B. Braun Avitum UK Limited

Forest Dialysis Unit

Inspection report

Newtown Road
Cinderford
Gloucestershire
GL14 2YT
Tel: 03004228760
www.avitum-bbraun.co.uk

Date of inspection visit: 02 September 2022
Date of publication: 14/03/2023

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We rated this service as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- There were gaps and discrepancies between the provider's safeguarding policy and staff knowledge.
- Governance processes between the provider and the responsible body that operated the site were inconsistent.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis services	Good 	We rated this service as good. See the overall summary for more information.

Summary of findings

Contents

Summary of this inspection

Background to Forest Dialysis Unit

Forest Dialysis Unit is operated by B. Braun Avitum UK Limited. The service provides haemodialysis and dialysis for patients in renal failure to NHS patients over the age of 18 under a contract with Gloucestershire Hospitals NHS Foundation Trust. The unit is located in a purpose-built building in a rural area on the outskirts of Cinderford, Gloucestershire. It has 12 dialysis stations, 4 of which are in private side rooms.

Patients typically live in the Forest of Dean although the unit also provides treatment to patients in the area on holiday under an NHS England scheme. Patients receive care in dialysis chairs and the unit is open 6 days per week from 7am to 6.30pm.

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

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

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

We last inspected the service in May 2017. At that inspection we did not have a duty to rate and instead published a narrative report. We found 5 breaches of the Health and Social Care Act (2014) in relation to regulation 12 and regulation 17 and issued requirement notices to the provider. At this inspection we found the provider had made some improvements and addressed some of the issues that contributed to the previous breaches of regulation. However, there were still areas for improvement.

How we carried out this inspection

We carried out an unannounced, focused inspection of the service on 2 September 2022. Our inspection team consisted of a lead inspector and a specialist advisor with clinical experience of renal services.

While the NHS trust does not form part of our report or judgement, we refer to them because renal services are delivered from premises for which they are responsible, and patients are under their substantive care.

After our inspection we carried out a remote interview with a member of the senior provider team and asked the provider to send us additional evidence of working standards and practices.

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

Summary of this inspection

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure safeguarding contact and escalation details are up to date and that all staff have a clear understanding of them
- The service should ensure safeguarding policies are up to date and reflect agreements with the responsible body NHS trust
- The service should ensure staff are included in governance processes including discussions and learning related to corporate provider activity and the responsible body NHS trust
- The service should ensure adverse patient outcomes are categorised to support learning

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dialysis services	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

Good

Dialysis services

Safe	Good
Well-led	Good

Are Dialysis services safe?

Good

Mandatory training

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

Staff received and kept up to date with their mandatory training. At the time of our inspection all staff had completed training and updates.

Mandatory training was comprehensive and met the needs of patients and staff. It included up to 36 modules depending on the individual's role. The provider supplemented mandatory training with ad-hoc specialised training, such as to help patients with needlephobia feel more confident about their care.

The registered manager and training link nurse monitored mandatory training and alerted staff when they needed to update their training. A training and development lead nurse worked nationally and visited different provider sites to support staff with targeted spot training and as-needed support.

Most training was delivered by the provider and the NHS trust offered additional mandatory training to support consistent patient care. The national lead liaised with the trust and ensured staff completed this in line with their requirements.

Safeguarding

Staff understood how to protect patients from abuse although there were inconsistencies in understanding of escalation processes. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. The provider's safeguarding lead was the UK operations manager and they were supported by the head of nursing, who was undertaking level 4 safeguarding training.

Nurses and dialysis support workers completed safeguarding training for adults and children to level 3, healthcare assistants completed training to level 2, and clerical support workers completed training to level 1. The service did not provide treatment to children and young people and staff maintained up to date training as good practice in case young people accompanied patients. Staff completed national 'PREVENT' training, which aimed to identify people at risk of radicalisation.

Staff knew how to identify adults and children at risk of, or suffering, significant harm but there was inconsistent understanding of escalation and referral processes between staff and the provider. All patients were under the substantive care of the NHS trust and B. Braun Avitum UK Limited provided care under a contract. There was not a clear agreement in place between the organisations regarding responsibility and accountability for safeguarding. For

example, the registered manager told us their team were instructed during safeguarding training to contact the trust's team for support and referrals. However, local guidance for staff instructed them to contact the provider for support. The information was out of date and staff were unaware of the provider's recent change in safeguarding lead. These discrepancies meant safeguarding protocols were not clearly understood.

Staff provided care for patients with complex, long-term needs, including people living with a diagnosis of a dementia, those with terminal kidney failure and other conditions that presented a risk of vulnerability. While staff understood the principles of safeguarding, they could not identify any previous safeguarding concerns or learning from safeguarding incidents at other locations in the provider's network. This meant the provider did not have assurance safeguarding processes were effective.

The registered manager said they liaised with NHS hospital renal consultants and senior emergency care staff to help provide support to vulnerable patients.

The provider told us a recent audit by a head office team highlighted inconsistency amongst staff in their understanding of safeguarding processes and contacts. A senior member of staff told us the provider subsequently issued single point of contact information for staff to contact their internal safeguarding lead. However, none of the individuals we spoke with were aware of this and printed contact information for safeguarding staff differed between units. In addition, the registered manager told us this was incorrect, and that staff should contact the NHS trust's safeguarding team in the first instance as they were based on the hospital site.

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Estates and facilities were provided by, and remained the responsibility of, the NHS trust. Unit staff were responsible for cleaning and infection control and the trust, as responsible body, was responsible for the building.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The service performed well for cleanliness. The clinical services team audited monthly standards in 9 areas, which included all areas of the unit. In the previous 12 months the service reported 98% compliance with expected standards of practice.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw good standards of practice amongst staff delivering care, including in the use of the aseptic non-touch technique (ANTT).

Staff monitored access site infections. In the previous 12 months they reported 2 central venous catheter (CVC) infections. Documents indicated staff investigated each infection with a review of the patient's known comorbidities and contributing factors followed by a care plan to manage the immediate infection and reduce future risk. Documentation reflected good standards of practice.

Staff audited hand hygiene and use of the aseptic non-touch technique (ANTT). In the previous 6 months audit results demonstrated 96% compliance with expected standards. This was an average across all members of staff and reflected a range from 89% to 100%. The senior team worked with individual staff to improve consistent levels of practice.

Staff followed the NHS trust's standard operating procedure in relation to the management of CVC exit site infections. They applied prophylactic chlorhexidine dressings to newly created CVC's and those with recurrent infections. This met national standards.

Environment and equipment

The design of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. The design and size of the unit meant staff could see all patients from the nurse station. All areas were equipped with emergency call equipment.

The design of the environment followed national guidance. The service was compliant with the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09 in relation to clinical environment design and HBN 00/10 in relation to infection control in the clinical environment.

Staff carried out daily safety checks of specialist equipment and knew how to contact service teams for support.

The provider used a programme of planned preventative maintenance to ensure dialysis machines were serviced in line with manufacturer guidelines. The programme maintained equipment to a standard that was better than manufacturer guidance. This meant the service had assurance of equipment safety.

The service had enough suitable equipment to help them to safely care for patients. The service offered pre-planned treatment and staff allocated equipment in advance. Equipment manufacturers provided training and updates to staff to ensure they maintained up to date practice.

Staff disposed of clinical waste safely and in line with DHSC Health Technical Memorandum (HTM) 07/01 (2013) in relation to the safe management and disposal of healthcare waste.

Staff managed chemicals subject to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) in line with national requirements, including in relation to storage and use.

The service had suitable equipment to provide care for bariatric patients.

The service was compliant with DHSC HTM 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste

Spill kits were stored in key locations and included equipment to help staff contain bodily fluid spills and other similar risks.

Staff carried out daily water flushing of all outlets in the service as a strategy to reduce the risk of Legionella build-up. This approach reflected good practice and meant the service was compliant with DHSC HTM 04/01 in relation to the management of safe water in healthcare premises.

The trust carried out a fire risk assessment in 2020 and found the unit had a low risk of harm to staff and patients and that fire safety was well managed. The registered manager audited fire safety in 2022 and found low levels of risk and compliance with fire safety regulations.

The registered manager carried out 2 practical, unannounced, simulated fire drills each year. They monitored staff response to ensure they acted safely and in accordance with their training. During our inspection staff demonstrated a good understanding of local fire safety rules, including in relation to the relatively isolated location of the unit and the need to evacuate people whilst awaiting the fire service.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. For example, staff had acted quickly to stabilise 2 patients who became unwell during dialysis. They used therapeutic oxygen appropriately, contacted 999, and liaised with each patient's consultant to coordinate immediate care and hospital admission.

Patients received care on a long-term basis and staff maintained an up to date understanding of their health needs, including holistic elements of their care that impacted treatment outcomes.

Staff knew about and dealt with any specific risk issues. They carried out a monthly falls risk assessment, and a 6-monthly manual handling risk assessment for each patient, or more often if their health condition changed. The assessments ensured staff provided appropriate support to patients when moving between transport, wheelchairs, and dialysis chairs.

Staff had introduced new risk assessments for patients with mental health needs and those living with dementia to reduce the risks associated with patients dislodging venous catheters during treatment. This included staff training and new patient-specific risk assessments relating to their ability to understand the treatment and associated risks.

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

Staff carried out a huddle before the start of each shift to plan the service and discuss any issues or pressures. Once treatment commenced, a member of staff carried out a walkaround of the service to provide support if needed. Routine treatment did not require planned handovers and staff knew how to carry out ad-hoc handovers to other health professionals in specific scenarios.

An on-call consultant nephrologist at the NHS trust was available for urgent clinical discussions and referrals while the service was in session.

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

Staff undertook practical training in fluid assessment, anaphylaxis and vascular access and were trained in basic life support.

The unit was equipped with emergency equipment including an automatic external defibrillator (AED), oxygen, and breathing support equipment. A sepsis box was available in line with national guidance. Staff documented regular safety and stock checks on the equipment.

The provider had established patient eligibility criteria using the NHS England framework for holiday dialysis and triaged patients using this before accepting a patient for temporary care.

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

Staff recognised a common risk of treatment failure was related to patients choosing to shorten their prescribed dialysis time. In response they prepared a poster campaign to raise awareness of the risks. The team displayed these prominently around the unit and staff said they discussed the risk with patients.

The provider had improved sepsis training for all staff and introduced new policies in line with the NHS trust. Posters were displayed in key areas of the unit reminding staff of the national standard and staff had prepared information posters to highlight signs and symptoms to patients.

Staffing

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

The team included 5 dialysis nurses, 1 dialysis support worker, and 3 healthcare assistants. The service provided care with a nurse to patient ratio of 1:4, which was in line with national standards. Dialysis support workers provided specialist support and healthcare assistants supported the smooth running of each clinic, including patient triage. Rotas from the previous 6 months indicated the service consistently met these standards. The registered managed maintained relationships with bank and agency staff to enable continuity of care during staff sickness or annual leave.

Bank and agency nurses completed the same training and induction as substantive staff.

The service had low turnover rates, with over 99% retention in the previous 12 months and 1 nurse vacancy at the time of our inspection.

The service did not employ doctors and the NHS trust always had a consultant nephrologist and renal registrar on call.

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

Good

Dialysis services

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

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The service kept contemporaneous records as part of long-term treatment. These included each patient's latest haemodialysis prescription, blood borne virus test results, and COVID-19 status.

When patients transferred between teams, there were no delays in staff accessing their records, such as when patients received dialysis temporarily while on holiday. An electronic system meant each patient's NHS consultant had access to their continuing care records.

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

Staff audited standards of documentation monthly using a comprehensive tool that included clinical, demographic, and other care details. In the previous 6 months the service achieved over 99% compliance with provider standards.

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

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

Medicines

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

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

Staff completed medicines records accurately and kept them up to date. They stored and managed all medicines and prescribing documents safely.

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

Good

Dialysis services

The service maintained a stock of antibiotics that nurses administered on prescription from a trust consultant, such as in the event a patient tested positive for bacteraemia. This enabled staff to maintain a patient's dialysis schedule safely.

Incidents

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

Staff knew what incidents to report and how to report them, including near misses and incidents involving other services. Staff reported access problems such as fistula clots or poor blood flow to inform training, risk assessments, and local practices.

The registered manager shared learning about incidents that happened elsewhere through team meetings.

Staff understood the duty of candour. The registered manager assessed each incident in line with the provider's framework to identify if the policy had been triggered. They were open and transparent and gave patients and families a full explanation if, and when things went wrong. The NHS trust maintained oversight of this policy as patients were under their substantive care.

The provider maintained a record of patient safety alerts and communicated these using a register with local managers and staff.

The service reported 42 adverse patient outcomes (APOs) in the previous 12 months. APO categories included 33 pre-defined common incidents, such as difficulty cannulating or a patient fall. The most reported categories were treatment time shortened by over 10 minutes and missed dialysis. In 12 APOs, which represented 24% of the total, staff did not categorise the issue. This meant the provider had limited assurance the local team were able to identify themes.

Posters displayed around the unit encouraged to "call, don't fall" in a safety message staff had prepared to encourage patients with reduced mobility to call for help when they needed to move. Staff said this aimed to reduce the risk of falls and demonstrated learning from previous incidents. The approach was part of wider messaging around falls prevention including advice for patients to keep their shoes on at all times and to use a walking aid.

Are Dialysis services well-led?

Good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The registered manager was the unit manager and held significant experience in renal services and working with the host NHS trust. They also managed other dialysis units based on the trust's main hospital site and planned their week to include at least 1 day based at the Forest site. A team of senior dialysis nurses and deputy managers provided support and ensured there was always a senior member of staff available.

Staff spoke positively about their relationship with the manager and said they felt supported and looked after. The registered manager had acted to protect staff wellbeing during the pandemic to ensure they were treated with parity with their NHS colleagues. They recognised this location was geographically isolated from the other units they managed and made it easy for staff to contact them.

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

There were limited opportunities for staff progression and development. Staff highlighted this in forums and surveys and the senior team was in discussion to create new roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability and growth of services and aligned to local plans within the regional health economy.

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

Staff had variable buy-in to the vision and strategy and none of the nursing or support staff we asked knew about it in detail although the provider included it regularly in staff communications. Staff said they had not been involved in its development. The provider did not have assurance the vision and strategy were applied to staff at care delivery level.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

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

The provider facilitated a bi-monthly forum to provide space for staff to make suggestions and voice concerns. Staff acknowledged this process but were unable to identify any positive changes that resulted from it.

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

The service offered dialysis support workers considerable opportunities for development, including completion of a national vocational qualification (NVQ) delivered in-house with support from dedicated mentors.

There was a culture of continual learning and development for staff, such as training in kidney physiology and practical sessions delivered by manufacturers on new equipment and interventional resources.

Some staff had trained as mental health first aiders, which meant they could provide support to patients or staff experiencing mental health issues.

Governance

Leaders operated effective governance processes locally, although systems with the host NHS trust needed improvement. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

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

The governance structure included bi-monthly contract review meetings with the trust, 6 monthly internal clinical governance meetings, and monthly meetings with NHS consultants. The registered manager joined monthly renal operations meetings with the NHS hospital renal lead, although minutes indicated the team rarely discussed B. Braun services.

A quality manager worked nationally across all units and led the implementation of policies and procedures. They monitored audit outcomes and worked with local teams to support improvement. There was limited evidence the NHS trust, as the responsible body, had an integrated governance system with the unit. For example, staff had recently needed to report and seek assistance for a maintenance problem. Attention from the trust's team had been delayed because managers did not know that Forest Dialysis Unit was within their remit. After our inspection we raised this with the NHS trust, who took action to address the issue.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were governance systems in place, although we were not assured that these were fully effective. The registered manager had regular contract review meetings with the host NHS trust. However, they were not minuted and there was no system in place to track actions.

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

The service had an effective business continuity plan in place to ensure patients received care during service disruption. This was a rare occurrence as the unit was purpose-built with specialist back-up systems in place.

The provider was accredited to ISO:9001 standard, an international standard of quality management.

The provider operations manager was responsible for the risk register. The registered manager escalated issues to the register through the operations manager. Staff were required to demonstrate an up to date understanding of risks and

the registered manager provided protected time to each individual to help them maintain understanding. This reflected the extent of risks, which numbered 19 at the time of our inspection, and included issues related to staffing vulnerability due to COVID-19. The risk register did not identify mitigations or accountable officers although did note if a risk assessment was in place.

The service monitored performance based on patient sessions numbers, missed sessions, and compliance with the UK target of weekly dialysis time. From January 2022 to August 2022, the service performed better than the UK target of 86% of patients achieving 12 hours or more of dialysis time per week. The service achieved an average of 88% and exceeded the target in each month. In the same period the missed session rate was 3%. There was no national or provider target for this figure and staff worked to reduce failed sessions through health interventions with patients.

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

Information Management

Information systems were integrated and secure.

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

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

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

Engagement

Leaders and staff actively and engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The provider carried out an annual patient satisfaction survey as a requirement of their contract with the NHS trust. The provider's quality manager maintained oversight of results but noted only 2 patients (5% of the total under treatment at the time) had completed in a survey in the most recent collection in 2021. The manager said they had contacted patients who had not responded to the survey to try and improve responses but had not received any further completed surveys.

The provider's senior team worked with staff to make training and policy updates engaging and directly connected to their work. This was part of a programme to ensure updates and refreshers were motivational by nature and helped staff to deliver high standards of care.

Nurses adopted specialist link roles for areas such as equipment servicing, data protection, and water management. This helped staff to build skillsets and relationships with other teams as part of their work.

Good

Dialysis services

The provider carried out an annual employee survey. Results from the most recent staff survey indicated a need for improved development opportunities and a more structured workplace. Staff responded variably regarding their views on the provider as a good place to work.

Staff engaged extensively with patients, which reflected the nature of the long-term, structured care provided. For example, visual displays around units reminded patients of the importance of adhering to their renal care plan. Staff prepared displays reminding patients of the dangers of shortening dialysis time, in response to increasing trends for patients to do this.

Each patient had a named nurse or dialysis support worker who worked with them on a long-term basis to monitor their blood results and other indicators of treatment.

The unit came under the remit of the trust's patient advice and liaison service (PALS) for patient feedback and complaints and posters in the unit provided contact details.

A national shared care lead worked across units and with staff to provide training and insight into shared care principles and support them to complete a national training programme. This facilitated good standards of engagement between staff and patients. The service had created a patient representative role for a long-term dialysis patient familiar with national standards of care and patient needs. They acted as a link between staff and patients and liaised with the provider's operations manager to recommend changes and provide feedback.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The provider had received Investors in People Silver accreditation in recognition of their work with staff to build a high-quality work environment. They had also become the first independent dialysis provider in the UK to be accredited to deliver the aseptic non-touch technique (ANTT) training to their own staff.

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