

B. Braun Avitum UK Limited Yeovil Renal Unit

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

Overall summary

Yeovil Renal Unit is operated by B. Braun Avitum UK Limited. The service has 13 dialysis stations for patients and offers two shifts of daily sessions between 6.30am and 6.30pm. The service also offers three evening shifts on Mondays, Wednesdays and Fridays (from 6.30pm to 11pm). The service is open six days a week and operates 180 sessions for a current caseload of 55 patients. The unit has capacity for 65 patients. Facilities include a main unit with 12 dialysis stations, divided into three bays, and one isolation room with dialysis station. There was a manager and clerical office, consultant's office, rear service corridor, and patient toilet.

The medical care is covered by three NHS hospitals (Dorchester, Southmead and Exeter). The patients from Southmead and Exeter have their blood results reviewed monthly at a continuous quality improvement meeting and patients from Dorchester are reviewed in the unit. The dietetic cover is provided by a dietician who visits the unit twice weekly as agreed through a service level agreement with Somerset Commissioning Group.

Dialysis units offer services, which replicate the functions of the kidneys for patients with advanced chronic kidney disease. Dialysis is used to provide artificial replacement for lost kidney function.

The service is a nurse led unit and is supported by the renal unit at Dorchester Hospital in Dorset.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 19 June 2017 and further unannounced inspection on 29 June 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well led?

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 do not rate

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

We found the following areas of improvement that were required:

Summary of findings

- Staff were not fully compliant with mandatory training in line with corporate policy.
- Nurses did not check patients' identity prior to commencing haemodialysis treatment.
- There was no policy or guidance available to staff about the early recognition or management of sepsis. Staff had received no specific training for the early identification of sepsis and management (infection) in line with national guidance (NHS England, 2015).
- Patients' records were not securely stored on the unit during dialysis.
- There was no awareness of and evidence of compliance with the Workforce Race Equality Standard (WRES) which became mandatory in April 2015.
- Patients felt that it was difficult to have a private conversation on the unit.
- There was not an effective process to monitor how local service risks were identified, mitigated and acted upon.
- Some chairs in the unit were visibly damaged and many patients found them to be uncomfortable.
- Due to a lack of permanent unit manager prior to the inspection, unit staff were not having regular meetings, and some staff had not had an annual appraisal in the preceding 12 months.
- The unit had clear processes to ensure regular servicing and maintenance of equipment, and there were policies and procedures to follow in case of a failure in the water supply or power failure. Staff were aware of their roles and responsibilities to maintain the service in the event of a major incident.
- There was good multidisciplinary working and strong communication links with the lead consultant and the local NHS trust.
- There were effective processes for gaining informed consent, which was sought and documented prior to treatment.
- Staff understood the impact of the treatment on patient's emotional wellbeing and actively supported patients.
- Services were planned and delivered to meet individual patient needs and improve their quality of life.
- There was a system to monitor and deal with complaints. There had been no formal complaints at the unit in the year prior to our inspection.
- Staff felt valued and supported in their roles and reported a positive working culture.
- There was a replacement programme for the dialysis machines, in line with the Renal Association guidelines.

However, we found the following areas of good practice:

- Evidence based practice and the Renal Association guidelines were used to develop how care and treatment was delivered. All policies and procedures were based on national guidance and updated when required to reflect change to national guidance and then distributed to staff. Patient outcomes were monitored in line with best practice guidelines.
- There was a good incident reporting culture and the staff were aware of the procedure to follow when reporting an incident or an adverse patient incident. Staff followed company policy with regards to infection, prevention and control.

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

Edward Baker

Chief Inspector of Hospitals

South Region

Summary of findings

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Yeovil Renal Unit

Services we looked at:

Dialysis Services.

Summary of this inspection

Background to B. Braun Avitum UK Limited Yeovil Renal Unit

Yeovil Renal Unit is operated by B. Braun Avitum UK Limited. The service opened in July 2008 and provides haemodialysis primarily to patients from the local areas of Somerset and Dorset. The unit also accepts patient referrals from outside this area.

The hospital had a registered manager in post since 2010, although they had left in January 2017.

At the time of the inspection a new manager had been recently appointed and were on induction at the time of the inspection. They had not yet applied for the registered manager role.

Yeovil Dialysis Unit had previously been inspected in February 2013. We found the service met all required standards at that time.

We inspected Yeovil dialysis unit on 19 June 2017 and carried out an unannounced visit on 29 June 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Nikki Evans, and one other CQC inspector. The inspection team was overseen by Catherine Campbell, Inspection Manager, and Mary Cridge, Head of Hospital Inspection.

Information about B. Braun Avitum UK Limited Yeovil Renal Unit

The unit is registered to provide the following regulated activity:

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

During the inspection, we spoke with nine staff including registered nurses, health care assistants, reception staff, and senior managers. We spoke with eight patients and one family member, and we reviewed 10 sets of patient records and associated documents.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

In the reporting period June 2016 to January 2017, the unit provided 9,406 haemodialysis sessions to patients. All sessions were provided for NHS-funded patients. The unit did not support patients who completed their

dialysis at home or received peritoneal dialysis (dialysis where the peritoneum in a patient's abdomen is used as membrane). These patients were supported from dialysis centres in nearby NHS hospitals.

The unit employed 6.2 full-time equivalent (FTE) registered nurses, 3.8 FTE care assistants and one clerical assistant.

Track record on safety in the previous year:

- The unit reported no never events in the reporting period from January 2016 to January 2017.
- The unit reported no clinical incidents in the reporting period from January 2016 to January 2017.
- The unit reported no serious injuries in the reporting period from January 2016 to January 2017.
- The unit reported no incidents of healthcare acquired methicillin-resistant *Staphylococcus aureus* (MRSA) or healthcare acquired methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia from February 2016 to February 2017.

Summary of this inspection

- The unit reported no incidents of hospital acquired Clostridium difficile (C. diff).
- The unit had received no complaints in the reporting period from February 2016 to February 2017.

Services accredited by a national body:

- Investors in People accreditation (2016)
- ISO 9001:2008 (accreditation given to organisations, which fulfil a set of quality management standards).

Services provided at the hospital under service level agreement:

- Dietetics
- Clinical and non-clinical waste removal
- Building, plumbing and electrical maintenance
- Maintenance and repairs on dialysis chairs
- Electrical testing and medical device servicing and calibration
- Pharmacy support

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We found the following areas where the service provider needs to improve:

- Not all staff were fully compliant with mandatory training in line with corporate policy.
- Staff did not follow the Nursing and Midwifery Council 2015 guidelines with regards to checking a patient's identity prior to administering intravenous medicine.
- There was no policy, standard operating procedure or specific staff training to promote the early identification of sepsis (infection) in line with national guidance (NHS England, 2015).
- Patients' records were not securely stored on the unit.
- Five of the dialysis chairs were damaged, which meant the chairs could not be disinfected effectively.

However, we found the following areas of good practice:

- The unit had a good safety record. There had been no never events or serious incidents from June 2016 to May 2017.
- All areas appeared visibly clean and staff followed B. Braun policy and procedures to prevent the spread of infections.
- The unit had clear processes to ensure regular servicing, maintenance and replacement of equipment.
- Patient care records were written in a way which kept patients safe, and comprehensive risk assessments were carried out for people who used services and risk management plans were developed.

Are services effective?

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

We found the following areas of good practice:

- Patients had outcomes that were as good as or better than other similar renal units.
- Evidence based practice and Renal Association guidelines were used to develop how services care and treatment was delivered. Patient outcomes were monitored against best practice guidelines.
- There was a comprehensive training programme to ensure new nurses were competent to carry out their role at the haemodialysis unit.

Summary of this inspection

- There was good multidisciplinary working and strong communication links with the lead consultant and the local NHS trust.
- Staff at the unit had access to information about patients, which enabled effective care and treatment, including access to local NHS patient records, via computer systems.
- Informed consent was sought and documented prior to commencing treatment.
- Patients had access to a dietician every week who could offer advice and support.

However, we found the following areas where the service provider needs to improve:

- Mandatory training rates were low.

Are services caring?

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

We found the following areas of good practice:

- Patients were treated with dignity, compassion and respect.
- Staff took the time to interact with patients and patients found staff to be supportive.
- Staff communicated with patients so they understood the treatment they received and were encouraged to ask questions.
- Staff understood the impact of the treatment on patient's emotional wellbeing and actively supported patients.

However, we found the following areas where the service provider needs to improve:

- Not all patients felt that they could have privacy on the unit if they required.

Are services responsive?

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

We found the following areas of good practice:

- Services were planned and delivered to meet individual patient needs and aimed to improve patients' quality of life.
- Patients had access to entertainment during their haemodialysis session.
- Patients were supported to arrange haemodialysis at their holiday destination.
- There was a system to monitor and deal with complaints. There had been no formal complaints made at the unit in the year prior to our inspection.

Summary of this inspection

Are services well-led?

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

We found the following areas where the service provider needs to improve:

- The unit had not had a permanent manager in post for six months, and the new unit manager was still on induction at the time of the inspection. There were no senior dialysis nurses employed at the unit at the time of the inspection.
- Staff were unfamiliar with the vision and strategy for the organisation and the unit.
- Improvements were required to demonstrate how local risks had been identified and action plans put in place to mitigate against these risks.
- There was no forum or formal group to represent the patients who attended the unit at the time of the inspection. Following our inspection, the organisation told us a new group had been established and met in late September for the first time.
- The registered manager for the unit no longer works for B. Braun.
- There was no awareness of and evidence of compliance with the Workforce Race Equality Standard (WRES).

However, we found the following areas of good practice:

- Staff felt valued and supported in their roles and reported a positive working culture.
- There was an effective systematic programme of audit which was monitored regularly and corporately.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dialysis Services	N/A	N/A	N/A	N/A	N/A	N/A

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

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

Incidents

- The unit had a good safety record. There had been no never events at the unit between January 2016 and May 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- The unit reported no serious incidents between January 2016 and May 2017. Serious incidents include acts or omissions in care that result in unexpected or avoidable death or unexpected or avoidable injury resulting in serious harm.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. There was a policy and system in place to report incidents which was available to staff and outlined the procedure for reporting incidents. Staff provided us with examples of incidents and near misses they would report, including when patients made a choice to finish their dialysis sessions before the expected time period.
- Staff did not receive individual feedback on incidents they had reported. Staff were unable to provide us with any feedback following any adverse patient occurrence they reported. Once the adverse patient occurrence had been reviewed by the unit manager and the quality manager it was then closed. There was no evidence on the staff meetings minutes to demonstrate that adverse patient occurrence incidents had been discussed with the staff at the unit.
- Incidents were reported on two different systems, which included reporting adverse patient occurrences (APO) in relation to treatment, and reporting incidents such as injuries or falls on the environmental health and safety system (EHS). Incidents were reviewed by the unit manager and the quality manager to ensure actions taken were suitable, and whether any further learning was needed following the incident. Between January and May 2017 the unit reported 17 adverse patient outcomes. The quality manager maintained a log to monitor trends and themes from the incidents reported. Adverse patient occurrences and environmental health and safety incidents were then closed by the senior management team.
- There was evidence of service wide learning from incidents to drive improvements in practice. There had been a trend in venous needle dislodgement in some B. Braun units. Following this, changes had been made to practice, such as taping lines to patients and line anchorage were put in place to reduce the risk of reoccurrence. Learning had been shared with the Yeovil staff, and they were able to tell us about the changes to practice following this incident trend.
- Staff were aware of the duty of candour, and could explain the requirement to be open and honest with patients when things went wrong. The duty of candour is a regulatory duty that relates to openness and

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transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- The Operations Manager for B. Braun Avitum was the lead for Duty of Candour, and when an incident occurred in the unit they completed the investigation, issued the apology and gave actions to prevent it from reoccurring.

Mandatory training

- Not all staff were up to date with their mandatory training, which meant they were not compliant with their corporate policy and local target for 100% of staff to have completed their mandatory training. Records showed that no staff had completed the manual handling practical training, and two out of eight (25%) had not completed the interactive infection control training. One nurse had not completed the hand hygiene module. The service had a contemporaneous training record for mandatory training and regular updates. Not all staff had completed all mandatory annual updates required by B. Braun, and no member of staff had completed all five required annual updates at the time of our inspection.
- Staff told us the mandatory training was of good quality and comprised of on line training and face to face sessions. Staff supported each other to complete the training.
- The unit did not have a policy for the management of sepsis management in line with national guidance (NHS England, 2015). The operational manager told us that sepsis was covered by the infection control policy. However, sepsis was not specifically mentioned in this document. Staff did not receive training in sepsis screening.

Safeguarding

- The service had processes to ensure staff were trained to recognise vulnerable adults at risk of abuse and there was a standard operating procedure to provide guidance. Staff were aware of signs of abuse and knew how to report concerns. They completed mandatory e-learning updates in both child protection and adult safeguarding at level two every year. We saw that all

staff were up to date with the vulnerable adults and child protection awareness training module. However, this training did not include information about female genital mutilation

- B. Braun had a corporate safeguarding lead trained to level two, but there was no one with a higher level of safeguarding training at the unit. Any referrals for patient safeguarding would be directed to the individual NHS Trusts' safeguarding lead, within clinical supervision contractual requirements. Senior staff told us level three training was planned for members of the corporate management team in July 2017.
- The service carried out Disclosure and Barring Service (DBS) checks for clinical staff every three years in line with their corporate standing operating procedures. DBS checks help employers to make safer recruitment decisions and prevent unsuitable people working with vulnerable people. We reviewed six staff records and found that all staff had had a DBS check within the last three years.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained through a series of monthly audits. The audits monitored compliance with aseptic non-touch technique (ANTT) and hand hygiene. The handwashing and aseptic non-touch technique audits between January and June 2017 had achieved 99% compliance. Environmental health and safety walk rounds were completed by the unit manager and reported to the quality manager monthly, and feedback was given to staff. The latest data from the audits showed the unit had an overall compliance of 93.6%.
- We observed staff following ANTT procedures. One member of staff had scored lower than 90% and the manager confirmed verbal feedback had been given to them following the audit along with advice to help them improve their compliance with both hand hygiene and ANTT.
- Seven of eight staff had completed the B. Braun hand hygiene e-learning modules for hand hygiene and aseptic non-touch technique. Posters on the unit reminded staff and patients of the five moments of hand hygiene in the dialysis unit, covering: before

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patient contact; before procedures; after body fluid exposure; after patient contact; and after contact with the patients' surroundings. We saw that staff were vigilant in this during the inspection. Training records showed that six out of eight staff had completed the annual mandatory e-learning update in infection control, as required by the B. Braun mandatory training, at the time of our inspection.

- There were reliable systems in place to prevent and protect people from healthcare-associated infections. Staff applied infection control measures efficiently when dealing with patients. The service had a standard operating procedure (SOP) for infection control to provide guidance. Staff had access to and wore appropriate personal protective equipment such as gloves, aprons and full-face shields. We observed staff wash their hands before and after patient contact.
- The unit had a policy for the disinfection of haemodialysis machines, which outlined specific instructions for the safe decontamination of the equipment used for haemodialysis. Decontamination of medical devices, including dialysis machines was carried out regularly in line with policy. Staff cleaned the dialysis machines after each session in accordance with corporate and manufacturer guidance. There was an internal decontamination schedule after each patient use and once a week the machines were programmed to carry out an extended internal cleaning and decontamination process. Each dialysis station was cleaned with an anti-bacterial solution after each dialysis session. Solutions were prepared and dated according to recommendations. All equipment-cleaning records we looked at were complete and up to date with no omissions.
- We saw staff cleaning equipment thoroughly between patients, using antibacterial wipes, and all areas we visited were visibly clean and free from clutter. We saw cleaning checklists for the main dialysis area, isolation room, kitchen and patient toilet that showed 100% compliance in from January to May 2017.
- All clinical staff we saw were bare below the elbow and had long hair tied back in line with infection prevention control and uniform policies. We saw that staff did not wear watches or jewellery in line with policy.
- The dialysis chairs were deep cleaned every week and we saw records that confirmed this. However we noted that five of the twelve dialysis chairs in the main unit had damaged footrests and these would be unable to be cleaned properly. As the contract to extend the provision of dialysis unit to March 2019 had recently been agreed by the clinical commissioning group (CCG) managers were in the process of reviewing the chairs for replacement. However, if chairs required immediate replacement managers told us that they could request and receive chairs from head office.
- There were procedures in place to assess patients as carriers of blood borne viruses (BBV) such as Hepatitis B and C as part of the patient's initial assessment prior to commencement of treatment at the unit. Patients with Hepatitis B were not accepted at the unit as agreed in contracts with the local NHS trusts. If a blood borne virus was identified, patients were treated accordingly.
- The service had effective processes for screening patients for blood borne viruses. All patients were screened every three months and patients who returned from holiday were screened when they got back. When patients returned from holiday or if they had been admitted to hospital, they received dialysis in a side room until screening showed they did not have any transmittable infections or viruses. All patients returning from holiday dialysis return to the Yeovil unit and were dialysed in the isolation room to screen for Hepatitis B and C, human immunodeficiency virus (HIV) and MRSA. There were standing operating procedures to guide staff in additional infection control measures if required.
- The service reported no dialysis related infections from January to May 2017. There had been no reported cases of *Clostridium difficile* (C. diff), methicillin-resistant *Staphylococcus aureus* (MRSA) or methicillin-sensitive *Staphylococcus Aureus* (MSSA) bacteraemia at the unit between January 2016 and May 2017.
- There were effective processes for infection control screening in accordance with the corporate standard operating procedure for infection control. There was

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an MRSA protocol with action cards to provide guidance for staff about screening. All patients were screened when commencing dialysis treatment at the unit and every three months thereafter.

- Dialysis patients were swabbed frequently for MSSA in line with local policies. Patients referred to the unit from North Bristol NHS Trust were swabbed fortnightly, and all other patients swabbed monthly. Patients with MSSA picked up through these regular swabs were offered treatment, as per the supervising trusts' infection control policy and were classed as community acquired infections.
- Patients had their own blood pressure cuff, which they wore for the duration of their dialysis treatment, and this was replaced every three months.
- Safety goals had been set and a monthly report listing and reviewing all environmental health and safety events was compiled and distributed by the operations manager. Safety targets, linking to infection, falls, water quality, needle stick incidents and vigilance reporting were recorded in the monthly management review. Infection rates were below that national average at 0.04 per 1000 catheter days. The water quality log showed that each machine was checked every month and no bacteriology issues had been identified. There had been one fall on the unit this year.

Environment and equipment

- The dialysis unit was designed, maintained and used in a way that kept people safe. The dialysis area was purpose built, and met Department of Health: Health Building Note: 07-01 guidance. There was sufficient space around dialysis chairs for two people and they could be accessed from either side. The flooring was intact and easy to clean.
- The unit maintained and used equipment in a way that kept people safe. The service had effective processes to ensure all medical devices were regularly serviced and maintained in line with manufacturer guidance. The unit held a register of all medical devices, which showed when regular servicing or replacing was required. Staff were aware of processes to report faulty equipment.
- The unit had effective process to deal with clinical waste. There were a sufficient number of waste bins, which staff emptied before they were overfilled. Staff used sharps boxes in line with guidance and closed these between usages to avoid accidental needle stick injuries. There was a dirty utility area, which was clean and tidy, and staff separated clinical and non-clinical waste in line with national recommendations.
- All dialysis sets were single use. The unit kept a record of batch numbers of all the dialysis set components used, including the fluids and medicines administered, which were recorded on all of the 10 dialysis prescriptions we looked at.
- The unit had a resuscitation trolley that had been stocked in line with national resuscitation council guidance for community hospitals. Staff checked the trolley on a daily basis and all of the records we saw were complete and legible.
- Patient weigh scales were available on the unit and we saw where they had been appropriately service tested. A spare set of scales were available on site, in the event the weigh scales on the unit developed a fault or were unfit for use.
- There was an equipment replacement programme and processes to alert managers when equipment was due to be replaced. All dialysis machines were due to be replaced every ten years in line with the Renal Association guidance. Records were kept of machine maintenance and the unit complied with the guidance. There were three spare dialysis machines in case any of the other machines developed a fault. Senior staff told us the machines were eight years old, and were due to be replaced at the same time the current contract ended. The unit manager was unsure what plans were in place for this as the current contract had only recently been finalised. However, B. Braun also had a stock of used machines that could be sent to the unit if required. Senior staff told us that since the contract had been renewed, a strategy for machine replacement was being finalised for the unit.
- A healthcare assistant was responsible for ensuring these were disinfected on a daily basis so they would be ready of immediate use if required. Each machine had a disinfection screen where all disinfection dates/times were logged as an official evidence.

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- Managers assured us technical staff maintaining the equipment had appropriate training, although records were kept off site. The unit maintained records of annual servicing of equipment at the unit which demonstrated full compliance. Technical services formed part of B. Braun, and performed all planned preventative maintenance on all the dialysis machines annually and performed any repairs as required.

Medicine Management

- The unit had processes in place for the safe management of medicines. Patients attending received prescribed medicines as necessary for their dialysis or continuing treatment only. Ongoing prescribed oral medicines that were taken by the patient at home were not administered by nursing staff.
- Medicines stock was stored in a large storage room, which was secured with a keypad access door, and behind the nurses' station in locked cupboards and a fridge. We noted during our inspection that the fridge was unlocked although there was a facility to lock it. We reported this to the unit manager during the inspection and found the fridge locked at our unannounced inspection the following week. The records confirmed that the fridge had been checked on a daily basis in April and May 2017, and was found to be in the correct temperature range. In June 2017, the fridge was out of order, and medicines were moved to an alternative fridge. The fridge check register was signed on a daily basis.
- Medicines that were temperature sensitive were monitored closely. We saw that the fridge and stock room temperatures were recorded daily, and had been maintained within the recommended parameters. All staff were aware of the escalation process for a temperature spike. We spoke with staff who told us that changes in temperature were escalated to the nurse in charge who discussed the medicines with the renal pharmacist.
- The unit held medicines routinely used for dialysis, such as anti-coagulation and intravenous fluids. The unit also had a small stock of regular medicines such as EPO (erythropoietin – a subcutaneous injection required by renal patients to help with red blood cell production). These were securely locked in a cupboard in the unit. Controlled drugs which require extra security of storage and administration were not used or available on site.
- A healthcare assistant completed weekly orders of medicines and medicine stock level audits every three weeks when the amount and expiry dates were checked. Checks and rotation also took place on a weekly basis when stock deliveries arrived. On the inspection we confirmed that all stock was dated and rotated.
- Medicines came directly from the local NHS trust. Ordering of medicines occurred on a weekly basis, when stock levels were assessed. A specialist drug company courier completed delivery. Upon arrival at the unit, the qualified nurse accepting delivery checked the medicine against the order form to confirm it was correct.
- There were processes in place to ensure prescriptions for dialysis treatment were available. The consultants prescribed treatment for each patient for one month at the time. Staff printed off dialysis prescriptions for patients for each session, which meant it was the most up-to-date prescription for patients booked for treatment. Prescriptions contained information about the haemodialysis filter to be used, length of treatment time and dry weight (weight after dialysis treatment). We saw staff checking the prescription against the parameters set on the dialysis machine prior to the start of treatment. We also saw that when staff had any concerns about the patients' measurement of their weight that they would reweigh the patient to ensure the parameters were correctly set.
- All patients had a medicines prescription chart, which had been provided by the supervising NHS trust. It contained all routine medicines used during dialysis including the strength, dose, route, reason for use and duration of use for each medicine listed. In addition, patients who had specific medicines had individual medications charts for each medicine, which were signed as and when they were used. We looked at ten sets of patients records and saw the medicines prescriptions were up to date, legible and contained no omissions.

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- The unit did not have a dedicated renal pharmacist. Pharmacy support was provided through the supervising NHS trust as part of the service level agreement. A weekly order of stock items were ordered from the pharmacy and delivered to the unit by a courier. The nurses checked and audited the medicines weekly, once the new order was received. Records confirmed the unit was 100% compliant with checking stock and expiry dates of medicines.
- The renal consultant prescribed all patients' medicines, which were regularly reviewed for each patient. We saw that prescription charts were clearly written, showed no gaps or omissions and were reviewed regularly.
- We noted however that when a patient was given a fluid bolus this was not recorded in the patient's record as a prescribed medicine.
- A registered nurse held the keys to medicines cupboards and healthcare assistants collected anti-coagulant intravenous medicines from the medicines cupboard and put this out ready when preparing dialysis stations for the next patient. The registered nurses delegated this task to healthcare assistants who were knowledgeable about how to carry out the task safely, and had completed competency based training. They had a list of patients and equipment needed for individual patients attending for dialysis that was checked against each patient by the registered nurse responsible for that patient before treatment started.
- However, staff did not ensure the safe administration of intravenous medicine to patients in line with guidance from the Nursing and Midwifery Council (NMC, 2015). Although we observed five nurses checking the anticoagulant provided was in date and correct for the patient, staff did not formally check patient's identification before administering intravenous medicines. The unit manager confirmed that this was because the nurses knew the patients well.
- When changes were made to a patient's prescription, the changes were communicated to the GP by the lead consultant in the form of a letter, which summarised the changes and reasons why they had been made.

Records

- Individual patient dialysis records were written in a manner that kept patients safe. Staff completed paper records and electronic records. This information was shared with the consultant who was responsible for patients' dialysis treatment. Staff entered information onto the hospital renal database following dialysis treatment. This included information about patients' vital signs before, during and after dialysis, patients' pre and post dialysis weights and blood test results.
- Consultants managing patients who attended the unit were able to access the patients record and blood results via the local NHS trust computer system. All nurses were also able to access the patients full NHS record via this system. Patients were not routinely given a copy of their own blood results but could request this.
- We noted that during the unannounced inspection that the computer on the nurses' station was left unlocked with patients details visible. Patient paper files were also left on the station. As the station was next to an unlocked door on the unit, this was accessible to anyone in the waiting room, including other patients, relatives and carers as well as transport staff. We notified the unit manager about who told us that she would ensure staff locked the computer after using it, and ensure patient records would not be left unattended.
- Consultants sent clinical letters to the unit which were reviewed by a dialysis nurse. Letters were then stamped as 'actioned', and filed in the patients' notes.
- The service used a 90-day care pathway for new patients commencing dialysis at the unit. This pathway included information about infection screening; patient education programme and assessment of parameters at different points during the first 90 days of patient dialysis and the stage at patients new to haemodialysis treatment had an increased risk of mortality and required closer monitoring. Once the dialysis was well established, staff used a continuing care pathway which was re-assessed every three months and ensured on going care using evidence-based guidance.

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- Day sheets detailed dialysis sessions by date, time and the number of the machine used during the session. This meant any changes in treatment and any problems occurring during the session and any treatment changes could be identified.
- The unit kept paper records for each patient, which included dialysis prescriptions, next of kin and GP contact details, risk assessments, clinic letters, medicine charts and patient consent forms. Paper records were stored in clear files and were kept in a locked cupboard overnight and when not in use. All ten sets we looked at were completed legibly. Records were kept at the unit until a patient stopped dialysing, at which point the records were archived and locked away. However, we noted that the files were put out next to the patients chairs before the patients arrived for their session which was a risk because patients may have changed chairs prior to the commencement of their treatment. We discussed this with the unit manager who told us that they would ensure records were put next to beds as patients arrived.
- Staff carried out documentation audits once a quarter. The results demonstrated each nurse's thoroughness when completing patient records. However, the unit manager did not have access to the results of the documentation audit at the time of the inspection.
- Staff monitored patients throughout their dialysis treatment. Prior to commencement of the treatment patients had their general health, weight and blood pressure recorded. Throughout the treatment, staff monitored patients' vital signs (blood pressure, pulse and temperature) every hour and when the treatment had finished. We saw that when a patient's blood pressure dropped staff would raise the patient's legs and administer a fluid bolus. Patients were encouraged to rest in the dialysis chair for a little while post dialysis to ensure there was no bleeding from the fistula and that they did not feel unwell/light headed. We saw one patient who had bleeding from their fistula at the end of their session, and the nurse was extremely patient and took their time to ensure that the bleeding had completely stopped before redressing.
- Staff did not confirm the identity of patients before commencing dialysis treatment, as staff explained that they knew patients well. If there were new patients or patients on holiday receiving dialysis, nurses followed guidance from the Nursing and Midwifery Council. This included checking it was the right patient; the right medicine; the right dose; the right route; and the right time.
- Staff responded quickly to alarms on the dialysis machines and we saw nurses responding to patients promptly, checking their vital signs before turning the alarms off. The alarms were assessed appropriately and not overridden.
- Staff accessed standard operating procedures, policies and protocols through the company online electronic system. All policies we looked at were in date, and staff told us they did not print policies, as it would not guarantee they were looking at the most up to date policy.
- The service did not have a sepsis policy or guidelines to follow. Staff could, however, explain what to do if they suspected a patient had sepsis; the patient would be transferred to the local NHS hospital, by emergency ambulance if appropriate.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for people who used services and risk management plans were developed. We saw falls risk assessments completed in all ten of the patient records we looked at.
- The unit did not employ any medical staff, which meant there was no immediate access to medical staff in the event of a medical emergency. The service had processes to follow which included calling an ambulance for emergency transfer to the local NHS hospital.
- The service had a corporate operating procedure for staff to follow in the event that an urgent patient transfer was required. This included information about who to contact regarding the transfer, organising the transfer and ensuring information was shared with patients' next of kin.

Staffing

- The unit had safe staffing levels which were in line with The Renal Workforce Planning Group (2002) and the Renal Association (2009) recommendations. Actual

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staffing levels were equal to the planned levels of staff, which ensured the unit was staffed safely to care for and treat patients. The unit employed 6.2 full time equivalent nurses and 3.8 full time equivalent healthcare assistants. One member of staff had left the service in the last 12 months. At the time of our inspection, there were 1.5 full time equivalent senior dialysis nurse vacant posts. However, recent recruitment had identified two nurses and the unit were waiting for employment checks and job acceptances to be agreed.

- The unit was staffed with one qualified nurse to four patients, and there was also a healthcare assistant on duty on every shift. Staff worked either six or 12 hour shifts, according to their contract. We checked rotas for May 2017; these rotas demonstrated there were always three registered nurses on duty, but that there were 60 six hour shifts that were not covered by a nurse with a renal qualification in the last three months. This was a potential risk to patients if something went wrong and there was no senior nurse available
- The unit had processes to cover for staff sickness. Between April and June 2017 there had been 4.4% sickness in dialysis nurse posts and 4.1% in healthcare assistant posts. Staff working extra hours covered shifts. The unit used any agency staff to cover vacant posts, and extra shifts were covered through overtime. Over the previous three months 43 shifts were covered by agency staff. There were arrangements in place to ensure any agency staff coming to work in the service had a competency document completed, and there were three regular agency nurses used by the unit to try to ensure consistency in patient care. We saw that competency documents had been completed for agency staff at the unit. The registered manager kept information sent to them by the agency, which confirmed their training, competence and disclosure, and barring checks.
- There were effective arrangements for handovers and shift changes that kept people safe. Once the patient had been put onto the machines, all nursing staff gathered and discussed each patient for that session

including any risks identified. Handover information was also recorded in the unit diary to ensure all staff were aware of discussions held during handover and any actions taken.

- There was no medical staff on the premises, which meant staff called an ambulance in the event of a medical emergency. A consultant nephrologist from Dorchester visited the unit every month on alternate days and times to ensure they had an opportunity to see their patients. Where staff had any concerns about a patient they could contact the consultant and told us that they had a quick response. Nurses were either able to get advice over the telephone or book the patient in to see the consultant at Dorchester renal unit. Staff told us it was easy to get hold of one of the consultants if they had concerns about patients.

Major incident awareness and training

- Staff were able to tell us what they would do in the event of an emergency situation at the unit.
- Each patient had an emergency evacuation plan which was completed when they started treatment at the unit. The plan outlined the procedure for patients in the event of a fire which the nurses went through with patients at their first session at the unit.
- There was an emergency contingency plan folder available for staff at the unit. Staff knew where to access this. It contained policies and procedures in the event of a power failure or a disruption to the water supply, as well as emergency contact numbers, emergency transfer of patients policy, information for the fire brigade and the patient register. There was a copy of the emergency contact list in both the main treatment area and the main office for staff to use in the event of an emergency.
- Potential risks such as adverse weather, were taken into account when planning services. Patients were prioritised following review of fluid levels and bloods results and contacted by phone to establish who could and could not get into the unit for dialysis. If a patient was identified as requiring urgent dialysis and could not get to the unit, staff told us they spoke to staff from other units to see if the patient could be accommodated as an emergency.

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

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

Evidence-based care and treatment

- Treatment was managed in accordance with national guidance. There was a 90-day treatment plan, which was followed by a continuing treatment pathway. These pathways were evidence-based on national guidance from the Renal Association haemodialysis guidelines (2009) and the National Institute for Health and Care Excellence (NICE, 2015): Renal replacement therapy for adults.
- The unit set key performance indicators (KPIs) based on Renal Association and B. Braun Group guidelines. Each month, all patients had pre and post dialysis bloods taken to monitor dialysis adequacy and efficiency, and staff ensured changes to treatment were made where necessary. The Unit Manager collated this data and a report was generated, using these results, to assess the effectiveness and quality of the treatment and any variances. Results were discussed at the continuous quality improvement (CQI) meeting, held every month with the lead consultants from Dorchester, Southmead and Exeter, unit manager and dietician. Examples of changes made during the CQI meeting included changes to be made to dialysis prescriptions and medicines.
- Staff followed evidence-based guidance when carrying out checks before patients' dialysis treatment. Patients weighed themselves before entering the dialysis unit. Staff checked their vital signs: blood pressure, pulse and temperature before commencing dialysis treatment. During treatment, staff checked patients vital signs hourly or more often if there were concerns or identified trends of any abnormality. At the end of the dialysis treatment, patients weighed themselves again and reported their dry weight to the nurse. This weight helped staff assess the effectiveness of the dialysis session.
- The unit underwent an annual system and process audit programme conducted by the senior managers which covered many areas including cleanliness, documentation and incident reporting. The audit took place over a day, and the unit managers received a report from the senior managers highlighting three categories of advice.
- The unit used the B. Braun quality management system (QMS) to ensure all policies and procedures were reviewed and amended within agreed timescales. All policies were available for staff to access through the Integrated Management System. All Standard Operating Procedures had an allocated reviewing manager who oversaw all reviews and amendments were distributed to all managers, who then circulated these to the staff.
- The unit did not facilitate peritoneal dialysis (which is a type of dialysis which uses the peritoneum in a person's abdomen as the membrane through which fluid and dissolved substances are exchanged with the blood. It is used to remove excess fluid, correct electrolyte problems, and remove toxins in those with kidney failure).
- Staff monitored patients receiving dialysis in line with Renal Association Haemodialysis Guidelines (2009). For example, guideline 6.2: monthly monitoring of biochemical and haematological parameters (blood tests).
- Water testing, disinfection of the water plant and dialysis machines were all carried out in line with best practice guidelines. The unit followed recommendations from the Renal Association, manufacturers instructions and the European Pharmacopoeia Standards for the maintenance of water quality for haemodialysis.
- Staff monitored and recorded patients' vascular access in line with NICE Quality Statement (QS72) statements 8 (2015): 'Haemodialysis access – monitoring and maintaining vascular access'. The majority of patients (46 out of 55) had an arteriovenous fistula (AVF) as their vascular access. An AVF is a surgically created vein used to remove and return blood during haemodialysis. We saw individual care plans for those patients who were difficult to cannulate. If patients' fistula were difficult to

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cannulate this was undertaken by more experienced staff. The AVF was the most common of type of vascular access for the patients on the unit. We saw that visual assessments, evaluations and actions to take if issues were identified. This formed part of the patient's care plan.

- Staff followed evidence based guidance when commencing patient's dialysis training. Nurses used a technique referred to as wet needling, when connecting patients to dialysis machines. They followed clinical care pathways to ensure secure vascular access.

Pain relief

- Patients' pain relief needs were assessed and managed appropriately at the start of and during their treatment. Patients did not routinely receive oral analgesia during their dialysis sessions. However, local analgesia in the form of a gel was available during cannulation of the patients' arteriovenous fistula or graft (AVF/G). Needling is the process of inserting wide bore dialysis needles into the fistula or graft which some patients find painful.
- Local analgesia was prescribed as a 'to be administered as necessary medication', which enabled it to be used at each attendance to the unit. Staff told us they could offer local anaesthetic cream prior to cannulation of the fistula if patients found this process uncomfortable or painful, and patients were appreciative of how staff considered their comfort during dialysis.

Nutrition and hydration

- The unit addressed patient's nutritional and hydration needs which was recorded in the patient's care plan.
- Patients in renal failure require a strict diet and fluid restriction to maintain healthy lifestyle. Patients and staff at the unit had access to specialist dietary advice through the renal dietician from the supervising NHS trust. The dietitian visited the unit every twice a week to ensure they saw and reviewed all patients regularly. The dietitian wrote up their records and spoke with staff about any changes on the same day, before leaving the unit. They also used the malnutrition universal screening tool (MUST) to identify adults at

risk of malnutrition. These assessments were undertaken on each patient twice yearly. The dietician had recently made ice-cream from a high protein supplement for the patients on the unit.

- We saw that patients were provided with written information and guidance relating to their diet and fluid management.
- Patients were weighed on arrival to the unit at each visit. This was to identify the additional fluid weight that needed to be removed during the dialysis session. This varied from patient to patient. Some patients were observed weighing themselves prior to dialysis, and inputting this into the dialysis machine.
- Patients had access to food and hydration whilst undergoing their dialysis, Staff did a tea and biscuit round for patients during their session. They also provided porridge for a diabetic patient.

Patient outcomes

- The unit collected data which was submitted, to the UK Renal Registry by the local NHS trust. This allowed the service to compare treatment outcomes to similar outcomes from other services in England. The service collected data about ten haemodialysis key performance indicators. These included data about dialysis frequency, treatment time, blood pressure recordings and blood test results such as haemoglobin, phosphate and calcium levels. The services performance indicators were similar to the country average for all key indicators. For example, dialysis frequency data showed that the average number of weekly treatments for patients was three sessions per patient between January and May 2017 with three sessions per week being the recommended frequency. The unit reported that 96.6% of patients received three dialysis sessions per week, which was in line the national average for other B. Braun units for five out of eight months in the same time period.
- The unit set key performance indicators (KPIs) based on Renal Association and B. Braun Group guidelines. Each month, all patients had pre and post dialysis bloods taken to monitor dialysis adequacy and efficiency, and staff ensured changes to treatments

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were made where necessary. The unit manager collated this data and a report was generated to assess the effectiveness and quality of the treatment and highlight any variances.

- One set of patient outcome data looked at the effectiveness of haemodialysis treatment and how much waste product was removed from the patient's body. This was measured by the rate the blood passes through the haemodialyser over time, related to the volume of water in the patient's body (Kt/V) and should be less than 1.2. The units target was to achieve a minimum target of 90% of patients achieving less than 1.2, and Yeovil had achieved an average of 95.4% between January and May 2017, demonstrating patients had received an effective haemodialysis treatment.
- The unit recorded patient blood data and urea reduction rates in a monthly report which was returned to the quality manager. This document audited the percentage of patients who had achieved the standards set by the Renal Association. Parameters audited included: haemoglobin, phosphate, calcium, dialysis adequacy, treatment time, albumin and the type of access used. This data formed part of the continuous quality improvement meetings with the lead consultants, and highlighted where prescription changes were required. For example, outcome data was also reviewed at the quarterly B. Braun Avitum managers' meetings. Data from all units was compared and discussions held and also formed part of the analysis presented at the supervising NHS trust's dialysis meeting held at the unit.
- We saw patients care plans were reviewed every month following monthly blood tests taken from all patients. The care pathway document covered all aspects of patients care, and other assessment tools were also used to provide a holistic approach and any variances were accounted for within the patient's notes.

Competent staff

- All new staff members had a six-month probationary period, during which a competency document was be completed. Their progress against this document was assessed through one, three and six month reviews. All

new dialysis nurses completed a Nurse Development Programme, specifically about renal failure and dialysis. Once through probation, all staff members received six-month appraisals in which they gave examples to show they were continually meeting various competencies linked to clinical care and the requirements of the business. We spoke to a nurse who had started six months ago and was currently working through their competencies. They had been allocated a mentor to support them during their training.

- An internal audit had identified that one new member of staff was signing off their own competencies rather than their mentor. This was not in line with the local target for 100% compliance. However, the new unit manager was keen to ensure that staff were supported and mandatory training was completed as soon as possible.
- Bank and new staff were inducted using a staff checklist which included the awareness of safety procedures (fire safety, resuscitation equipment), equipment training (dialysis monitor, infusion pumps, and glucometers) knowledge of governance policies, patients data requirements and uniform policy. We saw that the induction checklist was completed by staff at every attendance to the unit and signed by a substantive member of staff.
- Staff had been given the appropriate training to meet their learning needs, which included the opportunity to attend the external renal course. Three of the six nurses employed by the unit had completed this training and one had recently applied.
- All staff had completed their annual appraisal in September or October 2016. Annual appraisals identified any areas for development and an agreed timescale for completion. All staff completed competencies, which were measured against a B. Braun knowledge and skills framework. Staff told us that their appraisals were helpful and enabled them to develop as well as provide an opportunity to raise issues. These were reviewed biannually as part of the staff member's appraisal. At the time of the inspection there were two members of staff due their six monthly appraisals because the lack of a permanent manager

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at the unit meant that they were behind with completing the six months appraisals. However, the new manager had conducted one to one meetings with all members of staff since April.

- Up-to-date staff training was carried out on the use of specific medical devices, including the dialysis machines and we saw specific training documents in staff folders containing competency based training and assessments, which were all complete and up to date. Staff explained how they could adapt treatments depending on the patient's general health at the time of the treatment.
- There were no 'link nurses' in the service at the time of our inspection. Link nurse roles are a way to share information, for example about infection control, or other specific topics. However, the new unit manager told us they had plans to offer nurses an opportunity to become 'champions' in subject areas such as medicines, access and transplant.
- The unit used a basic general health and safety induction, which the agency nurse signed when completed. This included emergency procedures, fire equipment, layout of the building, basic renal information about dialysis prescriptions and how to operate essential equipment such as the dialysis chair.
- B. Braun trained nursing staff in dialysis and all staff had completed renal training programmes. Three out of six staff had completed or were in the process of completing the national renal training course. One member of staff had applied for this course.

Multidisciplinary working

- There were processes to ensure effective multidisciplinary working. The consultant nephrologists from the supervising NHS trusts had the overall responsibility for managing patients' care. Nurses played a vital role in ensuring care and treatment was carried out as prescribed and communicated any deviations in treatment to the consultants. Nurses told us their working relationship with the consultant nephrologists was good and that they were supportive.
- Each month, all patients had pre- and post-dialysis bloods taken to monitor dialysis adequacy and efficiency, and staff ensured changes to treatment

were made where necessary. The effectiveness and quality of the treatment and any variances were discussed with the lead consultant and unit manager. We saw that patients' current condition, their care plans, most recent blood results and medicines were discussed and recorded in the electronic patient record. Each patient review was recorded on a written table, and any changes to patient medicine were communicated to the GP in a letter from the consultant.

- Staff had effective working relationships with the nearby NHS hospital. This was confirmed by feedback from the consultant nephrologist. Staff were friendly, knowledgeable and experienced and had processes to support safe delivery of care.
- There were effective working relationships with regional transplant centres. Patients waiting for a renal transplant received specialist care, including psychological support, from the regional centres. Once patients were accepted onto the renal transplant waiting list, staff obtained regular monthly or three monthly additional blood tests, which were sent directly to the renal centres.
- The unit planned to hold engagement meetings with the local hospital trusts. However, attendance had been poor and the meetings had been regularly cancelled. The clinical commissioning group had requested that these meetings were reinstated and the next meeting was due to be held in the week following the inspection.

Access to information

- All of the information needed to deliver effective care and treatment to patients was available to all staff involved in their care in a timely manner. The unit had access to the most recent clinic letters following a patient's appointment with the consultant. This enabled staff at the unit to keep up to date with the patient, their condition and any other concerns or issues arising from their review with the consultant.
- The unit had access to the dedicated renal database used by the supervising NHS trust, which allowed for central storage of patient information. All dialysis information was inputted to record treatment activity. The system allowed staff to access blood results, medicine lists, recent clinic letters, multidisciplinary

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team planning and all demographic and identity information necessary to provide safe care. Patients were also able to access their own information if they wished.

- The unit had specific documentation and information requests which had to be returned to the unit prior to a holiday patient attending the unit for treatment. Information was shared appropriately with the host unit from the admitting unit to ensure the patient was suitable to attend the unit and the nurses had all the information required to provide effective ongoing care for the patient.
- When people moved between teams and services, including at referral, discharge, or transfer to another unit or for transplant all the information needed for their ongoing care was shared appropriately. Nursing staff completed telephone referrals for additional support or specialists. This process was followed by a written letter or email to the relevant service to ensure details had been shared.

Consent, Mental Capacity Act and Deprivation of Liberty

- Staff obtained consent and acted in accordance with patients' wishes. Staff obtained written consent from all patients when patients started treatment at the unit. We saw that each patient completed consent forms for the completion of treatment and for dialysis. This consent form was filed in the patient's paper records and updated annually. We looked at 10 patient records that all contained this information and were signed within the past 12 months.
- Thereafter staff obtained verbal consent before treatment and care interactions were commenced. This consent was not documented in patient records. Staff explained that there was also implied consent as patients attended for their treatment.
- There were no patients being dialysed at the unit with a learning disability or without the capacity to consent. However, the manager of the unit was able to clearly articulate how they would discuss treatment with the consultant and ensure a mental capacity assessment was completed.

Are dialysis services caring?

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

Compassionate care

- We spoke with seven patients and one family member of a patient during the inspection and received 29 completed comment cards from patients who fed back about the care they had received. Staff were described as friendly, caring and helpful.
- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate manner.
- Staff understood patients' personal, cultural, social and religious needs. We saw that these were taken into account when planning treatment. For example, patient's dialysis sessions were planned around their work, social events, and hobbies.
- One patient told us that they had a heart attack whilst being dialysed on the unit. They told us that staff had supported his wife emotionally during this distressing time.
- Patients commented positively about the care they received. Comments included: "The unit is as comfortable as it can be for the treatment provided", "I haven't had to raise any concerns but would raise with staff any issues if needed", "Nurses are helpful and informative", and "The dialysis can be emotionally draining, but staff are very reassuring and explain what is happening". One patient commented "The new unit manager is very impressive, business-like and patient-oriented".
- However, some patients told us "I am unsure what to do if I want to complain", and "There is no privacy if you want to speak to a member of staff [on the unit]".
- Patients were encouraged to complete the annual patient satisfaction questionnaire. This was distributed to all patients, was anonymous and allowed for open and honest feedback. The results of this questionnaire were reviewed at senior level, and

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the unit manager. An action plan was created to improve patient experiences at the unit and sent to all patients. The most recent survey in 2016, showed a 63% response rate (38 patients).

- Of those responding 34 patients stated that they were very or quite satisfied with the renal unit in general. However, 15 patients stated that they were barely or not at all satisfied with the comfort of the armchair/bed. The results of the patient survey were sent to all patients and the covering letter to the patients stated that the chairs would be replaced when the clinical commission group had decided whether it would extend the contract, but that patients could raise this with the nurses during their treatment and that pillows were available to make patients more comfortable. The action plan showed that pillows had been provided by 31 January 2017. At the time of the inspection the contract extension had been agreed and the unit manager planned to replace some of the chairs.
- Staff treated patients with compassion, kindness, dignity and respect. We observed staff interact with patients in a compassionate manner.
- Staff understood of the importance to provide care for their patients and ensured individual wishes and needs were met wherever possible.
- Some patients told us they were able to speak to nursing staff and management in the units office if they wanted to discuss some issues in a more private setting.
- Staff were mindful of maintaining privacy but individual dialysis stations could not easily be screened off when care interactions took place including during physical or intimate care. We saw screens were used to surround the dialysis station when patients felt nauseous. However, during the inspection we saw, and patients expressed to us and in the patient survey, that the privacy screens did not give much privacy because they were quite small, and patients could be heard when they vomited.
- The unit had a consultation room where patients could speak with staff in private, which patients told us they were aware of.

- Patients all had access to individual ceiling mounted TV units. Patients supplied their own headphones, and also had access to free Wi-Fi on the unit.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in a manner that ensured patients understood the information they were given. The serviced used a 90-day clinical pathway that included a patient education programme. Patients received information about the treatment, fluid management, diet, vascular access, medicines, how to adapt to dialysis and information about kidney transplant. We observed staff took time to explain for example blood results and checked the patients had understood the information by asking further questions.
- Patients had ongoing education provided by the nurses to ensure they and their family were able to make informed choices about the future of their treatment. Nurses ensured patients understood their kidney condition and how this related to other medical problems they may have, which impacted upon the life choices made by patients. The unit had a 'patient and carer shared/self-care training check list' but only one patient carried out the treatment themselves. A competency booklet had been developed to help patients self-care, which was comprehensive and patients could be signed off as competent by nurses. The new unit manager was keen to encourage patients to become more involved in their own care.
- Nursing staff told us that as they saw their patients frequently they were familiar with their moods and were able to identify when patients were having a bad day or were feeling unwell. This enabled them to spend additional time with the patients as necessary to support them with their treatment or assist with any concerns they may have.
- Most patients spoke positively about the staff and treatment at the unit, and comments we received from patients included 'staff are caring' and 'I have always been looked after with caring and respect'. 'I have always received courteous attention, the staff without exception have treated me with professional

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skills'. However, some comments said 'the unit is currently understaffed as senior nurses have resigned over the last three years and 'the chairs are very uncomfortable'.

- On referral to the unit, patients were encouraged to visit for an initial assessment and a look around. On arrival, staff gave patients information packs about the unit, which detailed what to expect from the service and information on haemodialysis. Patients and their relatives were encouraged to spend time with the staff and other patients to ensure that they were satisfied with the unit before agreeing to start treatment at the unit.
- Patients new to dialysis were given additional time and support by staff prior to commencing treatment. Information leaflets were used by staff to inform patients of side effects and common risks and benefits of treatment, and were discussed throughout the patients visit to the unit.
- We saw that patients were fully informed of their blood results at each dialysis session. Patients spoke with the nurses about the impact of their blood results and whether any changes would be made to their treatment. We saw that any changes to treatments were written and given to patients to ensure they were informed of the reasons why things had changed.
- All patients were reviewed monthly by their consultant and weekly by a dietitian who enabled discussions about any concerns, medicines, treatment changes, and future plans for different dialysis. Following each meeting, patients were given a printed summary of the discussion and any planned changes to treatment. We saw that nursing staff spoke with patients about the discussions and answered any queries relating to the changes.
- Staff understood the importance of involving family members and close relatives as partners in patients' care. We spoke with a family member and carers who had accompanied patients to the unit and stayed with them during the session. They told us they felt they could ask questions if they wanted to and were as involved as they were involved as much as they wanted to be with the care and treatment of their loved one. They told us the staff were accommodating and always offered them refreshments.

Emotional support

- Staff were aware of the impact that dialysis had on a patient's wellbeing, and staff supported patients to maintain as normal a life as possible. Staff encouraged patients to continue to go on holiday, and participate in the management of their treatment.
- There were processes in place to ensure staff assessed patients' quality of life and emotional wellbeing. Patients received information about adapting to dialysis as part of the patient education programme when they started dialysis treatment. Staff could refer patients to a clinical psychologist at a nearby NHS trust if required.
- We saw that the unit provided details of support networks for patients and their families and carers. This included organisations such as the Kidney Patients' Association, access to psychosocial support and emotional health and wellbeing.
- Patients from Dorchester had access to a renal social worker who was able to offer financial advice and support. The social worker visited the unit once a fortnight. For other patients staff would refer them directly for social support.
- The unit recognised that encouraging patients to participate in their care could lead to better outcomes. Linking with the supervising NHS trust, shared care audits had been performed to identify which patients wished to participate in their treatment and to what degree. As part of the shared care process patients were encouraged to access Renal Patient View. This on-line system allowed patients access to their most up to date blood results, and in conjunction with the care pathways, encouraged a collaborative relationship.

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

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

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Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. B. Braun was contracted to complete a programme of work by a number of local NHS trusts. The trusts and local clinical commissioning group had defined the scope and specifications of the service.
- The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care. Patients who required dialysis in the catchment area were assessed by the nearby NHS trusts for suitability to dialysis in a satellite unit, and then referred to the unit.
- The unit was not secure on the days of our inspection. The unit consisted of four main areas on one level. The reception area and office, dialysis stations and services corridor. The dialysis room was open plan and was accessible through a door with a key code. However, the key code was disabled when we visited the dialysis room. Patients arriving in the reception were required to be buzzed in through a secure door from the patient waiting area. This area had a camera to enable staff to identify callers upon arrival. The key code locked service corridor contained all treatment storage, water treatment room and maintenance room. Clean and dirty utility rooms were located off the main treatment area, and were key code locked.
- A named nurse was not allocated to each patient on starting treatment at the unit which would provide patients with continuity of care. However, the new manager planned to introduce this to give patients better continuity and gave them a point of contact if they needed support or advice.
- The unit had arrangements available to patients attending the unit with additional care needs. There was access to a hoist, dialysis specific chairs, hospital beds and one single room for isolation.
- There was adequate parking and disabled parking adjacent to the dialysis area, for patients who organised their own transport to and from dialysis, and patients told us they never had any problems either parking themselves, or when transport arrived to collect them. There were two disabled parking spaces directly outside the unit.

- Staff acted in accordance with patients' wishes, which sometimes meant that patients' dialysis session was shortened. When this happened staff explained the potential consequences of shortening the dialysis session but took account of the patients' wishes and disconnected them from the dialysis machine. Staff noted this in the patients records, and also reported this as an adverse patient occurrence. This had happened between two and four times each month between January and May 2017.

Access and flow

- The service met the needs of the local population and was well utilised. The unit provided on average 784 dialysis sessions per month between July 2016 and June 2017. At the time of the inspection the unit was dialysing 60 patients, but had capacity for 65 patients. Renal consultants at three local NHS Trust's main dialysis units referred patients to the unit. Once the unit manager was informed of the patient, they contacted the patient to arrange the first appointment and this included arrangement of transport to and from the unit. The unit manager invited new patients to visit the unit before starting their treatment to ensure the location met their expectations.
- Patients did not have to wait long for their treatment to start from the scheduled time given. A patient satisfaction survey from 2016 showed that of the 37 patients responding, 17 patients waited on average less than 15 minutes, 14 patients waited between 15 and 29 minutes, and six patients more than 30 minutes. Messages for patients regarding waiting times and potential delays were written on a whiteboard in the reception area for patients to read on their arrival to the unit.
- Managers told us the unit would not cancel appointments unless there were issues with the water plant when treatment and safe dialysis could not be assured. If patients could not attend their regular appointment, staff invited them to attend at a different time as soon as possible. If patients missed their dialysis appointment, staff telephoned the patient to check they were well and to arrange another appointment the following day. They also informed the consultant and the patient's GP. Staff reported missed appointments as an adverse patient

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occurrence (APO) on the B. Braun electronic incident reporting system. From January to May 2017, the service reported 14 unscheduled missed dialysis appointments.

- The dialysis service provided flexibility and choice for patients. Most patients attended the unit three days a week and had the choice of available morning or afternoon session to suit their preference.
- All appointments with the consultant or dietitian were scheduled for the same day as patient's dialysis sessions to prevent multiple attendances at the unit where possible.

Meeting people's individual needs

- The service took account of patients' individual needs when they received dialysis treatment. The dialysis stations each had a television and patients brought in their own individual headset. Each station had a table and staff offered hot and cold drinks and a biscuits while patients received dialysis. Some patients brought their own food in as well as books, electronic devices or similar items to help them pass the time.
- There were provisions for patients attending for haemodialysis to be able to visit the toilet before dialysis commenced, and nurses were responsive to patients who needed to urinate during or close to the end of the dialysis treatment.
- The service supported patients with arrangements for dialysis while on holiday and welcomed patients from other regions for dialysis sessions. The staff acted as holiday coordinators and liaised directly with patients, consultant nephrologists and co-ordinators to arrange dialysis for patients going on holiday that required dialysis at a different unit. They also arranged dialysis for patients on holiday nearby.
- Patients were provided with support once they had booked their treatment at a dialysis unit at their holiday destination. Nurses completed all the paperwork required by the chosen treatment unit in order to ensure a seamless transition into the haemodialysis unit for the patient going on holiday. Nurses at the unit liaised directly with the holiday dialysis unit, to arrange treatment for patients who were coming on holiday to the area and who wanted to attend the Yeovil unit. The unit had set criteria for

holiday patients and paperwork requirements to be completed and reviewed prior to a patient attending the unit for treatment. The information requested ensured the patient was treated safely and effectively. Information required included details of the dialysis prescription, including maximum fluid removal and all treatment parameters. Recent blood biochemistry, haematology and virology results were also required at least four weeks prior to attendance.

- The services had an operating procedure (OP) to ensure patients with protected characteristics were not discriminated against. The OP provided guidance to staff about accessing for example translation services or written information in large-scale print or Braille.
- The unit was easy for patients with disabilities to access. All treatment areas were on the ground floor and were spacious to accommodate people in wheelchairs. Two toilets were specifically designed to provide easy access and hand rails for patients using a wheelchair. The toilet facilities also had an emergency call bell so patients could summon assistance if required.
- The Equality Act 2010 places a legal duty on all services to 'make reasonable adjustments' in order to avoid putting a person with disabilities at a substantial disadvantage when compared to a non-disabled person. Staff obtained information about patients' communication needs in line with the Accessible Standards (2016). This was done as part of each patient's initial assessment. Staff ensured patients' needs were met wherever possible for example by purchasing specific equipment or using the single room if required.
- Information leaflets in the unit were all in English, but staff told us that they could access leaflets in some other languages if required. We were told the unit had not had a patient whose first language was not English. However, staff could describe how they would contact a translator if necessary to ensure consent was understood.

Learning from complaints and concerns

- People who used the service knew how to make a complaint or raise a concern, and told us they were encouraged to do so. Patients felt confident to raise

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complaints. Patient complaint information was displayed on the board in the unit. It identified whom patients could make complaints to and the ways of contacting them. The first contact was the unit manager, but alternatives were available if the patient felt it was necessary. At the time of our inspection, there had been no patient complaints made in the last 12 months.

- There was a comprehensive complaints policy and procedure to ensure all complaints were handled effectively and confidently. The procedure ensured complainants received a timely response, acknowledgement within five working days and a full response in 20 working days. The complaints policy also outlined the complaints process flow chart documenting the stages a complaint would go through with regards to a complaint.
- On referral to the unit, patients and their relatives were given a copy of the patient booklet, which contained details of the complaints procedure. Detailing how a complaint could be made, the process for investigation and the timescales.

Are dialysis services well-led?

Leadership and culture of service

- At the time of the inspection a new unit manager had been in post from April 2017. The new unit manager had the skills, knowledge and experience to manage the service. From February 2017, a manager from another unit had covered the management role at Yeovil in the absence of a unit manager. This manager had less capacity to carry out her role at Yeovil, for example, holding staff meetings more regularly and having oversight of compliance and completion of mandatory training due to the increased work load.
- At the time of the inspection the manager who was registered with CQC had left the unit in January 2017. The previous registered manager had not informed CQC that they had left the unit.
- The unit had also recently recruited two new senior dialysis nurses who had yet to start work at the unit.
- On the day of our unannounced visit to the unit the new manager was on their induction. There were no

senior dialysis nurses in post at the unit at this time. We spoke to the band 5 nurse who was in charge for the day and found them to be confident in their responsibilities and could clearly explain what they would do in an emergency and when to escalate any issue to senior managers.

- Nursing staff confirmed that the new unit manager was approachable and responded positively to any contact and always spoke with patients. They told us that the manager was very supportive and introducing new ways of working which has improved the working environment. They told us that they felt very comfortable to raise concerns, and were encouraged in their staff development. The unit manager was contracted to work 50% of their time clinically, although at the time on the inspection they were new to the role, and therefore was focusing their time on management tasks and induction training.
- The senior management team also understood the challenges to ensure effective oversight of the unit. They were not at the unit every day, and to ensure they maintained oversight of the unit, a member of the senior management team had weekly telephone calls with the unit and visited once a month. This was to check on staff wellbeing and make sure there were no problems or concerns they could support with. The unit manager also told us if there was a problem, the senior management team could be contacted by either telephone or email at any time.
- The organisation obtained an accreditation with 'Investors in People' in 2016 at level two (Silver Award). This accreditation is awarded to organisations who meet their standards for people management.

Vision and strategy for this core service

- B. Braun's corporate vision was commitment to provide safe patient care and to engage with local communities. In addition, they wanted to reward and recognise good staff. The company had a strategic vision of how to achieve this. It focussed on four elements: clinical care, multidisciplinary working, the importance of additional support for patients and their families outside of the dialysis unit and to have robust governance processes. The company had a strategy to support positive staff experiences. This strategy focussed on four Ps: prioritize people, practice

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effectively, preserve safety and to promote professionalism and trust. The corporate contract was reviewed and renewed every five years. Corporate managers oversaw the contracts and held the organisational overview of performances in different localities.

- Staff were aware of their role and responsibilities in providing effective and safe care to all patients. Staff spoke positively about providing safe care in the local area but we did not see the vision or strategy displayed in any of the clinical or staff spaces.
- Progress against delivering the strategy was monitored and reviewed using a monthly operational report management plan and a key performance indicator report, which helped staff assess the quality of treatment received by patients.
- There was a strategy to deliver safe care and treatment to patients. This was underpinned by evidence-based standing operating procedures (SOPs) and policies to provide guidance. Staff were aware of these and how to access them electronically.

Governance, risk management and quality measurement (medical care level only)

- There was a governance framework to support the delivery of the strategy and good quality care. Quality assurance was monitored at corporate level through regular audits. The registered manager completed an operational report management plan every month, which was sent to the head office. The management plan was set up as a dashboard and held information for example about key performance indicators, adverse patient occurrences and staffing. There were monthly operational management meetings where key performance indicators and benchmarking were discussed.
- There was a planned monthly contract review with the local NHS trust attended by relevant staff from the NHS hospital, the operations manager and the registered manager. However, there had been not been a meeting since December 2016 due to poor attendance, and the clinical commissioning group had raised this as a concern. The contract meeting was due to be resumed in July 2017.

- There was a systematic programme of clinical and internal audit used to monitor quality and identify where actions needed to be taken. This included the rates of patient falls, safety incidents, infection rates, staff hand hygiene and water system management. Following the audit, a report was produced for the unit manager along with a list of priority improvement areas. These areas were split into three categories, non-conformity, minor non conformity and recommendations. Areas for improvement included patient documentation and infection, prevention and control. Managers had eight weeks to provide an action plan which was monitored at corporate level. The senior management team carried out a three monthly follow up to review progress against the action plan and the unit manager continued to provide progress reports against the action plans on a monthly basis.
- We were not assured the corporate provider had an overview of local risks. The unit had a health and safety corporate risk register which covered all risks associated with service managers, clinical staff and senior management team and also held copies of risk assessments, including fire, arson, environmental risks and disability and discrimination specific for the Yeovil unit. We were told that the risk register was a 'live' document, but it did not contain risks that were specific to the Yeovil unit, such as the high use of agency staff or the lack of permanent unit manager and senior dialysis staff. However, the unit manager demonstrated a good understanding of local risks to the unit. Although risks were 'RAG' rated (rated red, amber or green according to the level of risk) according to company policy, there were no mitigating actions and dates for reviewing the risk and mitigating actions.
- The service had a calendar with details of when different performance reports should be completed and sent to the corporate operational manager for review. This included a monthly 'management plan' and a quarterly 'outcomes and explanation report'. The management plan held information about KPIs, which was reviewed against set targets, as agreed with the local NHS trust. Data from January to May 2017 demonstrated the service met all KPIs.

Public and staff engagement

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- The service gathered the views of patients via the annual patient survey. The results of the 2016 survey were not given to each patient or received personal feedback from the manager. The results were available on the information board in the patient waiting area. There was also a box in the waiting area where patients or their relatives could submit their views about the service or suggest improvements to the unit. Patients told us they mostly felt welcomed and respected. Staff were friendly, professional and listened if they had concerns, ideas or suggestions. Patients were pleased to have a permanent manager in post at the unit.
- It was identified by 24 patients that the room temperature could be improved and 14 wished that the room lighting could be brighter. The covering letter stated that the unit was maintained at between 23 and 25 degrees Celsius but acknowledged that the current system of heating created a downdraught. The letter also stated that should patients require lighting to be dimmed this could be done once all patients had been connected. Neither of these issues were identified on the action plan.
- The unit did not have a patient forum where patients could discuss the quality and standard of the service and any other information which is relevant. The new unit manager was keen to establish a patient forum, and two patients had volunteered to be part of that forum at the time of the inspection. However, a newsletter was produced by the unit manager for patients which provide updates about the unit for patients. This covered staffing issues, patient forum information as well as information about future changes to the unit and the service it provided.
- Patients and their relatives we spoke with, felt engaged and involved in decision-making. However, this was not reflected in the patient survey 2016. The service had identified an action to ask all patients and their relatives which aspects of their care they would like to be involved in. Staff were not aware of any feedback from this and of any changes to how care and treatment was delivered to ensure patient involvement.
- Patients told us they were encouraged to complete a patient satisfaction questionnaire every year, and senior staff told us the results helped them formulate an action plan. However, we saw that in the issues raised by patients in the 2016 survey did not all lead to actions.
- An employee forum met twice a year and also had teleconferences twice a year which provided a link between senior management and frontline staff. We saw minutes from these meetings which covered business updates, policies, training, and HR issues. Staff told us that operational and quality updates were shared in the forum meetings and representatives acted as advocates for the staff group, putting forward their own agenda of items they wished to discuss. Minutes from these meetings were then distributed to the staff group.
- Staff also attended staff meetings every three months. Recently these meetings had not been held on a regular basis because of the lack of management capacity. However, staff told us, and we saw that the new unit manager had reinstated these meetings. The standing agenda included changes in policies, issues and concerns, recruitment, contract updates and training.
- The unit manager did not have any knowledge of the NHS Workforce Race Equality Standard (WRES) published in 2016. This meant the service was therefore non-compliant with NHS England requirements. The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS acute providers and independent acute providers that deliver £200,000 or more of NHS-funded care. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. WRES looks at the extent to which black and minority ethnic (BME) background employees have equal access to career opportunities and receive fair treatment in the workplace. Although these reports may be written at corporate level, there should be data about workforce race equality collected and reported at local level.

Innovation, improvement and sustainability

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- The unit manager had plans to introduce new initiatives to improve patient engagement. These involved the reintroduction of a forum for patients to identify if any improvements could be made to the unit and their experience.
- Staff told us there were opportunities for development and the unit had a training budget. The unit manager

told us staff came to her with suggestions for training, and if they could justify why it would be beneficial to the unit, they would approve funding. Staff had also recently attended a three-day British Renal Society conference as part of their training and preparation for revalidation.

Outstanding practice and areas for improvement

Outstanding practice

The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure there is an appropriate policy and specific staff training for the early identification of sepsis (infection) in line with national guidance (NHS England, 2015).
- The provider must review their risk management processes to include evidence of how local service risks are identified and acted upon.
- The provider must ensure that all staff are up to date with their mandatory training.
- The provider must ensure staff receive safeguarding training which meets the requirements for their role.
- The provider must ensure that patients records are stored securely.

Action the provider **SHOULD** take to improve

- The provider should review processes to ensure patients identity is checked prior to starting dialysis treatment.
- The provider should ensure the dialysis chairs are in good condition to enable effective disinfection and cleaning.
- The provider should replace chairs that cannot be cleaned effectively.
- The provider should ensure there is documented evidence of all discussions which take place at staff meetings to identify completed actions, for example actions from the patient satisfaction questionnaire.
- The provider should ensure they have knowledge of and evidence compliance with the Workforce Race Equality Standard (WRES) which became mandatory in April 2015.

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

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

There was no policy, standard operating procedure or specific staff training to promote the early identification of sepsis (infection) in line with national guidance (NHS England, 2015).

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The risk register did not reflect local issues and concerns identified by management, staff and patients, and although risks were 'RAG' rated (rated red, amber or green according to the level of risk) according to company policy; there were no mitigating actions and dates for reviewing the risk and mitigating actions.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Patients' records were not always held securely, with records left on the nurses station and the door to the dialysis room was not secure. The computer on the nurses station was not locked and patient information was accessible.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Neither the unit manager nor the corporate named safeguarding lead had completed safeguarding training to level three as required by the Intercollegiate Document, March 2014.