Kings Norton Kidney Treatment Centre

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Kings Norton Kidney Treatment Centre is operated by Diaverum Facilities Management Limited. The service has 20 dialysis stations which includes four isolation rooms for patients who are or may be infectious.

The service provides dialysis for patients aged 18 and over.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on the 4 February 2020.

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

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

Services we rate

Our rating of this service improved. We rated it as **Good** overall.

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. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available six days a week.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. When problems were identified with accessing treatment due to third party providers (patient transport) the service worked to monitor and manage this.

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 to plan and manage services and all staff were committed to improving services continually.

We found areas of practice that required improvement:

The service external clinical waste collection area, and a sharps bin awaiting collection, were not secured. We found this at our previous inspection in 2018 and saw this was still the case in 2020.

We found a procedure relating to the preparation and administration of low molecular weight heparin (LMWH) medicine was unclear and may have left patients at risk of harm. Post inspection, we received an updated version of this procedure and a risk assessment to support this.

Summary of findings

The service did not always evidence how they had adapted written material, in particular consent forms, to be accessible to patients who required alternative formats.

The service had one set of scales for patient use. Although another set was available at a clinic nearby; if these were needed this could delay patient treatment sessions.

The patient satisfaction survey results had worsened since 2018 due to various factors. However, we saw action plans and engagement were ongoing to improve this.

Following this inspection, we told the provider that it must make an improvement as Regulation 12: Safe Care and Treatment (Health and Social Care Act) had been breached. In addition, we told the provider 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.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Midlands)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis services	Good	Kings Norton Kidney Treatment Centre is operated by Diaverum Facilities Management Limited. The service has 20 dialysis stations which includes four isolation rooms for patients who are or may be infectious. The service provides dialysis for patients aged 18 and over. We rated this service as good overall. We rated 'safe' as requires improvement and all other domains as 'good'.

Summary of findings

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Services we looked at:
Dialysis services

Summary of this inspection

Background to Kings Norton Kidney Treatment Centre

Kings Norton Kidney Treatment Centre is operated by Diaverum Facilities Management Limited. The service opened in 2014. It is a privately run satellite dialysis clinic offering dialysis to adult NHS patients from a large hospital trust located in and around Birmingham.

The service is registered to provide the regulated activity of treatment of disease, disorder or illness. It offers haemodialysis to patients with end-stage renal failure.

Haemodialysis is a method for removing waste products and water from the blood in severe kidney failure. Haemodialysis is one of three renal replacement treatments, the other two being kidney transplantation and peritoneal dialysis.

The clinic manager was the registered manager. They had been in post since August 2018, shortly before our previous inspection in October 2018 and were formally registered with CQC as a registered manager in September 2019.

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 twice previously, and the most recent inspection took place in October 2018, following which the service was rated Requires Improvement overall. Following the 2018 inspection, two requirement notices were issued in response to breaches of Regulation 12 (Health and Social Care Act): Safe Care and Treatment and Regulation 16 (CQC Registration Regulations): Notification of death of a service user.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC pharmacist inspector, a CQC assistant inspector, and a specialist advisor with expertise in renal medicine. The inspection team was overseen by Zoe Robinson, Inspection Manager.

Information about Kings Norton Kidney Treatment Centre

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury

The service employed a clinic manager who was the registered manager. The clinic manager managed the service. The service also employed a clinic development manager, a qualified renal nurse. The service employed 10 registered dialysis nurses, six health care assistants and one dialysis support worker. In addition, the clinic employed a clinic administrator.

The service opened six days per week and offered morning, afternoon and twilight sessions. Opening hours were 6.30am to 11.30pm Monday, Wednesday and Friday and 6.30am to 6.30 pm on Tuesday, Thursday and Saturday.

The service had 20 stations for dialysis patients. This was divided into three communal bays and four individual isolation rooms. Bay one had four stations. Bay two and three had six stations apiece.

The service accepted patients who had been assessed as suitable for satellite dialysis, and were referred by, the local NHS trust based in Birmingham. The service was the designated satellite clinic for patients who were Hepatitis B positive to be referred from the local referring trust. At

Summary of this inspection

the time of inspection, the service did not accept patients from out of area; for example, patients visiting the area on holiday due to it being required to keep its spaces available for local patients.

During the inspection, we spoke with 13 staff including registered nurses, health care assistants, reception staff, and managers. We spoke with 10 patients. During our inspection, we reviewed five sets of patient records.

Activity (January to December 2019)

- In the reporting period January to December 2019, there were 12,980 haemodialysis sessions undertaken. Of these, 5,366 were for patients aged 18 to 65; 7,614 were for patients aged over 65.
- The number of patients attending for dialysis as of December 2019 was 92. Thirty-eight of these patients were between 18 and 65 years of age, 54 patients were over 65.

The service did not store or administer any controlled drugs.

Track record on safety

- No never events
- No serious injuries or incidents (SI)
- One pressure ulcer reported not meeting SI criteria
- Four patient falls not meeting SI criteria
- Zero unplanned transfers to another healthcare provider
- Three complaints

Services provided at the clinic under service level agreement:

- Clinical waste removal
- < >
  Maintenance of machines
- Maintenance of water treatment plant
- Dialysis water monitoring
- Supply and removal of oxygen cylinders
- Facilities management
- IT management
- Domestic waste removal

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?

Requires improvement 

Our rating of safe stayed the same. We rated it as **Requires improvement** because:

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

- The service external clinical waste collection area, and a sharps bin awaiting collection, were not secured. We found this at our previous inspection in 2018 and saw this was still the case in 2020.
- We found a procedure relating to the preparation and administration of low molecular weight heparin (LMWH) medicine was unclear and may have left patients at risk of harm. Post inspection we received an updated version of this procedure and a risk assessment to support this.
- The service had one set of scales for patient use. Although another set was available at a clinic nearby; if these were needed this could delay patient treatment sessions.

We found the following areas of good practice:

- 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. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Are services effective?

Are services effective?

Good 

Our rating of effective stayed the same. We rated it as **Good** because:

- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available six days a week.

Summary of this inspection

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

- The service did not always evidence how they had adapted consent forms to be accessible to patients who required alternative formats.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Are services responsive?

Good

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. When problems were identified with accessing treatment due to third party providers (patient transport) the service worked to monitor and manage this.

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

- The service did not have a formal process to implement the Accessible Information Standard.

Are services well-led?

Good

Our rating of well-led stayed the same. We rated it as **Good** because:

- 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 to plan and manage services and all staff were committed to improving services continually.

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

Summary of this inspection

- The service patient satisfaction survey results had worsened since 2018 due to various factors. However, we saw action plans and engagement were ongoing to improve this.

Good

Dialysis services

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

Are dialysis services safe?

Requires improvement

Our rating of safe stayed the same. We rated it as **requires improvement.**

Mandatory training

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

Nursing and other staff mostly received and kept up-to-date with their mandatory training. We saw that mandatory training comprised of 23 modules. These included basic life support, infection control, fire training, hand hygiene, data protection, water treatment training, duty of candour, dementia, falls, pressure ulcer prevention training, blood borne viruses and manual handling.

Completion of mandatory training ranged from 68% to 100% as of January 2020. The three lowest levels of compliance at the time of inspection were dementia training, Prevent training and National Early Warning Score (NEWS2) training. Prevent is a government strategy that aims to provide support and re-direction to individuals at risk of, or in the process of being groomed or radicalised into terrorist activity before any crime is committed. Dementia training compliance was 65% (13 out of 19 staff), Prevent training was 70% (14 out of 20 staff) and NEWS2 training compliance was 75% (9 out of 12 staff). All other training modules were over 75%, with the majority over 90%.

The service sent through updated figures for February 2020 which showed improvement in compliance for Dementia training (compliance at 79%) and Prevent training (compliance at 85%). NEWS training compliance had risen to 92%. These figures showed that mandatory training compliance was improving in these three modules.

Staff received training on sepsis as part of the NEWS training module. All registered nurses and dialysis support workers completed this as part of their mandatory training package.

Managers monitored mandatory training and alerted staff when they needed to update their training. The practice development nurse (PDN) maintained an annual training plan which enabled oversight of the mandatory training needs to clinic based staff.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and support staff received training specific for their role on how to recognise and report abuse. As of January 2020, 100% of the unit staff (20) had completed safeguarding adults training (level 2). The clinic manager and clinic development manager were trained to level three. 95% of staff (19 out of 20) had completed safeguarding children training (level 2). 70% of staff had completed Prevent training (14 out of 20 staff).

Staff had access to a provider wide chaperone policy; although this covered a broad range of clinical specialities and was not dialysis specific.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. During our inspection we saw staff take action to protect a patient from harassment from other patients.

The service did not permit children (under 18) onto the premises; for example, patients' children. Despite this, a child protection policy was in place in case a child inadvertently entered with a patient, or a patient disclosed information about a child at risk.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

When patients did not attend for their treatment; staff followed a structured process which included contacting the patient, and if necessary informing the local authority if safeguarding concerns were noted. Staff also reported any non-attending patient as an incident; and alerted the satellite coordinator from the referring NHS trust.

The service had a safeguarding adults, and a separate child protection policy. These were mostly comprehensive although did not reference female genital mutilation (FGM) as a safeguarding risk. Given the nature of the service it is less likely that staff would directly observe signs of this. The most updated intercollegiate documents pertaining to safeguarding adults and children do specify that this be included as an area of training. The policies did not reference training requirements as per the relevant intercollegiate documents.

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.

All areas within the service were visibly clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We sample checked a range of cleaning records and found these to be complete. Each dialysis station was cleaned between patients.

Staff followed infection control principles including the use of personal protective equipment (PPE). When not in use staff stored visors (used to minimise the risk of splashing of blood or body fluids reaching the eyes, nose or mouth) on a row of hooks used for this purpose in the service corridor, not accessible to patients. Staff used the same visor and cleaned their own at least once per shift.

Patients who had a temporary infectious illness were well managed to prevent the spread of infection. In addition, patients returning from abroad were also required to use isolation rooms for a set period of time. Staff at the service routinely swabbed patients for MRSA every three months to monitor rates of this infection and reduce the risk of transmission. Managers undertook monthly audits of how staff managed patients with Hepatitis B or C. We saw in January 2020 the compliance rate was 100% which meant staff were following the correct processes to minimise the risk of transmission of these blood borne viruses.

The service offered treatment to patients who were human immunodeficiency viruses (HIV) positive. Staff followed the provider wide policy 609.01 Dialysis of HIV Positive Patients to ensure patients received safe treatment.

We observed staff to wash or gel their hands before and after patient contact. Managers audited hand hygiene weekly. We saw evidence that these audits were undertaken, and where non compliance was found managers set clear improvement actions.

The staff at the service were trained to use aseptic non touch technique when connecting or disconnecting patients to dialysis machines. This was also audited by the service manager. We observed this in practice and found two different staff members undertook this in different ways. When asked further, it was clear that the standardised approach promoted within the provider policy was not embedded. Despite this, all staff used a variation of the technique in a safe way which did not put patients at heightened risk of infection. We raised this at the time of the inspection and managers assured us they would assess and review staff technique and if necessary ensure re-training to maintain compliance to the policy.

We also noted that different staff used personal protective equipment differently again indicating that a standardised approach was not yet embedded across the

staff nurse team. For example, staff wore their visors for different lengths of time when working with patients. Some staff cleaned their visors in between each patient contact, whereas other staff did so less frequently. The required practice was to do this at least once per shift.

Staff monitored and assessed vascular access sites for each patient on every treatment session. This was to reduce the risk of a vascular site infection. Managers audited this every month. Where any areas of noncompliance were found, actions were set, and results shared with staff. For example, in January 2020, an arteriovenous (AV) access care audit was conducted. Managers observed staff on 20 occasions and found staff to be fully compliant with infection and prevention control requirements on 16 of these occasions. Where staff were non-compliant, managers set actions to improve such as ensuring the access point was adequately disinfected for at least 30 seconds.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff completed cleaning records to show all cleaning of dialysis machines was as per the provider policy.

During our inspection, the unit was visibly clean and tidy. During opening hours, unit staff completed any cleaning required. General domestic cleaners also attended to do routine daily cleaning. We saw that cleaning rotas were in date. For example, those confirming that dialysis stations had been cleaned between patients.

Managers ensured all staff were trained in water treatment to monitor for and reduce the risk of bacterial contaminants. Healthcare assistants checked the water used in the dialysis machines daily for contaminants. A third party service was commissioned to complete external sampling on a weekly basis. A separate external third party managed the water system and provided any maintenance.

Environment and equipment

The design and maintenance of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well in the clinic, however did not ensure this was secured safely.

Staff responded quickly when alarms sounded on patients' dialysis machines. We observed staff check the reason for the alarm before silencing this.

The design of the environment followed national guidance. Entrance into the unit was secure. During hours when the receptionist was present; they monitored the cameras before opening the locked front door. Outside of these hours, staff enabled entry. During our last inspection, we saw security could be compromised as patients in the waiting area were letting other patients and visitors in. On this inspection we did not observe this happen.

Entry into the clinical treatment area was also secure. Swipe card access was needed to gain entry; therefore, only staff could let patients through. Staff only rooms were locked; such as store rooms, the cleaner's cupboard and the maintenance area.

The area in which the water used in treatment was located met national guidance; for example, a 'lipped' area to prevent flowing into the main clinic had been built in as a protective measure should one of the water containers overflow.

Each dialysis station had enough space around it to allow enough staff to attend to a patient in the event of a medical emergency. There was space for wipe clean privacy screens to be positioned if required; to maintain patient privacy and dignity. Staff could easily access these screens.

Staff carried out daily safety checks of specialist equipment. We sample checked a range of equipment and found all to be serviced within the required timeframe and to be in working order. A technician who was employed by a third party company worked on site to monitor and manage this process; and ensured any repairs or routine maintenance was undertaken. This technician carried out repairs of dialysis. A different third party company was responsible for servicing and maintaining the water system used for dialysis.

Staff clearly labelled dialysis machines which were not in use and these were kept in a locked room.

The service had enough suitable equipment to help them to safely care for patients with one exception. The service had one set of scales. This was used to measure patients' weight pre and post dialysis to ensure treatment was

accurate in terms of how long the patient needed to dialyse. The service did not have a spare set on site at the time of inspection. Staff could access a set at a nearby clinic. Staff told us if neither of these sets of scales were available; the patients' pre and post treatment weight from the last session was used as a guide to decide how long to set the dialysis treatment for.

Managers maintained a unit risk register. We saw one of the identified risks was not having a hoist to support the moving and handling of patients that required this; particularly as more patients were presenting with more moving and handling needs. The service proactively set actions to obtain a hoist and for staff to be trained in this therefore minimising the risk of harm to patients. At the time of inspection, the service had obtained the hoist.

Staff had access to resuscitation equipment. We checked this and found it was well stocked, in a suitable location for ease of access and all consumables were in date.

Staff disposed of clinical waste safely within the unit, however did not always secure this safely in the outside waste collection area. Sharps bins were situated in each bay. They were secured correctly, clean and free from debris. The service had a waste disposal area situated in the car park which contained the large clinical waste bins and large sharps bins awaiting collection by a third party clinical waste disposal company. This was gated off from the general public; however, during our inspection we found the gate unlocked. This was also found during our previous inspection. This meant that patients, or the general public could access this area. In addition, we saw the sharps waste disposal box in this area was also unlocked.

The Control of Substance Hazardous to Health (COSHH) cupboard was secured and chemicals and equipment stored correctly.

The general store cupboard was secured. We checked a sample of consumable products. These were sealed and in date. Dialysis sets were single use.

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 undertook physiological measures to identify if patients deteriorated during treatment sessions; and where necessary escalated concerns appropriately. Ninety-two percent of the nursing staff were trained in the National Early Warning Score (NEWS2) as of February 2020. We saw staff used this tool to assess and monitor deterioration in patients when necessary.

During our inspection we checked five patient records. Within each patient record a haemodialysis flowsheet was completed for every treatment session. These demonstrated how often staff had undertaken checks on patients, including physiological checks, to monitor any patient deterioration or problems with connection points. The checks included blood pressure, pulse rate, temperature and where relevant needle and connection checks. We saw the minimum number of checks completed for each patient was five. These comprised a pre-connection check, a check immediately after connection, a check immediately before disconnecting a patient from a dialysis machine and a post connection check. In addition, a mid-treatment check was completed. Where appropriate, patients had additional checks throughout their treatment.

Staff were trained in basic life support and had access to resuscitation equipment. In medical emergencies staff would contact the emergency services to request an ambulance. Staff told us that emergency scenarios were practised in the unit.

If sepsis was suspected, staff had access to the 'haemodialysis satellite units sepsis screening tool' document to support early recognition.

Staff could contact consultants at the referring NHS trust for advice and guidance. Where this was out of hours, a protocol was in place which enabled staff to contact the trust based on-call registrar.

Managers at the service monitored transfers out of the unit; including where staff assessed that a patient was not fit to receive treatment. We saw data relating to this and saw appropriate actions were taken, including liaising with the referring trust on call consultant.

When patients' dialysis machines 'alarmed' during treatment, staff attended promptly and asked questions before turning the alarm off to check if a patient had deteriorated or was experiencing an access point bleed.

When patients were introduced to the clinic, staff explained what to do in an emergency should a patient not be at the unit; for example, in the event of a fistula bleed at home. Patients signed to say they had received and understood this information.

Staff completed risk assessments for each patient monthly, using recognised tools. Risk assessments included waterlow (assessment for skin damage), falls risk assessments, moving and handling and venous needle dislodgement.

Where risks were identified, appropriate actions were set such as encouraging patients to use a pressure relieving pillow or supporting patients with a high falls risk with actions such as placing the patient in a high visibility bay and allocating staff to escort the patient around the unit. These actions were reviewed, and re-set monthly as required.

Staff assessed patients' catheter exit sites at every treatment; and completed standardised monitoring tools to be able to identify and reduce the risk of infection.

Staff knew about and dealt with any specific risk issues. Staff placed patients with higher needs; such as a high falls risk, or a mental health condition such as anxiety, in bay one (of three). Bay one was located next to the main nurses' station; and was also near to the clinic managers office and therefore enabled a higher level of visibility from staff. As reported above, patients with known blood borne viruses were well managed.

Shift changes and handovers included all necessary key information to keep patients safe. Staff also had access to a communications book to review any important messages to keep patients safe.

We asked the service how staff managed patients with neurological and/ or developmental disorders such as autism, learning disability, or cerebral palsy. Data from the service showed there was no specific policy for working with patients with these additional needs. The data provided was the safeguarding adults policy which outlined how staff would manage patients at risk of abuse or neglect rather than providing any training or guidance on supporting patients with additional needs more generally.

We also asked how patients with mental health disorders such as depression, anxiety or schizophrenia might be supported by staff. Again, data from the trust referred to the safeguarding guidelines which outlined how to respond if a staff member felt a patient was at risk. Although this did not explicitly cover the risk of suicide and/ or self-harm the policy provided guidance for staff if they felt a patient was at immediate risk.

Data from the service did provide evidence that action was taken if a patient was expressing suicidal ideation which included making an urgent GP referral and informing the named consultant from the referring trust.

For any patients who showed symptoms of depression, schizophrenia or anxiety, concerns could be raised to the patient's consultant from the referring NHS trust. The consultant was responsible for following this up and arranging assessments and interventions as required. We saw staff did support patients with mental health conditions.

Staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. At the time of our inspection, the service was fully staffed. Ten registered nurses were employed to cover 9.3 full time equivalent positions (eight worked full time, and two part time). This was following a recent recruitment drive at a provider wide level due to low staffing levels across the country.

Six healthcare assistants were employed; along with one dialysis support worker. A dialysis support worker was trained in extra competencies to enable them to undertake some specific nursing duties.

Managers accurately calculated and reviewed the number and grade of nurses, dialysis support workers and healthcare assistants needed for each shift in accordance with national guidance. Managers staffed the unit based on one nurse or dialysis support worker to four patients, and one healthcare assistant to 10 patients. This enabled an appropriate amount of cover to ensure patient safety.

Managers reviewed the skill mix of staff allocated to shifts. 'Nurse in charge' roles were undertaken by qualified renal nurses per shift. This meant they had completed additional qualifications in renal medicine including dialysis.

The service used bank staff to cover shift vacancies. These staff came from an internal bank of staff who worked either at this unit; or another local unit. From October to December 2019, 239 shifts were covered by bank staff. No agency staff were used. Bank nurses were expected to be competent to undertake their role; managers checked this. Managers at the service told us bank staff covered shifts when permanent staff were absent through long or short term illness, maternity leave or annual leave. Bank staff were also used if necessary when new starters were still within their supernumerary stage of induction. We saw that the use of bank staff was reviewed and discussed at contract meetings held between the service managers and the referring NHS trust.

The clinic development manager was supernumerary to registered nurses planned on shift which allowed extra support for clinical care.

The service had no vacancy rates at the time of the inspection due a recent recruitment drive including a provider wide overseas recruitment programme. The service had high turnover rates from January to December 2019. In that time five registered nurses (50%) left the service and nine joined the service. This meant the workforce was mainly comprised of newly employed staff. This was identified on the local risk register and had actions set to mitigate risks to patient safety. For example, identifying an accurate skill mix of staff for every shift to ensure newer members of the team were supported. Also, the clinic manager and clinic development manager staggered their start times to ensure management cover was maximised.

Managers at the service analysed the reasons for the high turnover rates and found staff had left for unlinked reasons. No specific themes were identified.

The service had a moderate sickness rate for registered nurses. As of December 2019; the sickness rate was 9.1%. Managers had a staffing risk register where they listed any staff who needed additional support at work; such as member of staff who was temporarily less mobile due to an accident outside of work. This enabled staff to be supported and provided assurance that patient safety was maintained. Staff covered absences by offering the clinic staff the opportunity to work an extra shift as required. If this was not enough to cover sickness absences, managers used the provider wide bank of staff.

Staff told us they felt the sickness rate had improved recently.

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.

During the inspection we reviewed five patient records. All records viewed contained relevant information to keep patients safe and to ensure effective treatment.

Patient notes were comprehensive, and all staff could access them easily. Patient records were both paper and electronic based. Electronic patient records were shared with the referring NHS trust; and staff at the unit had access to the trust's electronic system for patients using the service.

Patient records were well ordered and maintained. All but one had the patient's photo on the inside front cover to help staff visually identify patients. Records contained a range of relevant information including dialysis prescriptions and treatment plans, check sheets of various safety checks such as fistula monitoring, admission assessments for each patient, a range of risk assessments and various patient consent forms. Staff reviewed care plans and risk assessments regularly; and associated action plans were updated as necessary.

Managers audited patient records monthly. We saw results from January to December 2019. This data showed that all audits were between 96% to 100% compliance demonstrating a good rate of record keeping consistently throughout the year.

Records were stored securely. Records were stored in lockable cabinets kept behind the main nurses' station in bay one. During our inspection, these were consistently locked when not in use.

Medicines

Good

Dialysis services

One provider procedure did not ensure national best practice was followed when preparing a specific medicine. However a risk assessment was developed for this post inspection. The service used systems and processes to safely prescribe and record medicines.

Staff followed systems and processes when safely prescribing and recording medicines. Medicines were available, safe and secure with restricted access to authorised staff. A locked secure clinic room was used for medicine storage.

Stock rotation was undertaken to ensure medicines did not go out of date. Expiry dates were clearly highlighted for medicines due to go out of date.

Medicine fridge temperatures were recorded on the days the unit was open. They were within the recommended range and staff were aware of what action to take if there was a deviation.

Medicines required in an emergency were readily available. Regular checks of emergency medicines and equipment were carried out and recorded by staff to ensure they were in date. Tamper evident seals were in place to ensure medicines were fit for use.

Staff provided specific advice to patients about their medicines. Nurses had access to advice from two consultants as well as a nurse prescriber based at the referring NHS trust. Prescriptions for medicines would be emailed directly to the service to ensure patients had access to available treatments such as antibiotics if needed.

Allergies were annotated within patient records. Where no allergies were reported, staff recorded this to avoid confusion.

Staff managed medicines and prescribing documents in line with the provider's policy. However, one procedure did not reflect best practice. This meant staff did not always follow national best practice when preparing and checking medicines.

A standard provider wide procedure was used to prepare and check Low Molecular Weight Heparin (LMWH) before administration which had last been reviewed on 10 October 2018 (3008:11 Preparing and checking LMWH). All the prepared and checked LMWH were left by each patient's dialysis station before any patients arrived in the treatment area. This meant that at the point of preparing the LMWH, the procedure of checking the right patient, right medicine, right dose, the right time, right route and right documentation was all undertaken with no patient present which was not in line with national best practice. In addition, the procedure contained several 'special deviations' which were directives to staff working within specific clinics. However, it was not clear as to which clinic these would apply to leaving the procedure document open to inconsistent interpretation and application. This procedure also implied that unlabelled LMWH medicine could be left unattended at patient dialysis stations.

At the time of the inspection, there was no risk assessment available to ensure the safety of LMWH medicines and the potential impact of any errors within this process; for example, if two patients were required to swap dialysis stations for some reason.

After the inspection, managers at the service provided us with a revised procedure and a risk assessment to support any deviations from national practice such as preparing medicines for administration before patients had arrived. We found the procedure to be significantly clearer which meant the risk of misinterpretation by staff and subsequent harm to patients was mitigated. For example, it clarified that all LMWH must be labelled with patient information as per the Royal Pharmaceutical Society guidelines. In addition, the supporting risk assessment clearly outlined the risks of processing LMWH in this way; and outlined clear mitigating actions which would reduce any opportunity for tampering or a medicine error.

When nurses did administer the LMWH when connecting each patient, we saw that the provider requirements in the procedure of checking the right patient, right medicine, right dose, the right time, right route and right documentation was followed at this stage therefore reducing the risk of the wrong medicine being given. This was an improvement from our previous inspection in 2018 when we found patients' identity was not always checked before administration. There were no reported incidents relating to LMWH in the reporting period.

The documentation for checking and administering the LMWH was a standard form provided from the referring NHS trust. This did not support the accurate recording of

the above described practice of collecting and checking a medicine (LMWH), leaving this and later returning to administer the medicine. The reason for this was the form had a box for staff to sign to say they had checked the medicine when preparing it and a separate box, which was just above the 'check' box, to sign to say the medicine had been administered. But due to the layout of these two boxes, it implied that the person who had signed the 'check' box was signing to say they had checked at the time of administration. In practice this was not the case. In practice, the 'check' box was signed before the actual administration record was signed. When the LMWH was administered to a patient the 'given' box on the medicine administration record was then signed by another nurse at a slightly later time.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Medicine alerts were received by the nurse in charge which were printed off and cascaded to all relevant staff. For example, national medicine shortages continued to be an ongoing issue however the service ensured that patient care was not impacted.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff we spoke with gave us examples of incidents they had reported, and how these had been resolved. Staff had access to an incident reporting policy which clarified what incidents were and when they should be reported; and listed serious incidents that required immediate reporting to senior management.

Staff raised concerns and reported incidents and near misses in line with the provider policy.

From January to December 2019 staff at the service reported 829 incidents. A large proportion of these (504) related to patients voluntarily cutting treatment sessions short. This was an area of concern the manager had added to the service risk register. Please see the 'Well Led' section for more information relating to this. 148 incidents were recorded for occasions when patients did not attend for their appointments. Staff followed a set structure of managing this type of incidents. Please see the 'Responsive' section for more details.

The service had no never events or serious incidents from January to December 2019. The service had not reported any incidents which met the legal threshold for the duty of candour to be applied. Despite this, staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

The duty of candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.

We reviewed root cause analysis documents that managers had completed after incidents such as patient falls. These clearly included the cause of the incident, actions taken during the incident and any learning. Actions were set and signed off as complete.

Managers debriefed and supported staff after any incidents. Staff received feedback from investigation of incidents, both internal and external to the service. Managers provided information and learning following incidents. This was usually during team meetings whereby staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback.

The service used monitoring results well to improve safety. From January to December 2019, the service reported one pressure ulcer and four patient falls. None of these incidents met the threshold to be considered a serious incident.

Good

Dialysis services

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

Good

Our rating of effective stayed the same. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice, although one policy did not reflect best practice. Managers checked to make sure staff followed guidance.

Staff mostly followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had access to a range of provider policies to support the delivery of care and treatment. We reviewed a sample of these. All those we reviewed were version controlled, were reviewed by the provider in reasonable timescales and contained references to national guidance, laws and best practice documents such as the Equality Act (2010) and National Institute of Health and Care Excellent (NICE) clinical guidelines. We did note, as reported in the 'Safe' section, that the safeguarding adults and child protection policies did not reference the relevant intercollegiate documents. Also, the policy for the preparation and administration of low molecular weight heparin (LMWH) did not consistently reflect best practice.

Managers completed audits into routine aspects of care and treatment; and shared results with staff. We saw results of a recent health and safety audit displayed on the staff room wall.

The service had been involved in a national research project with the British Renal Society (BRS) about improving vascular access for patients. As a result, the BRS had produced a standardised tool to flag any problems with a patients' vascular access; and to assess it using a structured system. We saw the tool was in place with relevant patients; and staff used it to assess patients' vascular access.

During the inspection, we generally observed staff to display competency when undertaking clinical activities, and to adhere to best practice guidelines. This included 'needling' (inserting a needle into an arteriovenous fistula or graft to connect the patient to a dialysis machine), securing needles to patients using the 'chevron' technique (a way of taping the needle and line to the patient to keep it in place), and disconnecting patients from dialysis machines.

Staff knew the importance of protecting the rights of patients' subject to the Mental Health Act and followed the Code of Practice. The service did not have any patients who were detained under the Mental Health Act. Where patients had mental health conditions; staff sought to support them. For example, where a patient was experiencing anxiety; staff enabled them to move to a dialysis station closer to the main nurses' station. This enabled the patient to have a greater level of support and reduced the risk of the patient stopping their treatment early, which is what had happened previously.

Nutrition and hydration

Staff gave patients appropriate food and drink during treatment sessions.

Staff provided hot drinks, water and biscuits to those patients who wanted this while dialysing. Where patients were on a restricted fluid intake, this was identified and accounted for; for example, providing a smaller amount of tea or coffee.

An audit of food provision during dialysis formed part of an annual unannounced clinical audit. This was undertaken at provider level. In January 2020, the overall compliance in this audit was 93.7%. One area was not compliant. Managers identified the need to improve this score and created an action to resolve the issue found. The issue identified in this audit was having the wrong documentation in place to monitor daily food storage.

When social events involving food were scheduled; staff ensured the food was 'dialysis friendly' to enable all patients to take part.

Specialist support from a renal dietitian was available for patients who needed it. The dietitian was employed by the referring NHS trust and worked from the unit when required to support patients.

Pain relief

Staff monitored patients to see if they were in pain and supported with pain relief in a timely way where appropriate.

Staff did not undertake formal pain assessments due to the nature of the service. Staff discussed pain generally with patients before each treatment session. Patients were able to bring their own analgesia such as topical numbing cream, to reduce pain and discomfort when being connected to dialysis machines.

Where patients had a prescription, trained staff could administer lidocaine and/ or paracetamol to patients.

If staff identified that a patient had ongoing pain, this would be reviewed. Staff encouraged patients to discuss this with their GP or staff could refer the patient to the relevant team such as the referring trust access team for issues with an arteriovenous fistula.

Patient outcomes

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

The service participated in relevant national clinical audits. Outcome data was submitted to the referring NHS trust to be included in the National Renal Register.

The unit reported on treatment adequacy outcome data and produced quarterly monitoring reports. The data was reviewed at quality assurance meetings at the trust.

The Renal Association national guidelines and standards specify 80% of all prevalent long term dialysis patients should receive dialysis treatment through a definitive access: arteriovenous fistula (AVF) or arteriovenous graft (AVG) or Tenckhoff catheter (used for peritoneal dialysis whereby the access point for dialysis treatment is through the stomach). AVF is where an artery and a vein are joined together, an AVG is where an artery and vein are joined together by an artificial tube to make a better access for needles used when having dialysis treatment. Data from the service showed that between 70% to 75% of patients received dialysis in this way from January to December 2019. This was in line with four out of five other local units from the same provider. In January 2020, 72% (63 out of 92) of patients were dialysing using a fistula. The unit maintained a specific risk register relating to this which was updated on a monthly basis and discussed at monthly quality assurance meetings.

The service did not dialyse patients with peritoneal access.

The Renal Association Clinical Practice Guidelines (2019) outline expectations of haemodialysis treatment. These include urea reduction expectations, the length of time a patient spends dialysing per week (more than 12 hours per week in total), the provision of a low molecular weight heparin (anti-coagulant medicine) be given to all suitable patients during treatment and centre-based haemodialysis patients should have opportunity and encouragement to learn aspects of their dialysis treatment (shared care). We saw the service considered these guidelines when providing treatment; and where required through their contract with the referring NHS trust, monitored and reported on compliance. All suitable patients at the service received anticoagulant.

Two of the main functions of kidneys are to regulate the amount of water and salts in the body as well as eliminating waste products such as urea. Where haemodialysis is used as a treatment for severe kidney failure; one of the ways to measure the treatment's effectiveness is to measure the reduction on urea post treatment.

Reduction of urea was a key performance indicator; specifically, the percentage of haemodialysis programme patients with a urea reduction ratio (URR) of >65% (greater than 65%). Data from the service showed that from January to December 2019, a URR of greater than 65% was achieved for between 93% and 100% of patients.

Managers at the service had identified that a number or patients were not receiving their prescribed treatment time due to choosing to end their session early; and therefore, not compliant with The Renal Association Guidelines. Managers had added this to the service risk register and described various actions taken to manage this. For example, engaging patients with games and activities to ensure they stayed to finish their treatment session, having conversations and providing written information about the importance of receiving full treatment. We observed an information board display in

the patient waiting area about this which clearly outlined the risks of reducing treatment for non-clinical reasons. One reason identified for this was patient transport timings. For example, if the patient was late to the start of their session, this meant if the patient wanted to get their pre-scheduled journey home, they felt they had to end their treatment early. Otherwise patients could be waiting for a significant time for another patient transport vehicle to be available to collect them. Therefore, patient transport was also an item on the service risk register.

Managers also reviewed both shortened treatment times and patients who chose to not attend for their sessions at monthly quality assurance meetings. The satellite coordinator from the referring NHS trust was an invitee to these meetings to ensure information was shared.

Staff at the clinic encouraged patients to be involved in shared care or self-care as per The Renal Association Clinical Practice Guidelines (2019). At the time of our inspection, one patient was learning to connect and disconnect themselves from the dialysis machine. Patients were also encouraged to take an active part in their treatment if they wished, such as washing their own arms before being connected to a machine (where the connection point was in an arm).

The service had no unplanned transfers to another acute hospital setting from January to December 2019.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment and shared this with staff. Data from the service showed that a comprehensive action plan was active and in use following a range of audits including internal audits such as hand hygiene, and audits to monitor adherence to national standards such as the time patients spent dialysing per week.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were qualified and had the right skills and knowledge to meet the needs of patients. All new nurses and dialysis support workers received an induction up to 12 weeks, which could be extended where more support needs were identified before undertaking their role independently. Nurses worked supernumerary for at least four to six weeks to support their development. This time could be extended where more support needs were identified.

A mentor was allocated to new staff to support them through developing competencies. Mentors were experienced staff nurses who were provided with support and training to undertake this role. Two members of staff had previously completed formal mentorship training; and a provider wide mentorship course was due to be re-launched in the future.

Staff members were required to undertake initial and ongoing competency based training. This included the provider wide mandatory training programme for all staff. The area practice development nurse oversaw competency training and took responsibility for signing off new starters.

Part way through the induction period for new starters, an interim interview was held to discuss progress and identify objectives. At the end of the induction, a final interview was held to review and sign off the new starter as competent. Managers encouraged new starters to continue to work with their mentor post induction for extra support and advice.

Managers supported staff to develop through yearly, constructive appraisals of their work and regular supervision. All staff who had been at the service long enough had received an appraisal.

Data from the service reported that the service had introduced peer training and learning into staff meetings to support nurse grade staff with their professional revalidation.

The practice development nurse (PDN) had written an article for a recent staff newsletter about nurse re-validation to support staff.

The PDN supported the learning and development needs of staff. The PDN covered all six clinics in the Midlands region. The PDN oversaw competence training in areas such as aseptic non touch technique (ANTT), priming dialysis machines, dialysis line (catheter) insertion and understanding dialysis.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers advertised team meeting dates in the staff only areas.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers alerted staff to training opportunities. We saw these displayed in the staff room.

Managers made sure staff received any specialist training for their role. Registered nurses were encouraged to undertake professional qualifications in renal medicine. At the time of the inspection two nurses had completed this qualification. This had been previously accessed through a degree course; however, was now completed through undertaking individual modules. Staff could access this through two universities; one of which provided the courses through distance learning. At the time of inspection, one nurse was undertaking this. Other staff told us the managers and PDN at the service were supportive of this process, but it was difficult to obtain the funding at times.

Nurses undertook link roles. This meant that nurses were allocated a particular area of clinical care and were supported to develop their knowledge and skills in this area in order to provide advice and guidance to their colleagues. Link nurse roles included blood borne viruses (BBV), health and safety and renal access. We spoke with staff who undertook some of these roles. They had a clear understanding of their area of focus and were aware of what the role of a link nurse involved.

Managers identified poor staff performance promptly and supported staff to improve. If managers identified poor performance; they liaised with the area practice development nurse to create an improvement plan.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff at the service, and a representative from the referring NHS trust told us that a supportive relationship existed. Staff told us that regular meetings held with the trust enabled all patients to be discussed openly; and ongoing treatment plans were confirmed. The service worked closely with the satellite flow coordinator based at, and employed by, the trust to ensure patients received effective treatment.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff kept copies of letters from consultants to the patients' GPs to ensure relevant information was shared.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Patients had access to specialist staff from the referring NHS trust at the unit. These included consultant nephrologists, a dietitian and a satellite clinic co-ordinator clinical nurse specialist. Patients could also access sessions with a specialist clinical psychologist; although these sessions tended to be held on site at the NHS trust. We saw meeting minutes that showed relevant professionals sharing information and taking responsibility for patient care. We observed interactions between staff from different organisations at the time of our inspection which was positive and supportive.

Patients had their care pathways reviewed by the relevant consultants. Staff at the unit shared information electronically with the referring NHS trust; and were able to request advice and guidance from trust consultants by phone calls, secure email or face to face if consultants were at the unit.

Six-day services

The service was open six days a week to support timely patient care.

The service was open for six days per week and offered morning, afternoon and twilight sessions. Specifically, it was open between 6.30am to 11.30pm Monday, Wednesday and Friday and 6.30am to 6.30pm on Tuesday, Thursday and Saturday.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in the unit. Leaflets were available to patients which promoted healthy eating and gave advice about local support centres.

Staff enabled and supported access to specialists who could promote health such as dietitians.

The service had a wide range of information for local support services including: safeguarding and social services, domestic abuse services, and domestic abuse services specific to the lesbian, gay, bisexual, transgender, queer plus (LGBTQ+) community, general LGBTQ+ support services, female genital mutilation (FGM), human trafficking, and ChildLine and the National Society for the Prevention of Cruelty to Children (NSPCC). During the inspection, the management team discussed where to locate this, so it was more visible and accessible to patients. At the time of inspection, it was located on a bookshelf in the patient waiting area.

Consent and Mental Capacity Act

Staff supported most patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff had access to provider wide policies 'Equality and Diversity' and 'Patients who lack the capacity to give or withhold consent' which outlined requirements for assessing and responding to the needs of patients who may lack capacity to consent to treatment.

Staff clearly recorded consent in the patients' records. We checked five patient records and found each patient signed a range of consent forms. These included; consent for dialysis treatment, consent for ongoing dialysis treatment, consent to have blood samples screened and consent for data protection principles to be applied including updated forms since the General Data Protection Regulations (GDPR) commenced.

The provider policy entitled 'Informed consent for dialysis treatment' outlined that staff must explain various aspects of what the patients were consenting to, and that signed written consent forms were not always necessary. All records checked had signed consent forms. However, we saw one patient had identified they were partially sighted (legally blind). This was in addition to several other conditions, some of which may have impacted upon capacity to consent to dialysis treatment, and other elements of care. Within the patient record we saw the consent forms, which were written copies, had all been signed by the patient but there was no evidence to say how communicating the consent forms had been adapted so this patient was able to fully review the information.

In addition, some of the information contained within the consent forms was complex which meant some patients; such as those with reduced cognitive development, may find hard to understand. With the patient referenced above, staff had not undertaken mental capacity assessments to ascertain capacity to understand, weigh up and consider the information being presented before making an informed decision. We discussed this with the unit managers who stated that the patient did have capacity; although at times a relative had also countersigned the consent forms. The managers were open to our feedback about this and assured us that although it was not annotated within the patient notes; the consent forms had been read aloud to the patient.

Staff respected patients' decisions to shorten their treatment; although also encouraged patients to desist from this when it was for non-clinical reasons to avoid the treatment being ineffective. During our inspection we found that where patients wished to shorten their treatment, staff requested patients sign a consent form to state the patient understood the risks of doing this, particularly for non-clinical reasons. We saw evidence of signed consent forms of this nature within patient records. We saw evidence that staff engaged with patients who wished to shorten their treatment. This was on the service's risk register. Please see the 'Well Led' section of this report for more information.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Good

Dialysis services

Staff received and kept up to date with training in the Mental Capacity Act. All staff were compliant with training as of January 2020 (100%, 20 out of 20 staff).

Are dialysis services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

During our inspection we saw a range of 'thank you' cards displayed on the wall in the patient reception area. These all shared expression of thanks and kindness towards staff from patients; and included specific comments about staffs' actions which had promoted patients' wellbeing.

During our inspection we saw staff take time and care to physically and emotionally support patients. For example, on several occasions different staff members supported more frail patients to their treatment station, or to the waiting room after treatment. Staff spoke kindly to patients at these times and ensured that the patient was walking or being supported in a wheelchair at a suitable pace for them. Staff carried patients' belongings where needed and clearly knew which patients may need additional care and support.

Patients said staff treated them well and with kindness. We observed a number of patient and staff interactions and saw that all staff spoke respectfully and kindly to patients. Staff, including newer staff members, were familiar with patients which enabled a friendly rapport to be demonstrated. Staff, where possible, took time to talk to patients and engage in general conversation.

During our inspection, patients and staff told us about several events that had been organised by service staff. These included a day trip to a seaside resort, a Christmas jumper day, a Halloween pumpkin carving competition, and a buffet. Staff told us how they actively took part in these events to ensure the patients experiences were positive when receiving dialysis. Managers ensured that funding was achieved by working closely with the local Kidney Patient Association representative.

In May 2019, the service had a formal visit from the Patient, Carer and Community Council who were from the referring NHS trust. The report following this visit identified that patients were treated in a dignified way and staff appeared aware of patients' needs.

We saw results of a patient satisfaction survey completed in June 2019 where patients said staff spoke to them with respect and were consistently pleasant and friendly; even when there had been periods of high staff turnover and regular bank staff use. However, we did note that one patient commented they felt they did not receive the same level of personalised care at this period of time.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff promoted an open and friendly environment. We found that the addition of a receptionist member of staff created a more inviting and positive environment for when patients arrived and were waiting to leave after treatment. The receptionist took time to purchase small items to support the patients to feel at ease; such as flowers.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. A representative from the Patient Kidney Patient Association attended the service on a regular basis to support patients and encourage patients to engage in activities outside of dialysis.

Staff referred patients to a renal specialist clinical psychologist based at the referring NHS trust where appropriate. The psychologist generally provided assessments and treatment sessions at a trust hospital; however, was flexible to attend the unit if a patient's need required this.

Staff could also refer to a social worker and a third party support worker for help with more practical support such as claiming benefits, housing, or care needs in the community.

A regular representative from the Kidney Patient Association attended regularly to provide support, advice and information to patients.

Staff supported patients who became distressed and helped them maintain their privacy and dignity. We saw examples of patients who had experienced thoughts of suicide and/ or self-harm had been listened to and supported appropriately. While staff told us they felt confident to go and discuss this with managers if a patient disclosed these thoughts to them, staff were unsure of the actual process to follow such as referring on to urgent or routine psychological support.

We received feedback following our inspection from a patient who reported that "the service and care I have received has been extraordinary" citing specific examples where staff, and in particular the manager of the service, had provided emotional support.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff assessed patients that were new to the service to understand any emotional needs. Staff understood the impact dialysis and long term treatment could have upon an individual's wellbeing and psychological state and took note of behaviour changes which could indicate a patient's emotional state was deteriorating.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us they felt involved in their care and able to make decisions about treatment. Patients reported that staff kept them informed of updates and changes to treatment.

Staff talked with patients in a way they could understand, using communication aids where necessary. Staff updated patients monthly about blood test results and any changes to treatment.

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

Staff had provided a post box in the waiting room where patients could write notes to both staff and patients they knew on other treatment sessions. This idea was introduced after staff were asked to pass messages on regularly. Both staff and patients felt this was a practical idea to enable better communication between patients, so they could support each other. Staff told us they did check the notes being left periodically to ensure no inappropriate messages were being sent by this method.

Patients gave mostly positive feedback about the service. Staff could give examples of how they used patient feedback to improve daily practice. Patient satisfaction survey results from June 2019 demonstrated a reduction in patient satisfaction across five of six areas measured compared to 2018. The areas where scores had deteriorated included trust, patient involvement, waiting times, care improvement and if patients would recommend the service. The area where scores had improved was diet understanding. Overall, the service scored 70% for the question of how many patients would recommend the service based on 43.7% patients completing the survey. This compared unfavourably to other Diaverum clinics. We noted patients were open in their feedback; both positive and negative. Managers at the unit used this feedback to create an action plan to address many of the issues raised; the majority of which centred around a high level of staff turnover and subsequent use of bank staff.

The next patient satisfaction survey, also conducted in 2019, showed an increase in patient satisfaction. In this survey, the service received an overall score of 88.7% which was an increase of 18.7% from the survey in June 2019. We noted that within this survey, 92% of respondents would recommend the service.

Good

Dialysis services

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

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. The service held a contract with a Birmingham based NHS trust. Managers worked closely and held regular meetings to ensure services provided reflected the needs of patients being referred.

The service worked to a strict criterion specified by the referring trust with regards to patients accepted for dialysis.

Facilities and premises were appropriate for the services being delivered. The service was in an industrial park; in a purpose built unit. The unit was all on one floor and was fully accessible to any patient. The unit had a large patient car park on site, a bus stop within reasonable walking distance and a local train station at Kings Norton approximately one mile away. Many patients accessed the service by patient transport services.

The service had a spacious reception and waiting area for patients waiting for their treatment session or awaiting transport post treatment. Male and female accessible toilets were available in this area. There was an adequate amount of seating and space for any patients who used a wheelchair or mobility scooter. The reception area had a low desk and was staffed from Monday to Friday, 9.30am to 5.30pm to support patients.

The service had 20 dialysis stations. Four of these were in isolation rooms. Of the 20 dialysis stations, four had beds for patients with additional needs and the remaining 16 had dialysis chairs.

Each dialysis station had an individual television screen for patient use. There was also a television located in the waiting room; we saw subtitles were on for patients with hearing loss.

The unit had two private consultation rooms for appointments such as consultant reviews and dietitian appointments.

The service had systems to help care for patients in need of additional support or specialist intervention. Upon admission to the unit, staff assessed new patients and sought to identify a holistic view of the patient. For example, information about language needs, social interactions outside of treatment, hobbies, and mobility levels was reviewed and updated if changes occurred.

Managers monitored and took action to minimise missed appointments. Between January to December 2019 148 patients did not attend (DNA) their treatment session. This figure included patients who were also offered alternative dialysis sessions.

Managers ensured that patients who did not attend appointments were contacted and offered an alternative treatment slot. If the clinic was unable to contact the patient, the next of kin was contacted. If this also proved unsuccessful, staff contacted the local police station to carry out a safe and well check. Any incidents of DNA were logged, and an incident report raised. In addition, the patient's named consultant was made aware of the missed treatment, along with any planned catch up session. This was also logged and discussed at governance meetings. Where patients were recurring DNAs, actions were taken to address this and ensure the patient's health did not deteriorate.

Meeting people's individual needs

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

Staff supported patients living with dementia, mental health conditions and learning disabilities by identifying the patients' individual needs within the admission assessment. Staff told us they could access communication cards to support patients who were Deaf or communicated by non-verbal methods. Three staff we

asked were not aware of the Accessible Information Standard (AIS; the legal requirements to provide communication support to those with a disability which meant communication would need to be adapted. We asked the service for information about how they ensure the AIS was met. Data post inspection contained information from the AIS website outlining what organisations were legally obliged to do. The service did not comment on how they specifically applied this and confirmed that the provider did not have a policy relating to this.

We did observe one patient who due to their individual needs (including sight impairment) would potentially require written information to be read out and communicated in simple terms. While we observed staff to communicate effectively with this patient during the inspection; we noted that numerous consent forms had been signed within the patient record. There was no evidence of how these had been adapted to ensure the patient had both received and understood the information presented. See the 'Effective' section for more information. We discussed this at the time of the inspection with the clinic management team. We were assured that the information had been communicated appropriately; however the team acknowledged that staff needed to record when they adapted communication to support individual needs.

The service did not have information leaflets available in languages spoken by the patients and local community. Leaflets about dialysis, kidney health and related topics were provided by the referring NHS trust who did not offer these in alternative formats than written English.

Patients could get help from interpreters or signers when needed. Interpretation services for medical consultations, such as consultant appointments, were organised through the referring NHS trust. Formal interpretation services were not used for day to day care and treatment; although the service was setting up a contract with a telephone interpretation service. Several staff were bi or multi-lingual and were therefore able to communicate with some patients in their first language if this was not English.

Staff organised events for patients that took into account social and cultural preferences. Staff showed us evidence of day trips to the seaside, and other social events including pumpkin carving and a Christmas time buffet. Where needed, funding was sought from the Kidney Patient Association to enable all patients who wished to attend.

When patients wished to go on holiday; staff signposted to a designated holiday co-ordinator who could help find dialysis clinics who would provide treatment for the patient while away.

Staff at the service completed an initial assessment with patients which detailed individual factors such as religious beliefs, social or work activities and interests. This enabled a suitable time for treatment sessions to be agreed to enable patients to fit dialysis around daily activities.

Access and flow

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

Managers monitored patient transport service times and supported patients to access the service when needed and received treatment within agreed timeframes and national targets.

Patient transport was highlighted as a risk to patients receiving effective treatment on the unit risk register. One of the key concerns was patients persistently being collected late before their session; which meant they were late being connected to their dialysis machine. This often resulted in patients either shortening their treatment as not to return home too late; or patients ending treatment later. This had a subsequent effect on the next cohort of patients needing treatment and also on staff working hours. Patients highlighted their concerns about this as part of the patient satisfaction survey carried out in June 2019 and through complaints and concerns raised. In addition, a visit from the Patient, Carer and Community Council from the referring NHS trust in May 2019 highlighted this as a concern. Although many of the concerns were with the patient transport provider which was separate to this service; we saw the unit managers took a proactive approach to try to resolve some of the issues around this. For example, patients were supported to claim funding for private taxis where possible, and work was done to discourage patients from reducing treatment times for non-clinical reasons. In addition meetings were held with a representative of the patient transport service to discuss concerns.

Managers monitored waiting lists for treatment. As of December 2019, 16 people were on a waiting list for a place at the clinic. This meant that they were receiving treatment either still at the referring trust; or at an alternate satellite clinic until a space became available.

Utilisation for the clinic was at 100% for the months from October to December 2019.

Managers worked to keep the number of cancelled treatments to a minimum. For the reporting period of January to December 2019, no sessions were cancelled or delayed for a non-clinical reason. We saw that on the 31 December 2019, a flood caused some patients to be delayed in their treatment time. While this was managed one patient was transferred to another local clinic of the same provider as they were unable to wait later. All patients received their treatment on this occasion and this incident was recorded on the unit risk register for ongoing oversight.

Within January 2020, 86% of patients started treatment within 30 minutes of their appointment time.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients we asked told us they knew how to make a complaint. All patients stated they felt comfortable and confident to approach either the staff or the clinic manager if they had a complaint or concern.

Patients told us, and we saw, that the clinic managers had an open door policy, both physically (the managers door was generally open unless working on confidential tasks) and in terms of feeling confident to raise concerns.

Patients gave us examples of where they had asked questions or raised concerns with the manager and these had been acted on.

The service clearly displayed information about how to raise a concern in patient areas. Information on the referring NHS trust Patient Advice and Liaison Service (PALS) was displayed in patient areas. A suggestion box was also available for patients to submit ideas or concerns within the unit.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. From January to December 2019, the service received three complaints, all of which were managed under the provider formal complaints procedures. Two of these complaints were upheld. All three complaints were responded to within 20 days as per the provider policy. Data from the service showed that suitable actions were taken in each case.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. The service received four written compliments from January to December 2019. One patient also contacted CQC to compliment the service within the inspection period of February 2020.

Are dialysis services well-led?

Good

Our rating of well-led improved. We rated it as **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. They supported staff to develop their skills and take on more senior roles.

Two managers ran the service at a local level. The clinic manager was the registered manager and held overall responsibility for all management decisions and actions. A clinic development manager was also in post. The purpose of this role was to provide clinic management from a clinical (registered nurse) perspective. Staff were aware of which manager to approach if they had a concern; for example, if staff wanted to clarify an issue of clinical practice they approached the clinical manager.

The two local managers held daily meetings to review the service needs. They provided managerial cover for each other during times of annual leave or other absence.

The local unit management was supported by an area manager; who also oversaw five other local clinics. In addition, a practice development nurse provided support. They also worked across an additional five clinics in the local area.

The senior management team at executive level gave provider level support and oversight. Local management told us they felt well supported by the managers above them, and the senior managers and provider level.

The local managers had monthly one to one meetings with the area manager; who in turn received monthly one to one meetings with a member of the senior management team.

Staff told us that local managers were visible and approachable. Staff reported feeling supported to develop where possible; and that the leadership style was one of openness and honesty.

Vision and strategy

The service had a vision for what it wanted to achieve and plans to turn it into action, developed with all relevant stakeholders.

The service had a clear, provider wide, vision which was to "improve quality of life for renal patients". Values of being passionate about involving patients in their care, being competent to deliver care and to be inspiring underpinned the provider vision.

During our inspection we saw that staff embodied the vision and values. Leaders were open and promoted kind and competent care. Staff we spoke with demonstrated these values in how they spoke about their job and patients.

Locally; the service had undertaken surveys with staff and patients and as a result had developed an improvement plan to develop the service. This was displayed in staff and patient areas.

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.

Managers presented as open and transparent with staff. We saw information was openly shared with staff for example, displayed on staff room walls. Staff told us they enjoyed working at the service and supporting patients. Newer staff we spoke with told us they felt integrated into the team and well supported by local management.

At a provider level; managers had undertaken large scale overseas recruitment for nurse positions. Managers at the unit provided support for new overseas staff who had moved to England to work for the company. This support was in part at a provider level; such as organising structured training, time to settle into new homes and areas and provided financial support to set up a new home. Locally, the service invited the new starters to team meetings and social events before their start date. Where appropriate, new starters were 'buddied' together to provide support; both practical and social. Shifts were allocated so new starters could travel to and from work together. Where staff had friends or family living in the UK, managers arranged so that shift patterns enabled the staff to have time with their families.

Staff told us that personal, religious and cultural requirements were respected; such as managing shifts to suit staff during religious celebrations and occasions and enabling quiet areas for prayer within the unit.

Managers supported staff to be involved in social occasions both within and outside of the workplace. For example, staff communal meals were organised for in and outside of work hours.

Staff could access an employee assistance scheme to get independent support for personal problems such as financial advice and counselling.

Operational meeting minutes from November 2019 highlighted mental health training was needed for colleague support. We saw in the minutes dated December 2019 that this was in progression with a date of quarter one 2020 set for implementation. One or two staff from each clinic volunteered to undertake the training to become a mental health champion, in order to support and signpost colleagues as needed.

Feedback following the patient satisfaction survey undertaken in 2019 highlighted some pockets of low morale within the staff team. The unit managers acknowledged this and reported that high staff turnover may have contributed to this. At the time of the inspection, the unit was fully staffed; and staff had been involved in team related social activities.

Although the service had not had any incidents that met the legal threshold for the duty of candour to be applied, managers and staff gave us examples of times they had been open and transparent with patients; and had apologised for mistakes made. The duty of candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. 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.

We found a clear line of governance to communicate information throughout the service, and to also escalate and cascade information up and down lines of management and staff.

The Midlands based area manager attended quarterly operations meetings with the other two area managers and the operations director. We reviewed three sets of minutes from October to December 2019 and found set items were discussed each month including risk registers, serious incidents, staffing and staff retention and training needs.

Every month, a clinical governance meeting was held. Attendees included the nursing director, operations director, the quality and compliance manager, three practice development nurses and three area managers.

Bi-monthly Midlands area team meetings were held. In attendance were all Midlands based clinic managers and clinic development managers attended, along with the area manager and area practice development nurse.

Locally, managers held monthly quality assurance meetings. Attendance at these included the clinic manager, the lead consultant from the referring trust, the satellite co-ordinator employed by the NHS trust and the trust based dietitian. We reviewed three sets of minutes from November 2019 to January 2020 and saw incidents, clinical complications, and patients who deviated from their treatment (such as did not attend for the session or cut the treatment short) were discussed. Audits and areas of improvement were also highlighted and discussed.

Contract meetings were held with the referring NHS trust and area management. We reviewed one set of minutes from January 2020. The attendees discussed patients' incidents, performance and concerns. Actions to address concerns were identified.

We saw minutes from a medical advisory board meeting chaired by a consultant, dated February 2019. The area practice development nurse attended this. We saw that local information was shared here including incidents, and updates. Changes to training and clinical practice was also discussed.

A provider level clinical governance policy clearly outlined who was responsible for different aspects of clinical care and clinic management. For example, clinic managers were responsible for auditing dialysis records monthly; this was reported to the area manager.

The provider held a preventative maintenance schedule which listed all clinics and highlighted what local actions were required; and when. This enabled a clear view of the schedule to be achieved.

Managers held team meetings with staff to cascade information from provider level, and to inform of updates and changes. Staff we spoke with were all clear about their roles and who they were accountable to. We reviewed three sets of minutes from August/ September 2019 to January 2020 and saw there was a set agenda which covered incidents, risk register, performance, audit results. We saw that praise was given for good audit results as well as actions identified for areas of improvement.

We reviewed provider wide policies during the inspection. We found that whilst the majority were robust and based on national best practice, the safeguarding policy did not reflect the intercollegiate documents pertaining to adult and children safeguarding training requirements. There

was no provider policy relating specifically to the Accessible Information Standard (AIS). The AIS is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. In addition, the provider procedure about low molecular weight heparin was confusing and did not reflect best practice, although this was updated post inspection. We understood that this was a provider wide responsibility rather than an individual service responsibility; however where policies were not robust or did not exist, this meant locally best practice and legal requirements may be missed.

Managing risks, 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.

Local managers were very clear about the risks to the service. The top three identified risks were patients choosing to shorten their treatments, having new workforce, and delays from the patient transport service in dropping off and/ or collecting patients.

Managers spoke openly of these risks and highlighted the action plans in place to mitigate these. For example, managers at the service had regular conversations with the patient transport provider; and also ensured that any patient eligible to receive funding for private taxis was made aware and supported to obtain this.

We also reviewed the risk register and saw this clearly articulated all identified risks to the service, with clear actions and expected completion dates. Archived (or closed) risks were also kept for the year of 2019 for review.

The service had a risk management policy which stated that risk assessments should be undertaken where risks were identified. While the risks on the risk register were managed in line with the policy, at the time of inspection no risk assessment had been undertaken to consider the current management and administration of Tinzaparin, which was not in line with national guidance. Please see the 'Safe' section for more specific details. A risk assessment was completed post inspection.

Managers provided examples of where learning about serious incidents from other sites was shared within this unit to ensure safety measures were implemented and monitored.

We reviewed root cause analysis documents that managers had completed after incidents such as patient falls. These clearly included the cause of the incident, actions taken during the incident and any learning. Actions were set and signed off as complete. We saw that information about these incidents was shared appropriately through the various governance and team meetings.

During our inspection, we notified the managers that some patients had expressed views that were in breach of laws against discrimination while chatting to each other in the waiting room. The unit manager worked quickly to address this; and assured us that patient expectations about expressing discriminatory attitudes would be re-enforced in the next patient newsletter. Where one patient had experienced negative behaviour from other patients due to protected characteristics; this was swiftly managed.

Performance was monitored and reported on monthly at contract meetings.

The service had plans to follow in the event of an emergency such as a disruption to the water supply, fire or other events. Staff had access to contact details to gain immediate assistance; and had relevant equipment to support medical emergencies while waiting an ambulance.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Managers at the service oversaw the collection of data relating to clear service performance measures. Managers monitored these and used the data to report to the referring trust with whom the service held the contact.

Managers undertook a regular programme of auditing to ensure clinical and non-clinical performance was monitored and maintained to a good standard. Managers communicated results of audits to teams locally through team meetings, and also up to provider levels through the governance structure. Data from the service showed that a comprehensive action plan was active and in use following a range of audits. The audits included hand hygiene and time patients spent dialysing per week.

The service had not had to make any statutory notifications to CQC from January to December 2019. However, managers did maintain an open line of communication to enable appropriate information sharing.

The service stored data securely including patient records. Where potential data storage breaches were identified, these were reported on the service risk register and robustly managed.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff at the service undertook patient satisfaction surveys twice per year. This was based on the NHS Friends and Family Test. Data demonstrated that the service had used suggestions made to improve the service such as acquiring an outside bench for patients to enjoy in the summer time while waiting for transport.

Results from June 2019 showed that 43.7% of patients responded to the patient satisfaction survey. This was lower than most other clinics managed by the provider. The overall patient satisfaction score was 70% which was also the lowest score. (Scores ranged from 70% to 97% across all clinics.

The survey results were broken down into six areas; trust, involvement, diet understanding, waiting time, care improvement and if patients would recommend the service. Compared to the 2018 survey results; patients' views of all areas except for diet understanding had deteriorated.

Results from this survey undertaken in June 2019 identified both positive patient feedback and areas for improvement. The areas for improvement were acknowledged openly; and clear actions were communicated for how these concerns would or could be resolved.

The next patient satisfaction survey, also conducted in 2019, showed an increase in patient satisfaction. In this survey, the service received an overall score of 88.7% which was an increase of 18.7% from the survey in June 2019. We noted that within this survey, 92% of respondents would recommend the service.

During the inspection, the clinic manager showed us a patient engagement folder which served as a record of several activities, trips and special occasions that had been organised and implemented by the service. To fund some of these activities, such as a day trip out, the service engaged with the Kidney Patient Association regularly.

The service provided a monthly newsletter to patients named 'In Touch'. The serviced provided a staff newsletter called 'Team Touch'. We reviewed a copy of each of these newsletters and saw they contained a mix of fun and practical articles and ideas.

The service took part in community activities, for example collecting food from patients and staff for a local foodbank.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

During the inspection, managers told us of a new electronic system which was due to be implemented in June 2020. The purpose of this was to enable accurate recording of patient information during treatment, while providing more time for staff to proactively engage with patients.

The service featured in a kidney patient magazine; Kidney Matters, which is issued by the charity Queen Elizabeth Hospital Kidney Patient Association in the October 2019 edition.

Good

Dialysis services

Managers and staff at the service organised a range of activities and engagement opportunities for patients to promote patients' quality of life outside of treatment. Staff were committed to helping patients to feel socially included and used innovative ideas to support this, such as the patient post box.

The clinic manager, and staff, had developed ways to encourage patients to stay for their entire treatment time therefore supporting effective treatment. This included an information display outlining the risks of shortening treatment for non-clinical reasons; and enabling staff to actively engage with patients through games and other activities.

Data from the service showed that the service had recently taken part in a research project linked to a university. This had the aim to develop and validate a questionnaire to measure patients' self-activation (motivation to achieve personal goals). During this study a standardised psychometric test was used to screen for depression. Where it was identified that patients of the service displayed signs and symptoms of depression; staff referred patients for urgent GP appointments and alerted the patient's named consultant.

Outstanding practice and areas for improvement

Outstanding practice

Managers and staff at the service organised a range of activities and engagement opportunities for patients to promote patients' quality of life outside of treatment. Staff were committed to helping patients to feel socially included and used innovative ideas to support this, such as the patient post box.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure clinical waste collection areas and bins are secured at all times. Regulation 12: Safe Care and Treatment.

Action the provider SHOULD take to improve

- The provider should ensure that they embed and audit the procedure "3008:11 Preparing and checking LMWH" which was updated following the inspection. The accompanying risk assessment should also be embedded within the service. Regulation 12: Safe Care and Treatment.
- The provider should ensure that all patients are given enough support and opportunity to be able to provide informed consent to treatment and associated care. Regulation 11: Need for Consent.
- The provider should consider obtaining a second set of weighing scales to be held on the premises in case the current set fail.
- The service should reference the Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) and the Intercollegiate Document: 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' (2019) within relevant policies to ensure they are training to the required standards.
- The provider should include information about female genital mutilation within their safeguarding as per the relevant intercollegiate documents.
- The service should consider training staff in working with patients diagnosed with developmental and/ or neurological conditions.
- The service should have a structured process to ensure they are adhering to the legal requirements outlined in the Accessible Information Standard.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment During the inspection we found the external compound containing clinical waste awaiting collection by a third party provider was unlocked and accessible to the general public. This was also the case at our previous inspection in 2018. In addition, we found within this unsecured compound, an unsecured sharps disposal unit.