Hull NHS Dialysis Unit

Quality Report

Hull Royal Infirmary
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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

Summary of findings

Letter from the Chief Inspector of Hospitals

Since 2008 Fresenius Medical Care Renal Services Ltd has provided haemodialysis for stable patients with end stage renal disease or failure at Hull NHS Dialysis Unit. The service is located within the Hull Royal Infirmary site. Hull NHS Dialysis Unit takes referrals from Hull and East Yorkshire NHS trust. It is a 39 station dialysis unit, with five side isolation rooms. Hull and East Yorkshire NHS trust contracted the unit to provide renal dialysis to NHS patients in April 2016. Fresenius Medical Care Renal Services Ltd also provided care and around 200 'in-reach' dialysis treatments to renal patients in a four bed bay inpatient area located in the nephrology ward of the Hull Royal Infirmary. In addition five patients are supported to receive home dialysis by the service, by the 'home dialysis' nurse who is based at Hull unit. The home dialysis service was not within the scope of the inspection.

We inspected this service using our comprehensive inspection methodology. We carried out an announced comprehensive inspection on 10 May 2017 and an unannounced inspection on 22 May 2017.

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

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

Services we do not rate

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

We found the following areas of good practice:

- We found that the unit was visibly clean, arrangements for infection prevention and control were in place and there was low incidence of infection. The environment met standards for dialysis units and equipment maintenance arrangements were robust. Staff were aware of their responsibilities in keeping the patient safe from harm and mandatory training was completed by all staff.
- Effective arrangements and support from a dietitian and social worker were in place and the individual needs of dialysis patients was a priority. There was effective multidisciplinary team (MDT) working and good collaboration with the unit consultant and the NHS trust renal team which helped support patients' treatment and positive outcomes.
- There was a good range of comprehensive policies in place to support staff; these were accessible and understood by staff we spoke with. Policies were based on national guidance and an audit programme was in place to monitor compliance. Key performance indicators for 2016/17 showed comparable performance against other Fresenius units nationally.
- Staff described the Fresenius incident reporting system and were aware of changes being made to transfer from a paper to an electronic system. Staff in the Hull Dialysis Unit recorded incidents in the Hull NHS electronic system as well as using the Fresenius Medical care systems. Staff reported incidents as clinical, non-clinical and documented additional information thoroughly in Treatment Variance Reports (TVR's).
- We observed staff working with competence and confidence and the training available in the unit supported all staff to perform their role well. Nursing staff were experienced and qualified in renal dialysis. Over 30% of nursing staff had a specialist renal qualification. One hundred percent of staff had received induction and appraisal at the time of inspection.

Summary of findings

- We observed that consent processes were in place and documentation was accurate. Easy access to complex patient information in the unit and across the NHS trust supported treatment and care of patients in the unit.
- Effective processes were in place for the provision of medicines. These were stored and administered in line with guidance and staff completed competencies annually to ensure they continued to administer medicines correctly.
- We observed a caring and compassionate approach taken by the nursing staff and named nurses during inspection.
- Nurse staffing levels were maintained in line with national guidance to ensure patient safety. There was use of a specialist nurse agency when required and block booking of agency nursing staff had improved consistency of staff working in the unit since 2015/16. Staff provided additional cover during peaks in activity or during staff shortage.
- Nursing staff had direct access to the consultant responsible for patients care.
- Patients were supported with self-care opportunities and a comprehensive patient education process was in place. Holiday dialysis for patients is arranged to provide continuity of treatment and support the wellbeing of patients.
- The unit provided a local service, with flexible appointment system for patients requiring dialysis and the service contract obligations were clear to senior staff. We observed a responsive approach to arranging appointments with the needs of the patient at the centre. Arrangements for contingency for appointments in an emergency was in place.
- The unit had detailed local risk assessments in place and we observed a new operational risk register; this was being developed by the national senior team and would be reviewed through the governance committee structure prior to implementation and training to unit staff.
- Activity was monitored closely for non-attendances of patients. The team worked flexibly to accommodate patients individual appointment needs to avoid non-attendance.
- Staff had an informal process for identification (ID) of patients as patients were well known to staff. We observed nurses asking patients for ID prior and during treatment and administration of medicines on both visits. However there should be greater assurance, through policy and audit, that all staff working in the unit consistently ID patients to ensure safe identification of patients, with particular regard to safe administration of medicines and treatment by staff.
- Local leadership shared lessons from incidents and complaints with the team and we saw good evidence of local leadership. Nursing staff and patients we spoke were consistently positive about the clinic manager overall and the open approach to leadership and governance in the unit.
- Employee surveys were performed annually and action plans supported the team to address any issues where required. Staff morale was good in the unit at the time of inspection and there was an improved picture over all survey results in 2016/17.
- Patient satisfaction surveys showed positive results and we spoke with patients who expressed high regard for the care and treatment they received from the team in the unit.

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

- The grading of moderate harm from incidents was not clearly described by staff. It was also not clear on the reporting forms. This would not support a clear trigger for the requirements of the duty of candour regulation. We did however see an example of the application of duty of candour for an incident that had been graded by senior staff in the Hull unit as moderate.

Summary of findings

- The classification of clinical and non-clinical incidents did not reflect the reported events, for example seven incidents of patients falling in the unit were reported under 'non-clinical' incidents, to the health and safety manager, rather than the chief nurse.
- We observed one nurse and one dialysis assistant not strictly follow IPC policy in regard to aseptic non touch technique (ANTT) and this was reported to the clinic manager.
- We listened to concerns from patients and staff around the arrangements for transport in the unit. Patients were subject to inconsistent waiting times before and after dialysis treatment which had an impact the quality of service delivered to patients who attended three times a week for treatment. The unit monitored the delays and met with the provider through, however improvement for patients experience was yet to be achieved.
- We observed the waiting room to be overcrowded during peak times of activity, especially at session handover times. Patients in wheelchairs were particularly affected as there was limited space for the numbers of patients needing to access the unit. When delays with transport occurred this exacerbated the overcrowding in the waiting area, which was otherwise adequate for the needs of the size of the unit.
- It was noted that the access code to the main unit from the waiting room had been restricted to a limited number of staff to improve security and prevent patients or visitors having unsupervised access. The majority of nursing staff did not have access to the code. A system needed to be in place where all staff had easy security access to the main unit through the main doors, to reduce the risk of not being able to get access in an emergency situation.
- Staff and patients we spoke with complained of a lack of control over the temperature of the unit, with patients having consistent concerns of being too cold and staff being unable to regulate or access the system to regulate temperature control in the unit.
- Documentation was inconsistently organised and not all completed in line with the Nurse and Midwifery Council (NMC) Code of Professional Conduct in relation to record keeping. All entries were legible. This was reported to the deputy clinic manager and clinic manager for immediate action. There was some improvement during the unannounced inspection to the overall organisation of the patient folders, however we observed some care record sheets had not been signed by staff.
- Observations were recorded regularly to assess the patient's condition, before during and after dialysis. We noted however that the unit did not use a recognised national early warning score (NEWS) system to support the recognition of the deteriorating patient. There was inconsistent recording of temperature and respiratory rate as directed by the care plan.
- We did not observe a system for reporting of pain assessment for patients in the unit who receive dialysis treatment.
- Unit staff did not have access to a designated member of Fresenius staff who had appropriate level 4 child safeguarding training for advice. This training requirement was also not included in the Fresenius policy. However we did see examples of adult safeguarding practice that had been thoroughly managed by the team.
- The arrangements for The Workforce Race Equality Standard (WRES) were not embedded in the unit.

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. Details are at the end of the report.

Ellen Armistead. Deputy Chief Inspector of Hospitals (North)

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 Hull NHS Dialysis Unit

The service provides haemodialysis treatment to adults. Hull NHS Dialysis Unit opened in 2008 and is operated by Fresenius Medical Care Renal Services Ltd and primarily serves the communities of Northern Lincolnshire, with occasional access to services for people who are referred for holiday dialysis.

The unit's registered manager had been in post since January 2011 who was available on the days of inspection. Fresenius Medical Care Renal Services Ltd UK has a nominated individual for this location. The unit is registered for the following activities;

- Treatment of disease disorder or injury.

The CQC have inspected the location previously and there were no outstanding requirement notices or enforcement associated with this service at the time of the comprehensive inspection in May 2017.

Our inspection team

Four CQC inspectors carried out the inspection. The inspection team included specialist advisors with expertise in dialysis services. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspection.

Information about Hull NHS Dialysis Unit

The Fresenius dialysis unit in Hull is a 'stand-alone' building located on the site of Hull Royal Infirmary. It provides treatment and care to adults in a 39 station unit and the service runs over six days, Monday to Saturday. There are no overnight facilities in the unit, however the unit staff provide around 200 in-reach dialysis and plasma exchange treatments a week in a dedicated bay of the nephrology ward. There is also an on-call emergency dialysis service overnight provided by experienced unit nursing staff to the NHS trust. In addition there is a home dialysis service provided by the unit and this had five patients currently accessing the services. This home dialysis service was not within the scope of this inspection.

There are three treatment sessions for patients dialysed on Monday, Wednesday and Friday with 36 patients dialysed in the morning, 36 in the afternoon and 28 patients receiving treatment on a twilight session. There are two treatment sessions for patients dialysed on Tuesday, Thursday & Saturday, with approximately 38 patients dialysed in the morning and 36 in the afternoon.

The usual times for dialysing patients are 6.30 hrs, 11.45 hrs and 17.15 hrs (Monday Wednesday and Friday) and 8.00 hrs and 13.15 hrs (Tuesday, Thursday and Saturday). The dialysis unit opens 30 mins before the first appointment.

The unit is large and spacious and has 40 beds in total, with 39 in use. There are five isolation rooms and five larger bay areas. The building is modern in design with ample storage, office space and treatment rooms. Access to the unit is on the ground floor with disabled ramp access and there is secure car park directly outside.

The unit takes referrals from the Hull and East Yorkshire NHS trust. This NHS trust provides the renal multidisciplinary team (MDT), with a consultant

Summary of this inspection

nephrologist visiting the dialysis unit three times a week for patient clinics and in addition for six separate monthly MDT meetings where patient outcomes and blood results are reviewed.

Hull is the largest Fresenius Medical Care Dialysis Unit with approximately 10% share of the overall business. There are on average 2,400 dialysis treatment sessions delivered a month. The service delivered 29,075 haemodialysis sessions in 2016/17. There were 179 people in total using the service. The unit does not provide peritoneal dialysis or services to children.

During the inspection of Hull NHS Dialysis unit we spoke with 12 staff including, registered nurses, dialysis assistants, clinic managers and consultant and reception staff. We spoke with ten patients and we reviewed ten 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. The service has been inspected previously which found that the service was meeting all standards of quality and safety it was inspected against. The service had received an NHS England peer review in July 2016.

Activity (April 2016 to April 2017)

- In the reporting period April 2016 to April 2017, there were on average 2,400 dialysis sessions delivered every month.
- The service delivered sessions in the same reporting period, with a total in 2016/17 of 29,075 and 13,279 sessions delivered to adults aged 18-65 and 15,796 sessions to adults aged over 65.
- Previous to the inspection visit 179 people were using the service, 90 aged 18-65 and 89 above the age of 65.

Staffing

The unit employed 29.2 Whole Time Equivalent (WTE) registered nurses, 18.2 WTE dialysis assistants and one receptionist. As part of the contract dietitians, clinicians and specialist nurses were available to support patients. The unit did not employee any medical staff. Three consultant nephrologist staff attend the unit weekly for clinics and monthly for MDT meetings. Nursing and administrative staff had been mostly transferred from NHS contracts to Fresenius in 2016 as part of the new contract for services. As part of the new contract in 2016 the nursing establishment was provided for the in-reach service.

Track record on safety (April 2016 to April 2017)

- There had been no reported never events.
- There were no serious incidents in the reporting period 2016/17.
- Forty four incidents were reported since January 2016.
- Seven patient deaths had been notified to CQC in the reporting period. Two were in-service patient deaths with cardiac arrests having occurred on the unit.
- There were seven recorded falls in the unit.
- There were no reported incidences of healthcare acquired Methicillin-resistant Staphylococcus Aureus (MRSA), with five reported Methicillin-sensitive staphylococcus aureus (MSSA), and two infections reported as 'other bacteraemia'.
- There were ten notifications made the Care Quality Commission (CQC) in the 12 months prior to inspection. Seven deaths, two safeguarding referrals and one security incident that had been escalated to the police service.
- There were 15 written complaints received during the reporting period by the unit, with eight of these upheld as part of the formal complaints process. The unit did not record compliments.

Services accredited by a national body:

- The unit is accredited against ISO 9001 and 14001 quality management system and are therefore subject to regular audit and review.

Services provided at the hospital under service level agreement:

- Counselling service.
- Clinical and non-clinical domestic waste removal.
- Cleaning and domestic services
- Catering service for patient refreshments
- Dietetics

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 found the following areas of good practice:

- We found that the unit was visibly clean, arrangements for infection and prevention were in place and there was a low incidence of serious infection.
- The environment met standards for dialysis clinics and equipment maintenance arrangements were robust.
- Staff were aware of their responsibilities in keeping patients safe from harm. Staff could describe the incident reporting system and staff were positive about the reporting culture in the unit.
- Nurse staffing levels were maintained in line with national guidance.
- Mandatory training was completed by all staff.
- Effective processes were in place for the provision of medicines. These were stored and administered in line with guidance and staff completed competencies annually to ensure they continued to administer medicines correctly.
- Risk assessments were carried out for patients and staff were aware of escalation policies and processes for transfer of patients to NHS hospitals.
- We saw examples of staff providing thorough safeguarding support for patients in their care.
- Arrangements for contingency in an emergency were in place.

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

- The grading of harm from incidents was not clearly described by staff. It was also not clear on the reporting forms. This would not support a clear trigger for the requirements of the duty of candour regulation. However we did see examples of the application of the duty of candour for two incidents that had been categorised as moderate by senior staff.
- The classification of clinical and non-clinical incidents did not reflect the reported events, for example seven patients falling in the clinic were reported under 'non-clinical' incidents, to the health and safety manager, rather than the chief nurse.
- One nurse and one dialysis assistant observed did not strictly follow IPC policy in regard to aseptic non touch technique (ANTT) and this was reported to the clinic manager.
- It was observed that the access code to the main unit from the waiting room had been restricted to a limited number of staff to

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improve security and prevent patients or visitors having unsupervised access. A system needed to be in place were all staff had easy security access to the main unit through the main doors, to reduce the risk of not being able to get access in an emergency situation.
- Unit staff did not have access to a designated member of Fresenius staff who had appropriate level 4 child safeguarding training for advice.
- We noted that the unit did not use a recognised national early warning score (NEWS) system to support the recognition of the deteriorating patient. There was inconsistent recording of temperature and no recording of respiratory rate as directed by the care plan.
- Staff did not use a recognised sepsis assessment tool and had not received any training or guidance on the management of patients with sepsis.
- Record keeping was inconsistent and care records were not organised well in the patient folders. We noted that these findings were consistent with unit audit data and that action had not resolved the issues at the time of inspection.

Are services effective?

We found the following areas of good practice:

- There was effective multidisciplinary working and collaboration with the NHS trust renal team helped support patients treatment and positive outcomes.
- There was a good range of comprehensive policies in place to support staff; these were accessible and understood by staff we spoke with. Policies were based on national guidance and an audit programme was in place to monitor compliance.
- Activity was monitored closely for non-attendances of patients and the team worked flexibly to accommodate patients individual appointment needs. Any unavoidable transfers to the NHS trust renal unit were appropriately managed.
- We observed staff working with competence and confidence and the training available in the unit supported all staff to perform their role well. Nursing staff were experienced and qualified in renal dialysis.
- Consent processes were in place, policy was robust and documentation was accurate.

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

- We did not observe a system for reporting of pain assessment for patients in the unit who receive dialysis treatment.

Summary of this inspection

Are services caring?

We found the following areas of good practice:

- We observed a caring and compassionate approach taken by the nursing staff, MDT and named nurses during inspection.
- Patients we spoke with knew their named nurse and described good relationships with the nursing staff. Patients told us that the 'were well looked after, couldn't be better looked after' 'they're first class, all of them'.
- Patients spoke highly of the team overall with specific references to individual named nurses, dialysis assistants and the clinic manager.

Are services responsive?

We found the following areas of good practice:

- The unit provided a local service, with a flexible appointment system for patients requiring dialysis. We observed a responsive approach to arranging appointments. These were arranged with the needs of the patient at the centre, taking into account their work and social commitments.
- Senior staff were committed to attending business and clinical meetings at the NHS trust to manage the achievement of contract obligations and key performance indicators.

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

- We listened to concerns from patients and staff around the arrangements for transport in the unit. Patients were subject to inconsistent waiting times before and after dialysis treatment which had an impact on delays and quality of service delivered to patients who attended three times a week for treatment. The unit monitored the delays, and had met with the transport provider, however improvement for patients experience was yet to be achieved.
- We observed the waiting room to be overcrowded during peak times of activity, especially at session handover times. Patients in wheelchairs were particularly affected as there was limited space for patients needing to access the unit. When delays with transport occurred this created overcrowding in the waiting area.
- Some staff and patients we spoke with complained of a lack of control over the temperature of the unit, with patients having consistent concerns of being too cold and staff being unable to regulate or access the system to regulate temperature control in the unit.

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Are services well-led?

We found the following areas of good practice:

- There was a clear leadership structure in the Fresenius Medical Care organisation and that was applied regionally to the Hull NHS Dialysis unit. The clinic manager was highly regarded by the team and staff morale was good at the time of inspection.
- Leadership was reflected in three nominated lead consultants from local NHS renal services, a regional business manager, area head nurse and clinic manager, who was based in the unit for 100% of the job role. The clinic manager liaised closely with the local NHS trust.
- We observed positive support in the unit team and nursing staff spoke highly of one another. This was reflected in our observations of their teamwork and communication and in the employee survey responses.
- The Fresenius governance framework was detailed and supported with a range of comprehensive policies, a structured committee and meeting system, a strategy and vision that directed the team to deliver 'the right care to the right patient at the right time'. Senior staff were conversant with these elements of their service and senior business and governance meetings were consistently attended.
- The implementation of the new local risk register was making good progress at the time of inspection. This work should continue to be embedded in practice.
- The clinic manager held regular team meetings that were well attended; minutes were recorded and demonstrated examples of sharing of learning and good practice.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- 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. Patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. During the reporting period, April 2016 to April 2017 there had been no never events reported.
- Serious incidents are incidents that require further investigation and reporting. There were no serious incidents reported within the unit during the reporting period April 2016 to April 2017.
- The unit had a policy for the reporting of incidents, near misses and adverse events. Staff we spoke with could explain the process for reporting incidents on the electronic clinical incident report form. Staff reported that the incident reporting culture was open and reporting was encouraged. Staff described, and we observed, examples of clinical and non-clinical incidents, and patient variance reports. Clinic managers reviewed each incident and treatment variance reports (TVR's) and shared with staff any themes or lessons in bulletins and unit meetings.
- There had been 44 clinical incident reports from January 2016 to January 2017. It was reported that there had been 3,611 TVR's in the same timescale.
- The service was implementing a new electronic incident reporting system in pilot sites to support ongoing improvement and data analyses of incidents. We did not observe this at the time of inspection; however staff in the Hull Dialysis Unit also had experience of using the electronic incident reporting system for Hull NHS trust.
- We reviewed one incident that had been graded as moderate harm by senior staff in the unit and had triggered a duty of candour response. We saw evidence of investigation, root case analyses and learning being shared with the team after the incident. The patient received a verbal and written apology and was offered a meeting with senior staff and consultants to discuss concerns further.
- We spoke with staff and there was a mixed account of understanding the grading of moderate and serious harm incidents. Subsequently there was inconsistent understanding of the application of the duty of candour regulation. Staff had received training for duty of candour and it was, however clear that they valued being open and transparent with patients, offering an apology when things went wrong in healthcare and treatment.
- The duty of candour is a regulatory duty; Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) introduced in November 2014. This Regulation requires the healthcare provider to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology in cases of serious and moderate harm.
- The unit monitored performance against patient harms, they reported against the number of falls that occurred on the unit. In the reporting period, April 2016 to April 2017 there had been seven reported patient falls on the unit. Falls however were reported as non-clinical incidents which is not an accurate assessment.

- We were told by senior staff that clinical incidents are monitored nationally with unit updates and learning bulletins distributed by the chief nurse to support lessons learned across the organisation. We saw evidence of sharing of incidents in the unit displays of information, minutes of meetings and in discussions with staff. Staff we spoke with gave us good examples of changes in practice as part of lessons learnt from incidents. We saw new systems in place for critical checks of equipment and tracking numbers for dialysis stations and patients to reduce the risk of infection.

Mandatory training

- All new staff undergo induction which includes mandatory training in safety systems, processes and practices linked to the care and management of patients. Preceptors train new recruits and record training in their integrated competence document. This document is designed to follow key stages; Induction, fundamental skills, advancing skills and management skills. Mandatory training was delivered as both face-to-face training sessions or via e-learning programmes.
- We observed 13 staff records that gave evidence of up to date training records for registered nurses and dialysis assistants, attendance and sign off by senior nursing staff and mentors was evident. Staff records were well organised and care had been taken to demonstrate professional development by the individual nurse and the mentor.
- We observed the electronic management system for training that was being upgraded and improved, it was well organised and senior staff could review and monitor individual staff training needs and were given prompts around the time for mandatory update. The tool included all aspects of training and competence sign off including medical devices.
- Staff in the unit were reported as 100% updated with mandatory training for 2016/17. Staff we spoke with told us access and quality of training was very good. We reviewed unit training reports and individual training records as evidence of 100% compliance.
- The mandatory training programme had a safety emphasis and included eLearning and classroom based training sessions. The programme included prevention of healthcare associated infections, waste, medicines and records management, and reporting of incidents. Senior staff attended training for root cause analysis and management of emergencies.
- All staff attended basic life support training and nursing rotas would indicate each shift where a member of the team had life support qualifications and training. Scenario training was carried out every 6 months.
- Mandatory training records for agency nursing staff are monitored by the Flexibank administrators to ensure training is up to date. If training lapses the member of staff is suspended from shift allocation until evidence of completion is received. Flexibank training records are retained centrally.

Safeguarding

- There were systems and processes in place to keep vulnerable patients safe. All staff we spoke with were aware of their roles and responsibilities for escalation of any safeguarding concerns. We observed contact details for the safeguarding leads with points of contact at the nurses station.
- The clinic manager was the designated safeguarding co-ordinator and they acted as the adult safeguarding lead for the unit. The policy directed staff to report any safeguarding issues to the chief nurse and also into the NHS trust safeguarding team. Staff we spoke with gave us examples of escalation of two adult safeguarding concerns raised in 2016, in both cases the patients were well known to the team and the appropriate process and support was put into place with clear documentation of the concerns and actions.
- We reviewed staff training records and saw that 100% of staff had received safeguarding adults training and safeguarding children level 2. The clinic manager had also trained to level 3 safeguarding for children. There was no local designated staff who had appropriate level 4 child safeguarding training, as detailed in the safeguarding children and young people: roles and competences for healthcare staff Intercollegiate document March 2014. However staff could access a lead with level 4 training in the NHS trust.
- The unit had a policy for safeguarding adults and children, which detailed training requirements and

areas when to raise a safeguarding concern. This document did not make reference to female genital mutilation (FGM) but we noted that staff had attended e-learning training in 2017 for increasing knowledge and awareness of radicalisation, which included the principles of PREVENT training programmes for staff to safeguard people and communities from the threat of terrorism, including FGM.

Cleanliness, infection control and hygiene

- There were comprehensive Fresenius infection prevention and control (IPC) policies in place with standards audited on an ongoing basis both at unit, central and external level. Cleaning, decontamination and clinical practice was observed to be compliant with policy during inspection, to include the technique for connecting and disconnecting patients to dialysis machines.
- The Fresenius chief nurse was the lead for IPC and had overall responsibility for providing infection prevention and control advice.
- There were no reported incidences of hospital acquired Methicillin-resistant Staphylococcus Aureus (MRSA), with five reported Methicillin-sensitive staphylococcus aureus (MSSA), and two infections reported as 'other bacteraemia'. The senior nursing team had conducted a root cause analysis following the bacteraemia incidents and this had led to an escalated programme of training for hand hygiene and IPC.
- We observed aseptic non touch technique (ANTT) amongst staff that was in line with policy and good practice when staff were connecting or disconnecting patients to dialysis machines. Aseptic techniques are methods designed to prevent contamination from microorganisms. They involve actions to minimise the risks of infections. However we observed one DA and one RN with practice that was not fully compliant with policy and training. This was feedback to the manager of the unit for action.
- Hand hygiene audit data we reviewed, was detailed, open and transparent for the reporting period. Results, which were on display, showed greater than the 90% compliance target for the reporting period October – December 2016. This was an improving picture and had previously been reported in June 2016 as 60%. The action plans were also thorough. The staff we spoke with told us that the improving stability in the team had improved the results alongside additional training and focus on repeat audit. Alcohol hand sanitiser was available at every dialysis station. We observed staff perform hand hygiene at appropriate times and all staff wore personal protective equipment (PPE) whilst performing clinical duties, including aprons and eye visors.
- Protocols were in place to screen patients returning from holiday in regions identified as high risk of infection for blood borne viruses. Screening for MRSA and methicillin sensitive staphylococcus aureus (MSSA) was also carried out.
- Procedures were in place to assess carriers of blood borne virus (BBV) such as hepatitis B and C, staff were able to describe the correct isolation requirements and actions required to mitigate the risk of BBV cross infection.
- Staff had access to five isolation rooms for nursing patients with a known or suspected infection.
- Staff were knowledgeable about the surveillance of water systems for presence of bacteria, and were able to explain the procedures required to test water samples. Staff were able to explain the procedure if a water sample came back as contaminated.
- Records we reviewed showed that staff carried out the correct procedures in regards to flushing of water outlets to prevent contamination of the water supply.
- Staff had access to clinical and non-clinical waste facilities; staff were able to dispose of waste including sharps, at the point of use. Staff were observed to use appropriate segregation of waste and the unit had targets for waste management, which were being met. The 10 sharps disposal bins inspected were assembled correctly and used as per policy.
- We observed staff decontamination of clinical equipment in between patient use. Staff were observed cleaning equipment as per policy. Equipment we inspected was visibly clean in all cases.
- Staff received training on infection, prevention and control through a range of methods, face to face and through e-Learning. IPC training compliance rates for

the unit were 100%.Staff were assessed annually by the IPC coordinator, this was the clinic manager at Hull NHS Dialysis unit. We observed staff competence documents to be up to date.

- The clinic manager had overall responsibility of cleaning by domestic staff. We observed the cleaning schedules and there was a good system in place. Domestic staff cleaned the unit and there was a communication system to inform the domestic of any increased infection risk or need for deep cleans to isolation rooms. We noted that the unit had disposable curtains around each bed space. These were all dated and replacement dates were clearly written on the curtain label.

Environment and equipment

- The unit was accessed via a single entrance and via an intercom system to reception as a security measure.Entrance to the main treatment area from the main waiting area was via a digital lock and all unit and storerooms were also kept locked. The waiting area also led to an upstairs suite of offices, staff rooms, changing areas and storage which was also accessed securely.
- There was good access, parking just outside the premises and disabled bays near to the entrance. The unit was accessed by patients and visitors by either steps or a ramp. The waiting area was adequate for the size of the unit, however inspectors observed patients, staff and visitors were restricted and the waiting area was overcrowded. This was noted in particular at the beginning and end of session times and it was observed that there was not sufficient dedicated space to accommodate the number of patients in wheelchairs, waiting to go home after treatment. We raised this with the clinic manager at the time of inspection.
- The unit was spacious, had natural light and appeared warm and welcoming for patients and visitors on the day of inspection. The unit had 39 dialysis stations with five of these being single isolation rooms. There were two nurses stations across the unit which afforded staff easy observation of patients across a large area.
- Maintenance of dialysis machines and chairs are scheduled and monitored using a maintenance and calibration plan, this detailed the dialysis machines by model type, serial number along with the scheduled date of maintenance. A similar plan existed for dialysis chairs and other clinical equipment for example; patient thermometers, blood pressure monitors and patient scales.
- Technicians maintain the dialysis machines, chairs, beds and water treatment plant with support from dialysis assistants. Records were maintained relating to the maintenance and calibration of all equipment used at the unit, from records we reviewed this provided assurance that equipment used was calibrated and maintained appropriately.
- Staff we spoke with knew how to log a call with the help desk regarding any facilities issues. The help desk allocated a job number and priority level to the call and requested a contractor to attend the unit. We saw evidence of this system in the communication diary where staff had documented minor faults for logging in the system and updated progress against any issues. Staff we spoke with told us the system worked well.
- The resuscitation trolley and equipment we checked was stocked as per checklist, there was a consistent system for checking in place and evidence of staff sign off for the previous three months. This included audit checks from the NHS trust resuscitation officer. All necessary equipment was available and easy to access in the main unit. The suction system and defibrillator was in working order and had been checked on a maintenance programme. Oxygen was available both on the trolley, and stored safely in a locked area outside of the unit. All single use items were found to be in date and stock levels were good.
- Staff we spoke with said there were adequate stocks of equipment and we saw evidence of appropriate stock rotation. Specific members of staff were given responsibility for stores and equipment ordering and this system was observed to be effective.
- We observed that some of the patients had pressure relieving additional mattresses that they could have for comfort if they chose to or if they were assessed as being at greater risk of developing a pressure ulcer. The mattresses were checked regularly and this was

evident on the cleaning checklist and in our observations. The dialysis treatment chairs were in good condition and patients reported them as comfortable.

- We observed appropriate management of alarm systems on equipment to alert staff of any potential risk, disconnection from dialysis or deterioration of patient condition. Use of alarms in the unit was understood by nursing staff and all staff had achieved competencies around understanding parameters and use of equipment. We observed nurses respond to alarms promptly. We reviewed sign off for competency and found reports to be up to date and as per policy. Patients did not cancel their own alarms during observation on the inspection.

Medicines

- The unit did not store any controlled drugs. Lead responsibility for the safe and secure handling and control of medicines was the clinic manager.
- The nurse in charge, usually the team leader or more senior nursing staff would be allocated duties as key holder for the medicines cabinet on a day to day basis.
- Medicines were stored securely in a locked cupboard.
- Medicines requiring refrigeration were stored in a fridge, which was locked and the temperatures were checked daily. Staff were aware of the action to take if the temperature recorded was not within the appropriate range.
- The nurses liaised with the local NHS trust pharmacy for additional advice relating to dialysis drugs. In addition, Fresenius staff had access to a provider pharmacist at head office should this be required.
- There were a small number of medicines routinely used for dialysis, such as anti-coagulation and intravenous fluids. The unit also had a small stock of regular medicines such as EPO (erythropoietin – a subcutaneous injection required by renal patients to help with red blood cell production). Stock medicines were ordered from Hull Royal Infirmary and Fresenius.
- The patient's consultant prescribed all medicines required for dialysis. Staff we spoke with said that there was regular review and good access to the Consultant for prescription changes. Therefore, there was minimal need to access out of hours support; however, the nursing staff could contact the local NHS trust doctor on call for any urgent prescription changes or advice.
- Emergency medicines were readily available and they were found to be in date in a sealed box on the bottom shelf of the resuscitation trolley. This was agreed locally and in line with Fresenius policy.
- We looked at the prescription and medicine administration records for five patients on the unit. These records were fully completed and were clear and legible**.**
- We observed staff asking patients to confirm identity prior and during treatment and administration of medicines in the unit. Nursing staff must always adhere to Nursing and Midwifery Council (NMC) standards for medicines management this includes being certain of the patients identity, checking allergy status and expiry date. A two nurse check at the bedside was also observed as part of the process.
- Medicine changes were discussed at the patient's multidisciplinary meeting and shared with the patient and the patients GP.
- There was an organisational medicines management policy; however, this did not include identification of patients prior to administration of medicines or arrangements for medicines audit.

Records

- The Fresenius Medical Care patient treatment database automatically transferred patient data into the clinical data base of the NHS trust where the patient is under a renal consultant. Staff we spoke with described this process as working well.
- We reviewed ten sets of patient records and saw entries of physiological observations made pre, middle and post dialysis as well as entries made for any variances during the period of dialysis. These entries were made at appropriate times in relation to the patient pathway.
- Documentation was inconsistently organised and not all completed in line with the NMC Code of Professional Conduct in relation to record keeping. All entries were legible. This was reported to the deputy

clinic manager and clinic manager for immediate action. There was some improvement during the unannounced inspection to the overall organisation of the patient folders, however we observed some care record sheets were not identifiable and had not been signed by the nursing staff in all cases.

- There was evidence of documentation audit and we reviewed three months of results for January, April and May 2016 which were recorded across each team, blue, red and green. There was evidence of inconsistent completion and actions were timely and clearly identified with responsibility for resolving omissions or issues. However we found similar issues during inspection as in the unit audit. The main issues were around non update of individual care planning, gaps in records and inconsistent risk assessments for patients.
- We observed patient records to be stored securely with respect for patient confidentiality during inspection. There were no information governance breaches.
- Named nurses can contact the GP services by telephone if they feel the patients' needs to be referred for extra care i.e. chiropody, or wound dressing clinics and this was documented in the care record.
- Each registered nurse held a caseload of dialysis patients, records we reviewed showed that each registered nurse had approximately 12 patients on their caseload as named nurses. Named nurses were not identifiable in all the records we reviewed. This system required further work to embed the principles described by Fresenius Medical Care and the senior team.
- Patient's needs were assessed and treatment was planned and delivered in line with their individual care plans. There was a comprehensive care pathway system in the care plans we reviewed with records containing a current dialysis prescription, dialysis summary charts and risk assessments, i.e. moving and handling and Waterlow pressure ulcer risk scores. However, we did see inconsistency in the organisation of patient folders and these documents and the completion of all aspects of the records.

Assessing and responding to patient risk

- Only stable patients were dialysed on the unit; if someone was acutely ill with renal problems, they were treated at a main NHS trust hospital. This was to ensure that patients who required additional support received their treatment at the local NHS trust where medical staff were available 24 hours a day. As the unit was a large main hub dialysis unit it did receive referrals from patients at nearby satellite units who were more complex.
- Patients weighed themselves before treatment began. They inserted an electronic card, which identified them, into the electronic walk-on weighing scales. This was to establish any excessive fluid, which had built up in between treatments.
- Observations of vital signs such as blood pressure and pulse were recorded before, during and after dialysis treatment. There was no regular record of respiratory rate on the observation chart, although the care plan did direct the recording of this physiological parameter. Temperature was recorded routinely.
- The unit did not use a modified early warning score system to identify the deteriorating patient. Nursing staff we spoke with were experienced and able to articulate the clinical condition of a deteriorating patient. Staff we spoke with had not had any training in national early warning score (NEWS) and could therefore not describe the recognition of the patient deteriorating in the same context. Senior staff had been in discussion with senior renal specialists in the Department of Health to progress the development of a modified renal NEWS or similar processes.
- Staff could describe how they would recognise a patient that was unwell and how they would get support and escalate concerns in the absence of a NEWS system. There was a detailed policy document, 'complications, reactions, and other clinical event pathway' but no system was in place to ensure that care was delivered in line with national guidance from the Department of Health or the National Patient Safety Agency. This meant there was a risk that deteriorating patients may not be managed appropriately, although there was no evidence of that during this inspection.
- There was no sepsis toolkit or pathway in use at the unit. This was not in line with the National Institute for

Health and Care Excellence (NICE) guideline (NG51) for recognition, diagnosis, or early management of sepsis. (Sepsis is a life-threatening illness caused by the body's response to an infection). Staff we spoke with were not knowledgeable about sepsis pathways. Staff however could describe what would happen if a patient developed signs and symptoms of infection.

- There was an agreement with the local NHS trust that patients who became ill would be transferred to the hospital. There were 211 patient transfers to the Hull NHS trust in the 12-month reporting period. There was no benchmark used within the organisation to inform whether this was a high or low number of patient transfers. We observed a log of details of transfers and did not have any concerns about the types or reasons for transfer of patients to the local NHS trust.
- Patients were referred from the parent NHS trust with a full medical history, personal details and blood results. Staff in the unit then contacted the person initially by phone to prepare them for their first visit. The clinic manager said that there were specific appointments available for pre-dialysis patients to visit the unit.
- Staff recorded variances during the period of dialysis in the electronic patient records for example, falls risks, mobility post dialysis and changes in vital signs measurements. Staff used this information to help plan the next dialysis session and to identify any themes occurring during dialysis.
- Staff we spoke with had a good awareness of the process for escalation of concerns with renal medics on call at the parent NHS trust. Staff could access the NHS trust emergency security number for assistance with any issues in the unit and would call emergency services on 999 as required.
- It was noted that the access code to the main unit from the waiting room had been restricted to a limited number of staff to improve security and prevent patients or visitors having unsupervised access. The majority of nursing staff did not have access to the code. A system needed to be in place were all staff had easy security access to the main unit through the main doors, to reduce the risk of not being able to get access in an emergency situation.

Staffing

- Hull NHS Dialysis unit worked to a predetermined one registered nurse to four patient ratio plus one dialysis assistant to eight patient skill mix which was defined by contract and policy agreements with the local NHS trust Hospital. In addition to this there is one health care assistant per shift.
- There were 29.2 whole time equivalent (WTE) registered nurses (RN's). There were 18.2 WTE dialysis assistants (DA's) in post. (31 RN's and 23 DA's).
- At the time of inspection the unit had 2.8 WTE dialysis RN vacancies. The turnover in the 12 months prior to inspection was reported as 13 staff having left the service and 20 staff recruited. There had been a significant turnaround in nurse staffing issues on the unit in Hull in the 12 months prior to inspection and the service had progressed a successful recruitment strategy.
- The unit senior team ensures compliance with staffing ratios through the application of an e-rostering system. The clinic manager completed rosters eight weeks in advance and forwarded to the Regional Business Manager for approval. Staff we spoke with did not raise any concerns over their current duty rotas.
- The clinic manager reviewed duty rotas on a daily basis to assess staffing levels based on the actual number of patients attending for dialysis and also for unexpected staff shortages caused for example by sickness. A snapshot of nursing staff sickness in the unit over a three month period prior to inspection was 3% registered nurse and 3% dialysis assistants.
- When staff shortages were identified action was taken including rearranging shifts with the cooperation of unit staff. Where staffing levels cannot be maintained the unit used staff from the organisation renal flexi bank. Where the flexi bank cannot cover shifts, these are covered by external nursing agencies. The unit had used 680 registered nurse agency shifts in the three-month period prior to inspection visit. They had previously managed a system of block booking to improve consistency of cover in the unit.
- We reviewed three duty rotas over a three-month period, we noted that staffing numbers were in line with expected levels and consistent across shifts. Skill mix of staff was also good with a balance of

experienced nurses with long service and newer staff. We observed the cover for the in-reach service on the nephrology ward and the out of hours, on-call allocation of staff on the rota.

- The team had introduced a weekly handover sheet, staff we spoke with said that this was currently used inconsistently and further work was planned to embed into practice. Staff also had a communication book where diary items were handed over to each team of nursing staff. Staff worked across three teams to improve continuity and management of patient care.
- Nursing staff covered an on call rota for an out of hours dialysis service. Staff on the rota had at least 5 years' experience and had achieved competency in dialysis. There were two RN's and one DA on the on call rota. Referrals to the on call service overnight were mostly from the 'in reach' nephrology ward, critical care and acute wards were patients admitted would require emergency dialysis. NHS In-patients with kidney disease, acute kidney injury or who were being prepared for elective surgery would also access the on-call dialysis service.
- The unit did not employ directly any medical staff. Consultants were contactable via telephone, e-mail, through the consultant's secretary or hospital pager. Out of hours, the on call Consultant covering Hull NHS Dialysis unit was contacted via the hospital switchboard. All unit staff we spoke with were aware of how to contact a patient's consultant.
- Consultant staff reviewed patients on a monthly basis at the multidisciplinary team meetings and ad-hoc as required. Staff confirmed the consultant staff were visible and accessible. Consultants attended clinics in the unit. Patients we spoke with also confirmed that the consultant was available outside of unit appointments and would also visit the unit to review patients.

Major incident awareness and training

- Appropriate clinical emergency equipment was available.
- An emergency preparedness plan (EPP) was in place for the unit detailing the plans for the prevention and management of potential emergency situations. This outlined the roles and responsibilities of individuals in the case of identified emergencies including loss of water supply, electrical failure, fire or flood, bad weather and pandemic illness. There were established links with other units and the NHS trust to enable transfer of patients in order to receive their treatment.
- Patients records we reviewed had personnel emergency evacuation plans (PEEP) applicable to patients whilst on and off dialysis. This included specific reference to their mobility needs during evacuation. Staff on a regular basis updated these plans.

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

Evidence-based care and treatment

- Services, care and treatment were delivered and clinical outcomes monitored in line with and against the Renal Association standards, National Institute for Health and Care Excellence (NICE) and the referring NHS trust's requirements. The Renal Association is the professional body for UK nephrologists (renal physicians, or kidney doctors) and renal scientists in the UK. We reviewed the guidance had been incorporated into the organisations 'NephroCare standard for good dialysis care'.
- Clinical care was led by three NHS consultant nephrologists. The unit was nurse led and care was based on plans and pathways individual to the patients. The team spoke with us about the expectations to work in line with the UK Renal Association Standards to dialysis quality outcomes.
- The unit used an International Standards Organisation (ISO) Accredited Integrated Management System (9001) to ensure all policies and procedures supported best practice evidence. An annual review was completed to ensure that the evidence remained current. However, we looked at a range of policies, these all had included a date they became effective, but did not have a date to indicate when the policy expired or would be revised. Policies were stored on the shared drive and staff we spoke with said they were able to access them.
- Individual care pathways and treatment prescriptions were available for dialysis patients. These were based

on relevant national guidance. We saw evidence of a range of standardised, documented pathways and agreed care plans that had been individualised for patients by named nursing staff, examples of these included pressure care and falls care plans. These were inconsistently organised in patient folders and not completed in full in all cases. We reported this to the clinic manager and deputy at the time of inspection.

- The local NHS trust was responsible for the creation of fistulas; staff at the unit were responsible for monitoring them. A fistula is a special blood vessel created in a patients arm, called an arteriovenous fistula (AV fistula). The blood vessel is created in an operation by connecting an artery to a vein, which makes the blood vessel larger and stronger. This makes it easier to transfer the patients' blood into the dialysis machine and back again. 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 unit monitored the AV fistulas, which forms part of the NICE quality standard.
- The unit had a local audit programme; the audit programme was discussed during governance meetings and was reviewed by the area head nurse on a regular basis. The unit took part in nursing audits for example; infection prevention and control practices, medication and pressure area care. Results of audits were displayed in the unit. The range and frequency of audit was comprehensive and the clinic manager had responsibility for nursing audits and water treatment, environmental and monitoring against the renal association standards.

Pain relief

- Individual pain control needs of patients were informally assessed by nursing staff and paracetamol was routinely prescribed by consultants for patients, however there was no documented formal assessment of patients pain control needs at the unit.
- Patients we spoke with did not report any pain or discomfort on the day of inspection.

Nutrition and hydration

- Patients were supplied with regular hot and cold drinks, in reach, at their bedside. Patients were offered biscuits and sandwiches and were able to bring in snacks and food from home if they required. Patients we spoke with were aware of the dietary restriction of their illness and appreciated the support of the team and dietitian. Dialysis assistants provided the patients with hot drinks and sandwiches during the treatment.
- We saw evidence of nutritional assessment in the care plans as the malnutrition universal screening tool (MUST) was completed in notes we reviewed. Patients were weighed pre and post dialysis treatment. This procedure contributed to assessment and the overall treatment prescription.
- A dietitian worked flexibly around the needs of patients in the unit. We spoke with the staff during the announced inspection, who told us that the dietitian reviewed dietary and nutritional needs of individual patients in the unit and reviewed all patients in the MDT meeting.

Patient outcomes

- Results and treatment data were captured in the unit database with blood results feeding into the NHS trust electronic system. Unit 'live' data was available to the clinic manager and consultant who monitor and audit individual patient performance month on month to identify where improvements and maintenance in achievement of national standards could be made.
- The unit data management system provided customised reports and trend analysis to monitor and audit patient outcomes and treatment parameters. This highlighted the opportunity to improve outcomes and in turn quality of life. The following outcomes were audited; achievement of quality standards (Renal Association Guidelines), patient observations, dialysis access specific data, treatment variances, infection control interventions and body composition monitoring.
- In addition, each month a report summary for each dialysis unit was produced for all clinics by the head office as part of a 'balanced scorecard'. The data collected, as part of the Treatment Variance Report (TVR) was monitored and reviewed by unit staff. This included monitoring or prescribed and delivered treatment times, fistulae and catheter care, admission

to hospital and quality standards for monitoring of patients' blood results. Within Fresenius, the dataset was shared monthly with the area head nurse who worked with the clinic manager to address any improvement areas.

- A new 'clinic review' process further captured overall month on month clinical effectiveness and improvement areas. As part of the Fresenius 'Clinical Governance Review' and reporting, a report defining the unit achievement of the Renal Association standards is sent to the NHS trust consultants.
- Submission of unit data to the UK Renal Registry was undertaken by the NHS trust. The unit data was combined with the NHS trust data and submitted as one data set. This data set, however only included patients under the direct care and supervision of the NHS trust therefore it would not include those patients undergoing dialysis in independent clinics.
- As the UK Renal Registry data is representative of all 'parent' NHS trust patients this does not permit the review of patients and outcome trends specifically treated within Hull NHS Dialysis Unit. Therefore data, specific to the unit, is available through the clinic database. Senior staff told us that this is used to benchmark patient outcomes both as an individual unit and nationally against all Fresenius Medical Care UK clinics. We did not have opportunity to review benchmarked data for Hull NHS Dialysis Unit.
- It was reported to us that there was a small percentage of patients who refused the prescribed four hours treatment durations. There was also a small percentage of patients who were prescribed less than four hours for example in March 2017, 84% of patients achieved the full 720 minutes of dialysis treatment time, and this included the patients prescribed less than four hours.
- The clinic manager monitored travel and waiting times for patients to be assured that they did not wait for treatment after arrival and for transport home after treatment. We reviewed a snapshot audit of February 2017 of delays beyond 30 minutes of appointment time, collated by the clinic manager. The audit gave evidence of numerous (over 20 events in two days) appointment delays associated to transport issues over the two days the audit was conducted.
- There were a number of concerns and issues reported from staff and patients and frequent transport delays. A meeting had been convened in May 2017 to discuss the transport issues with the provider, through the NHS trust and Clinical Commissioning Group (CCG). This meeting was stated as positive but actions were yet to be agreed and no clear plan of action was documented by the unit overall to assure the Fresenius Hull Dialysis team that improvements would be made.
- There had been 443 non attendances in the unit in 2016, with a consistent 30 to 40 each month. These were for a variety of reasons; some patients chose not to attend, also some numbers may have been attributed to hospital in-patient stay, but the unit was not informed. When patients persistently did not attend staff described that they had changed their appointment times to support appointment attendance. We observed good patient information in non-attendance advice sheets.
- Monthly multidisciplinary meetings were held, staff we spoke with said that all patients' blood results were reviewed; progress and general condition was discussed. The named nurses and dietitian discussed outcomes and changes with all patients. Staff we spoke with were clear about the changes for patients in their care. Written information was also provided as standard to ensure the patient has an on-going record of their treatment outcomes. Patients we spoke with were clear about their treatment and care plans and commented positively on the clinics being provided on site.
- Clinical outcomes for renal patients on dialysis can be measured by the results of their blood tests. The blood results were monitored on a monthly basis as directed by the NHS trust. Results were collated on the electronic patient database used at the unit. The data was available for the clinic manager and consultant to review so they could see individual patient outcomes. Changes in treatment were planned as a required.
- Monthly blood sampling was carried out and results were checked by the nursing staff. Urea reduction ratio's (URR's) were calculated and checked against the Renal Association (RA) guidelines. The URR is one measure of how effectively a dialysis treatment

removed waste products from the body. For April 2016 to March 2017, an average of 82% of patients achieved a URR of greater than 65% as indicated by RA guidelines.

- Staff we spoke with told us that they had experience of end of life care, they would liaise with GP and Macmillan services to facilitate preferred place of death for patients nearing the end of life. The clinic manager kept a local record of the number of expected deaths of patients who received care and treatment in the unit at Hull.

Competent staff

- We observed a clinically competent and confident team on the day of inspection. Staff we spoke with were experienced dialysis nurses and we observed care and treatment being delivered by a caring and knowledgeable team of nurses and dialysis assistants.
- In the 12 month reporting period prior to inspection 100% of dialysis nurses had received an appraisal and had their professional Nursing and Midwifery Council (NMC) registration checked by the clinic manager. Nurses were supported with revalidation processes. These checks gave assurance that nurses in the unit were fit for clinical practice.
- We reviewed a consistent level of detail in staff appraisal documentation in the five appraisal records we checked. We noted nurse appraisal documentation was detailed with a range of objectives.
- Staff we spoke with described good access and support for training. We reviewed 13 personnel files that gave evidence of a thorough induction program which included emergency procedures, training and supervision of clinical practice and sign off of competence. Each member of staff had a training & education file, staff we spoke with told us that there was good access to internal and external study days, and access to the Fresenius learning centre. We reviewed evidence of full competence assessment during staff probationary period for RN's and DA's. We observed that agency and bank nurses also received induction.
- We noted a 'Training and Education Progression Plan' which outlined a commitment to induction for new staff, it provided an overview of the first year of employment within the unit defining objectives for the following phases; supernumerary, probation, supervised practice, consolidation of knowledge and skills and then onto consolidation of managerial practice where appropriate. Staff we spoke with confirmed this arrangement.
- The service offered ample ongoing professional development opportunities for ongoing assessment and maintenance of competence which is pivotal to the Nursing and Midwifery Council (NMC) revalidation approach, for example; annual appraisal of competence, appraisal, mandatory and statutory training, access to external training such as accredited renal courses, dialysis specific study days, E-learning and virtual classroom training.
- Staff working on the unit received six weeks supernumerary period during induction and a six-month preceptorship period allowing time to achieve all the required competencies. Nurses we spoke with told us that supernumerary periods could be increased if the member of staff or mentor felt that this period needed to be longer.
- A mentor was allocated to support junior staff and sign off the competence records. Senior staff and policy stated that working as a mentor was supported to be supernumerary during the induction period.

Multidisciplinary working

- Staff we spoke with told us three renal consultants had overall responsibility for patient care and visited the unit weekly for clinics and every month to carry out a clinical review of patients.
- There were established multi-disciplinary team (MDT) meetings for discussions of patients on dialysis pathways. MDT meetings included attendance from dietitians, the renal social worker and vascular specialist nurse as well as members of the medical and nursing teams.
- Clinical nurse specialists from the parent NHS hospital attended the unit to provide clinical expertise and review patients if needed.
- Whilst on the unit we observed good communication and support between members of the team, nursing

staff and patients we spoke with described good working relationships amongst all staff involved in care and treatment, including clinical and ancillary staff and transport services.

Access to information

- The Fresenius Medical Care patient treatment database EuCliD automatically transferred patient data into the NHS trust clinical database system PROTON. Staff we spoke with described this process as working well. We noted that concerns had been raised previously during an NHS peer review and actions completed to ensure access for consultants and all relevant staff was good.
- The service was able to offer dialysis to patients from out of area who may be on holiday. Arrangements for referrals are through Fresenius head office or through the patient's own unit to the dialysis unit. The clinic manager provisionally allocates dialysis availability subject to receiving completed documentation and medical approval and acceptance. An Incoming Holiday Patient Form (UK-CR-03-40) is used to ensure all relevant information is gathered relating to the holiday patient, to reduce risks to all patients e.g. isolation requirements.
- We spoke with the dietitian who told us that paper records were stored securely. The team used a consistent document template across the unit and NHS trust. They had access to EuCliD and PROTON.
- The clinic manager ensured all unit letters were signed by named nurses and the dietitian. Staff we spoke with told us that named nurses would contact the GP services by telephone if they felt the patient needed to be referred for extra care such as, chiropody, or wound dressing clinics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing and this was clear in the Fresenius consent policy.
- We reviewed five patient consent to dialysis forms and noted all to be accurate. There was policy and systems in place to gain consent and review consent from people using the service. We observed staff asking for informal consent prior to giving care and treatment.
- One hundred percent of staff had received Mental Capacity Act (2005) training, and Deprivation of Liberty (DoLS) training (both attended 3 yearly). At the time of inspection all patients attending the unit for dialysis had capacity to make decisions in relation to treatment and care. Staff we spoke with described clearly the application of the MCA or DoLS in practice and senior staff had more experience in view of the admission criteria in the unit.
- We spoke with staff who told us of arrangement of best interest meetings for patients in order to discuss Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) with the patient and family members. This had been with the involvement of consultant. It was reported that patients would be admitted to the local NHS trust at the end of life.

Are dialysis services caring?

Compassionate care

- We observed a caring and compassionate approach by the nursing staff during inspection.
- Patients had access to a nurse call system and staff were careful to place the handset to the side not connected to the dialysis machine, this ensured patients were able to call for help if they required. During the inspection, we saw that staff answered patients' needs promptly, including alarms on dialysis machines. The staff assisted patients with warmth and compassion and gave reassurance where needed.
- The privacy and dignity of patients was prioritised. The curtain and screen system and space around the bed spaces was more than was needed to ensure conversations were not overheard and patients had privacy. Staff we spoke with told us of examples of using the quiet rooms to discuss sensitive information with patients.
- We spoke with patients who told us that 'they felt listened to and preferences were taken into account.'

We noted praise for specific members of the team, dialysis assistants were described as 'caring' and 'take time to provide good nursing care'. The clinic manager was praised as being visible and approachable by patients we spoke with. Patients described that they felt any concerns were listened to.

- The unit had consultation rooms where patients could have confidential discussions about their care with any members of the multidisciplinary team should they so wish.
- Patients we spoke with knew their named nurse and described good relationships with the nursing staff. Patients told us that the 'were well looked after, couldn't be better looked after' 'they're first class, all of them'.
- We spoke with one patient who described a different mixed experience of the unit and told us that in busy times the unit could be 'hectic' and that in times of staff shortage the machine alarms would not be turned off promptly. A request to have curtains drawn around the bed space had been denied by staff but the patient felt that 'there wasn't enough privacy for her'.
- The main concerns expressed by patients and staff we spoke with was the regulation of temperature of the unit and patients waiting to get onto the dialysis treatment due to delays and the knock on effect across the sessions. Most delays and patient waiting for long periods of time were described as a consequence of transport issues.

Understanding and involvement of patients and those close to them

- We observed the use of a named nurse approach, which had been recently implemented. Nurses had a caseload of patients and built relationships over a long period of time. This fostered familiar yet professional communication between patients and staff in the unit. The named nurse was responsible for ensuring patients had updates about their treatment plans and blood results after the monthly MDT meeting or at any other review by consultant staff.
- Staff told us that patients were encouraged to be as involved in treatment as possible. There was a comprehensive Fresenius Medical Care, 'patient and carer shared and self-care training checklist' which guided three supervised assessments by a nurse with the patient of each step of treatment. It included clear consent and sign off of understanding in the document. We did not review any patients using the shared care process during the inspection but observed patients being offered opportunities to be involved in their care such as, removing needles after treatment and self-weighing prior to treatment. There was good reported evidence of all elements of self-care by patients in Hull Dialysis Unit, from taking of their own blood pressure to self-administration of medication and priming of dialysis machines.
- On the day of inspection, we saw that the senior nurse was visible in the unit and had a close relationship with patients and staff. Relatives and patients were able to speak with the senior nursing staff if required.
- During treatment, there were activities available, albeit there are recognised limitations on what can be undertaken during dialysis. We observed patients using television, radios and internet access on their own electronic portable devices. Patients had newspapers and magazines or books that they accessed and most patients were sleeping during treatment. Staff made efforts to keep noise levels low, however this was challenging in such a large unit, staff respected the patients privacy and gave additional pillows where needed.

Emotional support

- Staff we spoke with were aware of how to access additional support for patients and liaised in partnership with the consultant nephrologist and a social worker allocated to the renal unit NHS trust. Clinical nurse specialists (CNS) were available from the vascular service to provide support and advice to patients and staff.
- Care plans, and care pathways were designed to provide nursing staff opportunity to document individualised care in detail with assessment of patient's emotional, social, cultural, spiritual, psychological and physical needs. It was clear that most nurses took opportunity to keep patients informed about their care, involving them and their families in decisions and ensuring that they have the opportunity to participate in their own care.

- Staff we spoke with described providing additional activities for patients such as seasonal raffles, bingo and competitions. Trips were organised when charitable resources were available. The unit had previously organised a Christmas party for patients.
- There was access to a renal user group, although this was not well attended by patients.
- The renal consultants were able to refer patients to the renal counselling service based at Hull and East Yorkshire hospitals.

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

Service planning and delivery to meet the needs of local people

- The unit provided dialysis treatment for the patients of the Humberside area. The unit had 39 dialysis stations including five isolation rooms and 4 additional stations in the NHS trust for in-reach dialysis care. The unit also provided an on-call service to dialysis patients across the trust and a home care dialysis service with a specialist nurse.
- Patients were referred to the unit for their haemodialysis treatment from the parent NHS trust renal unit. The unit had eligibility criteria to ensure that patients were physically well enough for treatment and lived in the local area. The unit provided a flexible service to local patients. Patient treatment was established at the NHS trust renal unit and they were then referred to the local Hull unit.
- Dialysis services were commissioned by Hull and East Yorkshire NHS trust. The contract for the unit was renewed in April 2016, and the acute NHS Hospital NHS trust renal team defined the service specification. Patients were referred to the unit for their haemodialysis treatment from the parent NHS trust renal unit. Senior unit staff attended business meetings at the parent NHS trust to manage the service and ensure that key performance indicators were being met. Staff working within the unit said that the recent contract had enable improved collaborative working, greater ownership and direction to the renal unit.
- We spoke with a patient who had been supported to take holidays and receive dialysis treatment in other units and they described this as being organised very well.
- The unit collected feedback through a 'Tell us what you think' anonymous leaflet system which allowed patients to comment on the service using freepost direct to Fresenius Head Office. We did not see specific results or actions from this feedback in the unit.

Access and flow

- The unit used an appointment system which staff we spoke with said ensured structure, timeliness and minimises delays as far as possible. The unit offered a flexible approach to the patient's dialysis sessions changing dialysis days and or times as far as possible to accommodate external commitments, appointments or social events the patients may have.
- Referrals for admission were directed by the consultant nephrologist team at the NHS trust renal unit, who would contact the unit, usually the clinic manager, to inform the team that they had a new patient for admission.
- There was no waiting list for treatment at the unit and staff we spoke with said that this was consistent.
- The utilisation of capacity in the unit in the three month reporting period was as follows: November 2016 95%, December 94% and January 93% and so had limited spaces to accommodate additional sessions although the team worked flexible to accommodate patient referrals.
- The unit had not cancelled any dialysis sessions for non-clinical reasons in the 12 months prior to the inspection.
- There had been 211 patient transfers to the NHS in the reporting period April 2016 to April 2017. Staff we spoke with said that all the transfers were necessary and we reviewed an informal log kept by the clinic manager, however there was no detailed analysis or benchmarking of this information.

- Access to the unit was good, patients could park directly outside the unit, however parking was limited on the NHS trust hospital site. Designated spaces were available for patients.
- A home dialysis service was also based on the unit and this currently had five patients accessing the service and providing their dialysis at home.
- Transport of patients was commissioned by the local clinical commissioning group (CCG) . Staff and patients we spoke with had a number of issues with transportation to treatment and home from this unit. We observed elderly patients waiting for long periods of time after dialysis treatment on both the announced and unannounced inspection. These issues had been raised with the provider and the clinic manager attended a monthly meeting to facilitate communication and progress on-going issues.
- It was recognised that 70% of patients who attended for dialysis treatment on Monday, Wednesday and Friday afternoon sessions were reliant on transport and the delays would had an impact on quality of life. Appointments were booked and managed well at the unit however Fresenius Medical Care Renal Services Ltd needed to ensure that the transport service met the needs of patients in the Hull unit.

Meeting people's individual needs

- Staff encouraged and supported patients to arrange dialysis away from base and welcomed patients to the unit for temporary holiday treatment providing medical approval was given and all pre-assessment checks had been made, in addition to having dialysis session availability.
- We observed good access to facilities in the main unit, which was spacious and modern in design with good provision for people with individual needs. We observed wheelchair users being supported with access to treatment and facilities. However, there were some restrictions in space to the waiting area which impacted on patients if they had to wait for long periods for transport.
- We observed the use of pressure relieving mattresses.
- Patients had access to Wi-Fi, personal televisions in each bed space and reading materials of their choice. Patients were supported to bring anything in from home to alleviate any boredom during their dialysis treatment session.
- Patients new to dialysis treatment were given a detailed information pack and the clinic manager met with all new patients.
- The unit offered specific appointment times to meet the needs of individual patients, including accommodation of school run times for mothers attending for dialysis treatment.
- We observed the needs of individual patients being met in respect to patients having a reduced number of staff caring for them to provide continuity and develop a trusting relationship where patients were particularly nervous or anxious.
- Hull NHS Dialysis unit provided haemodialysis treatment to patients by following an individualised treatment prescription. Changes to prescriptions were made during multi-disciplinary meetings. The outcome of the meetings and changes to care were discussed with the patients and provide a responsive approach.
- Patient information was available in four main languages but staff we spoke with said they were able to obtain information in other languages or larger print if required. Access to interpreter services was made through the NHS trust switchboard and staff we spoke with knew how to access when needed.
- The unit had an acceptance criteria and policy which was designed to be open and inclusive, accepting patients over 18 years, had functioning haemodialysis vascular access, were clinically stable for treatment in an independent facility and had medical approval. Staff requested these details as part of pre-transfer assessment to ensure all care needs could be met and transfer to the unit was safe with full communication with the patient and carer or family.
- Patients did visit the unit as part of the pre-assessment clinic prior to commencement of treatment to familiarise themselves with facilities, staff and routine.

- Senior and junior nursing staff we spoke with told us that the patient would be allocated a dedicated dialysis appointment time which considers: Social care and work commitments, day appointment availability for the elderly, vulnerable or those with more complex care needs, length of journey to the unit and number of hours or days of dialysis the patient was prescribed as part of their care plan.
- There was no formal evidence the unit met NICE quality standards about patients being collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis. All patients we spoke with using transport complained about the service and during the announced inspection, we observed three patients who had completed dialysis two hours earlier waiting for transport to take them home.

Learning from complaints and concerns

- The unit had a process and complaints policy that addressed both formal and informal complaints that were raised via the clinic manager. The Fresenius complaints process was displayed in the waiting area. The patient advice and liaison service (PALS) at the NHS trust had produced leaflets and posters to guide patients about the complaint process and these were visible in the reception area.
- In the reporting period, April 2016 to April 2017 the unit had received 15 formal complaints managed under the organisational formal complaint procedure and did not record compliments. 'Tell us what you think' leaflets were available for patients and these encouraged patients to make comments, raise concerns or compliments to be shared.
- It was the responsibility of the clinic manager or deputy manager to ensure all complaints were sympathetically dealt with within maximum 20 working days. The clinic manager spoke in detail of the formal complaints with the steps taken, including the involvement of the consultant.
- Staff we spoke with could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required.
- Staff we spoke with recognised that lessons for continuous quality improvement for people using the service might develop as a direct result of concerns or complaints. The approach was said to mirror the NHS approach.

Are dialysis services well-led?

Leadership and culture of service

- There was a clear leadership structure in the Fresenius Medical Care organisation and that was applied regionally to the Hull NHS Dialysis unit. Local leadership was reflected in a regional business manager position and area head nurse, who would be unit based approximately once or twice a week. The clinic manager was based in the unit for 100% of the nursing job role. There were two deputy clinical managers and three team leaders in senior positions in the unit. Senior staff were present during inspection. The clinic manager was also present during the unannounced inspection.
- Morale amongst nurses was described as good, and improving. A positive working culture was evident from all staff interviews, observations and survey information.
- Nursing staff we spoke with told us that senior leadership was consistent with good levels of visibility and support; this included the support given from the regional and national team. All staff we spoke with told us that the clinic manager was caring and listened to staff concerns. The clinic manager was highly regarded by the staff and patients we spoke with.
- The unit senior management team told us they held regular team meetings, staff we spoke with said these were planned and fairly well attended. Meeting minutes we reviewed which spanned 2016/17 confirmed good discussion and consistent agendas.
- Staff described their peers in a positive way and spoke about them supporting each other. The senior management team said they were proud of the staff working within the unit.

- The culture and leadership within the unit represented the vision and values of the organisation, encourage openness, transparency, and promote quality care. At ward and department level, staff we spoke with described the culture as open and supportive.

Vision and strategy for this core service

- Fresenius Medical UK in partnership with the NHS trust renal unit had a clear vision and strategy with quality and safety at the top of its priority. It was expected that this was cascaded to the local team through business and clinical meetings, and staff training and updates. The Fresenius clinical governance strategy document described a framework that the team used to deliver 'the right care to the right patient at the right time.'
- The senior team at regional and local level were aware of the strategy and values for achieving priorities and delivering good quality care. Staff we spoke with had a good understanding of the vision and strategy for the unit and organisation.
- The business strategy meeting was well attended at the NHS trust and the clinic manager was involved in monitoring progress in delivering the strategy. The use of dashboards had been recently introduced for monitoring of performance however these had not been embedded into practice or cascaded to all staff.
- The unit had a corporate vision for the service to improve the quality of life for nephrology patients. The unit also had a culture and quality statement. This was displayed on the walls of the waiting area.

Governance, risk management and quality measurement

- The clinic manager had leadership and responsibility for governance with support from the wider Fresenius and NHS trust team. Leadership and quality outcomes were a priority in the dialysis unit at Hull. The unit was the largest in the UK and operated within a defined management structure from a local, regional and national perspective. Person-centred care was prioritised by the team. The clinic manager closely monitored the performance of the unit with regular production of clinic reviews against key performance indicators, to feed into the quality assurance meetings with colleagues across the organisation and in the NHS trust. The unit meeting minutes gave evidence of learning from incidents and complaints.
- The unit had a newly developed risk register to better capture risks at a local level. This was part of a process that was being developed at a corporate level in Fresenius Medical Care UK. We reviewed comprehensive risk assessments that were complete and in date and thorough. The risk assessments reflected most risks and issues at the unit. Senior staff we spoke with did not have a full understanding of the new risk register update as it was still under development at the time of inspection.
- The clinical risk management policy was detailed about risk management principles and risk assessment processes, however the policy had not been updated to reflect the new approach to the corporate and local risk register.
- The unit local meeting was consistent and the agenda and content supported governance of risk and quality at a local level with the nursing team. The meeting focussed on business around infection control, health and safety and environmental issues.
- There were three nominated NHS consultant nephrologists as clinical leads for the unit, with one consultant as having specific clinical governance responsibilities. The team met quarterly to review unit performance against key performance indicators. The meeting was attended by the regional business manager, area head nurse and clinic manager, along with key NHS trust staff. We reviewed three sets of minutes with consistent representation in the group.
- There was a clinical governance committee as part of the Fresenius Medical Care group strategy. The clinic manager was responsible for monitoring and leading on delivering effective governance and quality monitoring in the dialysis unit, supported by the wider Fresenius management team. Data was collected by the clinic manager and reported monthly to the Fresenius and NHS trust team where it was input to the UK renal registry. It was through this process and shared meetings that validation of audit results and benchmarking occurred.

- The unit also provided an in-reach service to current inpatients in Hull Royal Infirmary, this service provided up to 17 dialysis points throughout the hospital which enabled patients to continue on dialysis treatment whilst a hospital in-patient or if patients were not medically stable enough to attend the unit. The unit provided a further 200 dialysis treatments to inpatients at the Hull Royal Infirmary via this service. The governance of this service was clearly in line with Fresenius Medical Care and the Hull clinic manager. The Hull clinic manager had responsibility for managing this service across the NHS trust.
- The Workforce Race Equality Standard (WRES) is a requirement for organisations which provide care to NHS patients. This is to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
- WRES has been part of the NHS standard contract, since 2015. NHS England indicates independent healthcare locations whose annual income for the year is at least £200,000 should have a WRES report. The unit did not publish data to show they monitor and assure staff equality and we did not see an action plan to address any data gaps in the future.

Patient and staff engagement

- The unit participated in the Fresenius employee satisfaction survey October 2016 that measured the staff's satisfaction at Hull NHS Dialysis Unit. The response rate was 51%. Twenty eight staff responded in 2016, with 30 in 2015. A greater number of staff at 83% would recommend the unit to friends and family requiring dialysis, against a 69% NHS response. A smaller number of staff would recommend their dialysis unit as a place to work at 40% than the NHS 52% score for the same question. Zero percent of staff reported experienced abuse or harassment at work, 82% delivered care that they aspired to. 96% of respondents felt that they were proud of the work they did in the dialysis unit.
- The unit participated in the Fresenius national patient survey in October 2016 that measured the patient's experience of care. Seventy five patients responded to the survey. The response rate was 42%, which was worse than the national average of 55%. An action plan was developed to address any improvements needed as part of the responses and results**.** Some of these actions were observed during inspection, i.e. the induction and information pack for patients and the named nurse system being implemented. Patients felt that the unit had a friendly atmosphere (96%) and they felt safe and treated with dignity (80%).
- We gave the patients an opportunity to complete a 'tell us what you think' survey during the inspection. We had no response to this request during the inspection.
- Within the unit, no patient representative was available on groups or committees, despite attempts from staff to recruit patients to this role. However, the clinic manager worked closely with local renal groups and representatives from the unit were members of these groups.

Innovation, improvement and sustainability

- Unit staff worked with the vascular surgeon as part of a research project for fistula cannulation. Ultrasound scanning methods were being introduced and work with the pre-dialysis and vascular nurse was in progress. Education was being provided to staff and to patients to improve preparation for vascular access.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provide must ensure that incident reporting is clearly graded for severity of harm, and staff understand the moderate harm trigger to support the application of the duty of candour regulation
- The provider must ensure unit staff have access to a nominated safeguarding children lead with level 4 training.

Action the provider SHOULD take to improve

- The provider should ensure that performance information is collected is used for benchmarking.
- The provider should ensure that all risks relevant to the local hospital are recorded on the risk register.
- The provider should ensure consistent recording in the patient record of patient identification and staff signatures. The risk assessments should be consistently reviewed and updated. Standards should meet the Nurse and Midwifery Council (NMC) Code of Professional Conduct in relation to record keeping in all cases of documentation and records should be well organised.
- The provider should ensure all staff adhere to infection prevention and control policy with specific regard to practice around aseptic non touch technique.
- The provider should ensure that the waiting area is not overcrowded and sufficient space is available for patients, staff and visitors to walk and access the area freely.
- Staff should be able to access the main unit at all times using a secure but unrestricted method. A system should be in place for staff to be able to access the waiting area and return to the unit without delay and the access code or system should not be limited to a small number of staff.
- The provider should improve the regulation of temperature in the unit for individual patient comfort. Staff should be able to access systems that support them to make temperature adjustments during all sessions.
- The provider should continue to monitor the delays experienced by patients and the long waiting times created through transport delays with external contracted providers. Issues should be raised and escalated and solutions progressed.
- The provider should ensure that the system in place to allow staff to identify patients receiving care and treatment is embedded into practice for all staff to continue to include the requirements for safe administration of medications.
- The provider should ensure that a recognised early warning score reflecting the risks of the dialysis patient is implemented to prompt recognition of the deteriorating patient.
- The provider should consider the value and implementation of sepsis toolkits and specific pathways.
- The provider should ensure that the workforce and race equality standards (WRES) are implemented in full.

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 20 HSCA (RA) Regulations 2014 Duty of candour Regulation 20 HSCA (RA) Regulations 2014 Duty of candour 20 (1) A health service body must act in an open and transparent way with service users in carrying on a regulated activity. (7) **How the regulation was not being met:** Staff we spoke with did not have a clear understanding of moderate harm triggers for duty of candour. This means that the duty of candour would not be triggered for moderate harm that requires (a) a moderate increase in treatment, and (b) significant but not permanent harm.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (2): Systems and processes must be established and operated effectively to prevent abuse of service users. **How the regulation was not being met:** Staff we spoke with were not aware of a member of staff in who had received training in safeguarding at level 4 that was available for them to contact for advice and escalation of safeguarding concerns within the organisation.