergency access and allow for privacy around each dialysis chair.
- The provider rented the ground floor and part of the first floor within a business park building. The ground floor designated treatment space and the first floor for staff and office facilities. The entrance to the building did not open directly to the centre's waiting area; the centre's entrance was inside the building entrance.
- There was adequate parking and disabled parking spaces however; these were not directly accessible to the entrance of the building. The parking spaces directly outside the centre entrance were unavailable for the use for patients due to the space allocation to another part of the building. This meant that there was not direct access to the entrance for ambulances or disabled vehicles and all patients had to walk from the car park along a path to get to the reception area.
- We saw records from December 2016 that senior management of the provider were in the process of negotiating the parking allocation directly outside and a new entrance to access the waiting area directly. This process was not finalised at the time of our inspection.
- We saw that the centre sent a letter written in English to all patients explaining the on-going negotiations with the property owner for the parking arrangements and asking them to inform staff if assistance was required to and from the entrance.

- Although the centre had 18 car parking spaces and two disabled spaces, patients told us parking was a persistent issue. One patient told us they always arrived early to ensure they could get a space.
- There was space for four wheelchairs and sufficient seating within the waiting area including two chairs suitable for bariatric patients. There were two consulting rooms for appointments with consultants and dietitian.
- There was not a transport user group or transport survey for patients to engage with. Senior managers told us that the centre actively fed back issues to the NHS commissioning trust in the monthly contract meeting.
- The centre had access to a renal social worker from the commissioning NHS trust that they could refer patients to for additional support.
- The centre was open plan with the nursing station situated centrally. There were four additional nursing desks with computers within patient areas. We saw that this meant nurses were visible at all times during treatment times.

Access and flow

- Referrals for treatment at the centre were co-ordinated by the commissioning NHS trust through the satellite co-ordinator. Patient preferences for treatment days and session (am or pm) were accommodated if there was an available slot.
- At the time of our inspection, the centre offered three dialysis sessions on a Monday, Wednesday and Friday: morning, afternoon and a 'twilight' (evening) session, and two dialysis sessions on a Tuesday, Thursday and Saturday: morning and afternoon.
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- All slots were filled at the time of our inspection and therefore the centre was at 100% capacity. Following the inspection the provider made us aware that additional capacity could be made available for twilight shifts on Tuesday, Thursday and Saturday.However, this was not suitable either because of clinical reasons or patient choice with the current cohort of patients.This meant that the centre may have had some difficulty accepting holiday patients or new referrals.
- There were six patients on a waiting list to receive their care at the centre. The satellite co-ordinator was monitoring and managing these patients until availability at the centre opened. Following the inspection the provider made us aware that additional capacity could be made available for twilight shifts on Tuesday, Thursday and Saturday.However, this was not suitable either because of clinical reasons or patient choice.
- Staff told us that they tried to accommodate patient preferences for day and time of sessions but it was difficult due to no available capacity but often patients would swap with each other. One patient told us the centre had been very responsive to their needs by changing their appointment time several times.
- Staff told us they tried to start patient treatment according to their appointment time as much as possible. If a patient arrived early, they would be asked to wait for their appointment time. This was to ensure enough time to safely start other patient's treatment.
- Patients told us that waiting times to commence their treatment could vary but staff kept them informed if their treatment would be delayed.
- The centre reported no cancelled dialysis sessions (for non-clinical reasons) between July 2016 and June 2017.
- During July 2016 to June 2017, the centre met the standard (90%) of treating patients within 30 minutes of their appointment time six out of the 12 months. The average was 81% with the range 84% (June 2017) to 91% (August 2016 and April 2017).
- The centre recorded the reasons for not meeting the 90% standard and submitted the data on a monthly basis to the commissioning NHS trust as part of their performance data. The main reasons included transport delays, delays due to previous patient, access problems and machine issues.

Meeting people's individual needs

- The centre had six beds for those assessed suitable by the satellite co-ordinator.
- There were two non-gender specific toilets in the waiting area and one located in the treatment area, all were disabled access.

Dialysis Services

- Patients told us they felt able to contact their consultant through the nurse if they needed to, or the centre would arrange for them to be seen by the consultant without any difficulty.
- The centre was not treating any patients living with dementia or learning difficulties at the time of our inspection. The satellite co-ordinator told us they assessed patients at the trust to ensure suitability for them to dialyse at the centre.
- Patients told us their consultant would review them at the centre and given dedicated appointments, which meant they did not have to travel to another hospital for their appointments.
- Records showed that during January to June 2017, the centre recorded that there were 122 shortened treatments times. The three main reasons included 19 patients arriving late due to delayed patient transport (24%), 14 occasions because patients arriving late (11%) and 10 delays due to the previous patient arriving late (8%).
- The centre is located in Aston, Birmingham. Aston is an ethnically diverse community with 71% of the area's population being of an ethnic minority compared with 30% for Birmingham. The largest ethnic group is Asian at 50% and specifically Pakistani ethnic group the largest at 27%.
- All posters and leaflets displayed in the waiting area were written in English despite the service providing care to an ethnically diverse population.
- We saw that interpreters were not used when patients who did not speak fluent English attended their dialysis sessions. A staff member told us they were used as an interpreter for consultant appointments at the centre but had not received professional training. The staff member had been working at the centre for over 12 months and they could not recall the use of a professional translation service for any patients.
- The registered manager and other staff told us they used relatives as interpreters if staff members did not speak a language of a patient, which is not considered best practice.
- Staff told us there was a Vietnamese, two Chinese and several Bengali speaking patients who did not speak English and an interpreter was not booked for dialysis sessions. No staff spoke these languages and no other means of communication was put in place.
- We saw that one patient had been assessed on admission as not requiring an interpreter however; we saw that they could not speak fluent English and the nurse caring for the patient said they could not effectively communicate with each other.
- The commissioning NHS trust provided language translation services that the Centre could access but staff confirmed they did not use the service. The centre did not have a translation policy in place.
- The centre displayed information about going on holiday for patients. Information was available on the providers website identifying where in the world their clinics were, giving patients opportunities to make enquiries.Staff told us that the centre did not have a designated holiday co-ordinator.
- Staff told us the patient has to find the place where they could have dialysis treatment, contact them, and ask them to email the centre with their details. The centre after that point would liaise with the holiday location. One patient told us they were aware of the process but would not know how to find out about where to have treatment.
- Each dialysis chair had a television and the centre provided wireless internet and we saw that patients brought their own activities during treatment.
- We saw one patient who self-needled and their carer recorded observations with the supervision of the nurse. The patient told us they had received training a long time ago at the NHS trust but there was no re-assessment in place. The nurse told us they had not received training for shared care. We asked if there was a support package in place but the manager confirmed there was not. A senior nurse told us the centre had two patients who self-needled.
- The centre had access to a clinical psychologist through the NHS trust if patients needed further support. The centre could also access counselling services through the patient's GP.

- The centre did not provide care during pregnancy due to the higher risk to the patient. These patients were treated at the commissioning NHS trust in collaboration with the local maternity unit.
- We asked for evidence how the centre met the 'Accessible Information Standard'. From 1st August 2016 onwards, all organisations that provide NHS care were legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment, or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services. Senior managers confirmed that they were not meeting this legal standard.

Learning from complaints and concerns

- The centre had a clear process for dealing with complaints and displayed the complaints procedure in the waiting area for patients to see.
- It was the responsibility of the centre manager or deputy manager to ensure all complaints were dealt with within 20 days as per provider policy. The manager told us they responded to the complainant within 72 hours to acknowledge the complaint.
- Overall, the patients we spoke with told us they knew how to complain. One relative told us their non-English speaking parent (a patient) did not know how to complain.
- The manager told us they had an open door policy and patients could complain at any point. Patients we spoke with confirmed this. We saw that patients were confident to approach the manager to raise concerns or queries.
- Patients told us that common issues they raised to the manager were regarding transport delays, access to the entrance from the car park and the temperature of the centre.
- Staff told us that the temperature of the centre was a particular issue for patients receiving dialysis and we saw they worked to adjust the temperature so it was suitable for as many as possible.
- The centre collected data on written and verbal complaints and submitted this monthly as part of performance data to the commissioning NHS trust. During the 12 months prior to the inspection period July 2016 to June 2017, there were two written complaints and one verbal complaint. There were no themes to complaints to date. We saw that action was documented in line with the provider policy to resolve complaints.
- One of the written complaints was regarding a broken call bell. The manager told us that they were awaiting maintenance to fix the problem but had issued an alternative bell for use in the interim.
- We saw in team meeting records that patient complaints and concerns was a set agenda item with a reminder of the complaints process seen in May 2017 meeting minutes.
- Staff told us that the centre responded to patient complaints relating to hot drinks being served in plastic cups by providing hot drinks in ceramic cups. The provider wanted us to be aware they had always served hot drinks in ceramic cups and the other practice related to a previous provider.We saw some patients brought in their own mugs to use.

Are dialysis services well-led?

Leadership and culture of service

- The centre was led by a centre manager (the registered manager) and supported by a deputy centre manager, a regional practice development nurse, a regional manager and the nursing director. The registered manager was a registered nurse with experience in renal nursing and held a formal renal qualification.
- The location of the manager's office meant they were accessible to both patients and staff. The centre displayed the manager's name, photo, and names of the senior staff nurses in the reception area. There was a poster with the photos and contact details for senior managers at Diaverum.
- Patients and staff told us the centre's manager was visible, supportive and approachable.

- The centre manager did not demonstrate an understanding of performance, patient outcomes and audit outcomes. We were not assured that the centre manager had robust oversight of clinical practice at the centre or the required skills to undertake their role.
- The manager was unable to show us evidence their current clinical competencies including aseptic non-touch technique. This meant that the most senior nurse of the centre had not been assessed as competent and therefore unable to assess other staff as competent.
- We saw staff working as a team and that they thanked each other for their help. They knew their roles and responsibilities.
- Both unit staff and commissioning NHS trust staff told us that there was a professional and positive working relationship with effective communication and teamwork across both sites.
- Staff told us that senior managers of Diaverum were approachable and that when they visited the centre, they take the time to ask individual staff how they are.
- On the day of our unannounced visit, we found the centre in our judgement to be 'chaotic' with a lack of co-ordination by the nurse in charge. When we asked who the nurse in charge was, it varied depending on which nurse we asked. The registered manager was due to commence the shift at 4pm but was delayed and arrived at 6.20pm, which meant another nurse worked over their hours to cover. We found that the twilight shift patients were delayed in connection for their treatment. We saw that the transport driver was waiting for staff to disconnect a patient for over 30 minutes and therefore caused a delay in transporting patients home.
- We observed that all staff were approachable, friendly and hard working to deliver patient care. Patient feedback supported this.
- We saw that nurses and health care assistants worked well as a team. They were all aware of their roles and responsibilities and supported one another during busier periods to deliver patient care.
- We found that there was no culture or focus on improving the safety and quality of patient care. The centre did not look outwards or have strong leadership to seek and adopt a learning culture.

Vision and strategy for this core service

- There was an organisational vision, developed by the provider, which was to be "the first choice in renal care". This vision was supported by three organisational values: competent, inspiring and passionate and an overarching mission to "improve the quality of life for renal patients." The centre displayed the vision and values in the manager's office.
- A strategy for achieving the organisation's mission included; focussing on improving the quality of life for patients, implementing patient care coordination in clinics, pursuing operational efficiency, increasing the number of clinics and being a great place to work.
- Staff told us that the company's vision and strategy was to improve patient's quality of life and increase the number of centres.

Governance, risk management and quality measurement

- The governance framework at a location level consisted of the monthly quality assurance (QA) meetings with the multi-disciplinary team. The registered manager and consultant nephrologists from the commissioning NHS trust were the leads for governance and quality monitoring at this centre.
- We saw quality assurance meeting minutes for each month January to June 2017 and found although there was a detailed agenda, they lacked detail to evidence to show the discussions held and actions to improve care.
- The organisation had systems in place for quality assurance and clinical governance that included; risk assessments, auditing and monitoring, training and development and work force planning. However, we found that locally, governance and risk management processes were not effective. There were inconsistencies between what the centre manager told us and what we found, which suggested the

manager did not have adequate oversight of the centre. For example, poorly completed risk assessments, poor hand hygiene and incorrect aseptic non-touch technique.

- We saw in that in three consecutive months of quality assurance meeting minutes (January to June 2017) that there were 30 incidences of changed dialysis times due to 'swapping of shifts' or 'machine problems'. There was no differentiation of which one and therefore this was a missed opportunity to learn and improve the service for patients. There was no detail in meeting minutes to identify reasons and actions taken to improve.
- There were regular managers meetings between the managers of the different renal centres within the local area. They discussed issues and centres that were performing well.
- We were not assured there were effective arrangements in place for always identifying, recording and managing risks. Our concerns identified during the inspection had not been identified on the risk register nor did the centre manager have an awareness of our findings. The manager was unable to describe risks to the service, such as incomplete nursing competencies and there were no location specific risks on the risk register. The area manager confirmed there were no centre specific risks on the risk register.
- We reviewed eight root cause analysis reports and found that there was an inconsistent approach, no clear root cause identified and a lack of governance oversight locally and corporately. Investigations lacked sufficient detail to understand the process.
- Staff did not complete root cause analysis and quality improvement action plans in line with provider policies. The manager had not received formal training on how to complete root cause analysis and did not understand duty of candour requirements. The manager told us that the nursing director reviewed all incident investigation reports however; we did not see any evidence of this.
- The centre was not following the 'mandatory education and training updates' procedure and had fallen behind with monitoring staff compliance with completion of clinical competencies.
- Managers audited dialysis records, prescription delivery, hand hygiene, care of central venous catheters and needle taping monthly and infection control every three months. However, we found several issues to suggest that audit processes were ineffective to make improvements.
- Collectively, the issues we found raised many patient safety concerns. The centre did not follow a consistent or robust governance framework and there was little evidence to show the centre strived to improve quality and safety.
- The centre was non-compliant with NHS England requirements relating to the NHS Workforce Race Equality Standard (WRES) published in 2016. The WRES is a requirement for organisations, which provide care to NHS patients to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Senior managers confirmed that this data was not formally collected.
- There was no process to meet national legislation in relation to the Accessible Information Standard and this was not on the risk register.

Public and staff engagement

- Diaverum invited patient feedback at each centre twice a year. Results from October 2016 showed an increase in response rate (103 compared to 96 responses) but a slight decrease in the average score from 88% to 87%. Out of 15 UK centres, the centre ranked highest for response rate and came fourth for the average score.
- Five out of nine questions had a decrease in score, three stayed the same and one increased. Eighty-six percent of respondents would recommend the clinic and 89% trusted the clinic team, understood the importance of diet and said staff improved care respectively.
- We saw an action plan following the results of the October 2016 survey, which included appropriate actions to patient comments however, the completion dates were missing and some comments were

repeated in our feedback and our observations. These included uncomfortable chairs, staffing issues, access to dietetic support, poor hand hygiene, patient privacy, waiting times and transport issues.

- The centre displayed patient survey results and accompanying action plan in the waiting area.
- The provider sent out an annual staff survey and developed an action plan based upon results. We saw the 2016 survey results with an average score of 3.95 out of 5 stars from 24 responses (100%). The main positive comments from the survey were positive teamwork and the care they provide to their patients.
- The staff survey strongly showed that staff wanted designated time to complete training and development. Other comments included poor connectivity affecting ability to complete electronic records and there was a lack of recognition and support from the senior management team. The lowest scoring question showed that staff did not know the strategy of the company. Although there was an action plan for the results, no completion dates were present.
- The centre did not have patient engagement or transport user groups.
- We found that the centre was not providing appropriate language support for non-English speaking patients and this meant that they were not actively seeking the views and experiences of all patients.

Innovation, improvement and sustainability

- The centre had recycling bins and we saw posters encouraging staff to become 'green champions'.
- Staff told us that Diaverum were encouraging of staff development, particularly to gain a university level renal qualification.
- Post inspection, the provider told us they have a plan to replace all dialysis machines every seven years. We did not see a replacement programme but they told us when budgeting is done annually in August, the age of machines are reviewed and money is allocated the following year to replace any machines requiring replacement.
- The provider had developed a patient phone application called 'd.CARE' to empower patients to take an active role in their health. The app gave patients 24-hour access to their medical data. The tool also included non-medical features to increase the user experience. Patients could rate their general condition, add notes as to why, and crosscheck information against their medical data from previous months. The centre had information leaflets to encourage the use of the app. We did not speak to any patients who were currently using the app.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure governance systems are in place and established effectively in order to assess, monitor, and improve the quality and safety of the services provided to patients. This should include more robust investigations, accurate data collection and an effective risk register.
- The provider must ensure that risks to patients are identified, assessed and monitored consistently. Ensure action plans in assessments and care plans are updated and contain enough detail to enable staff to reduce those risks effectively.
- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to medicines management, infection and prevention control procedures, staff clinical competencies, safeguarding, incident recording and reporting, and the overall governance of the service.
- The provider must ensure its clinical waste bags are labelled in accordance with the Department of Health's Health Technical Memorandum 07-01: Safe management of healthcare waste.
- The provider must take prompt action to ensure a process is put in place so that deteriorating patients can be identified early and managed in line with national guidance.
- The provider must ensure staff receive sepsis training and ensure staff are aware of a nationally recognised sepsis pathway.
- The provider must ensure staff are suitably skilled and competent to carry out their role.
- The provider must review the appropriate level of safeguarding adults and children training required by all staff in relation to their roles and responsibilities.
- The provider must ensure all records with patient identifiable information are stored safely and are not accessible to non-authorised persons.
- The provider must ensure patient dignity is respected at all times.
- The provider must ensure sufficient language support is given to non-English speaking patients to ensure safe care and to ensure informed consent is obtained.
- The provider must ensure processes are in place so patients who have a disability, impairment, or sensory loss are provided with information they can easily read or understand in line with the legal requirement of the Accessible Information Standard.

Action the provider SHOULD take to improve

- The provider should ensure compliance with duty of candour requirements.
- The provider should consider reviewing the effectiveness of audits such as infection prevention and control practice and documentation compliance.
- The provider should liaise with the external patient transport agency to improve collection times and therefore to meet NICE quality standards and to ensure staff are not working beyond their shift end time.
- The provider must ensure processes and appropriate training are in place to ensure compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The provider should consider arranging an active patient user group.
- The provider should ensure that all patients are given enough support and opportunity to be fully involved in the planning of their own care.
- The centre should make available written information in languages to meet the needs of all patients and actively seek the views and experiences of non-English speaking patients.
- The provider should ensure all appropriate action is taken to engage with the property owner regarding building access and parking facilities in a timely manner.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13(2) **How the regulation was not being met:** • Policies and procedures were not clear regarding the required level of adult and children safeguarding training for all staff. • Staff did not receive any training for safeguarding children despite children attending the centre's waiting area. • There was no clear procedure for children attending the centre.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and equipment 13(2) All premises and equipment used by the service provider must be suitable for the purpose for which they are being used and properly used. **How the regulation was not being met:** Clinical waste bags were not labelled in accordance with the Department of Health's Health Technical Memorandum 07-01: Safe management of healthcare waste.