Kings Norton Kidney Treatment Centre

Quality Report

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

Ratings

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

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

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

Summary of findings

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

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

Overall summary

Kings Norton Kidney Treatment Centre is operated by Diaverum Facilities Management Limited.

It provides haemodialysis services for adult patients living with chronic kidney failure including those with hepatitis B and HIV. The centre has 20 dialysis stations including four isolation rooms.

We inspected the centre using our comprehensive inspection methodology. We carried out an unannounced inspection of the centre on 17 October 2018.

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

Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

Services we rate

We rated this service as requires improvement overall.

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

- Staff relied on familiarity to identify patients instead of prescribed formal checks as outlined in local protocols. Patient records did not always contain a photograph of them to provide an additional form of visual identification to help keep patients safe, particularly when administering medication. Staff should follow local procedures and ensure all patient checks are carried out when administering medication to keep patients safe.
- Staff did not always observe infection prevention control and appropriate use of personal protective equipment to ensure risks of cross contamination were prevented. Staff did not always use aseptic technique practices and procedures, which meant applying the strictest rules to minimise the risk of infection.
- Staff did not always follow best practice to keep everyone safe from harm. For example, they did not always dispose of sharps safely, which increased the risk of needle stick injury and cross contamination. Staff did not always dispose of clinical waste appropriately.
- The service did not always have access to spare equipment, for example, scales to ensure patients received accurate measurements in advance of treatment.
- Fire regulations were not always observed. For example, a fire door was propped open, which did not meet fire safety regulations and presented a safety risk to those in the building.
- Loose leaf patient information was not always stored securely in folders. This increased the potential risk of medication errors and the potential for breach of confidentiality.
- Patients with English as a second language were not always provided with a translator to help them understand information that was being relayed about their treatment. All patients should have access to an interpreter when English is not their first language when providing consent to treatment.
- Managers did not always carry out investigations relating to incidents or make use of them for learning opportunities or to improve outcomes.

Summary of findings

- Managers did not always provide timely statutory notifications to the Care Quality Commission following serious incidents.

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

- There were good systems and processes to ensure staff met mandatory training requirements and oversight of compliance was provided by an onsite practice development nurse.
- Staff were trained to understand the principles of safeguarding both patients and children.
- The premises were clean and tidy and people had access to resources to practice infection prevention control.
- Side rooms were available for patients identified as a high risk of infection.
- There were technical personnel on hand to ensure the environment and equipment were maintained and in working order.
- Patients who were planning holidays were managed to ensure they received appropriate treatment while away. They were safely managed upon return, with special consideration for those patients returning from high risk areas.
- Staff demonstrated a good understanding of the key principles of the Mental Capacity Act 2007.
- Patients told us staff were caring and compassionate and we saw this in practice.

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

Amanda Stanford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis Services	**Requires improvement** 	Dialysis was the main activity of the centre. We rated this service as requires improvement for safe and well-led, although it was rated as good for being effective, caring and responsive to people's needs.

Summary of findings

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Summary of this inspection

Background to Kings Norton Kidney Treatment Centre

Kings Norton Kidney Treatment Centre is operated by Diaverum Facilities Management Limited. The service opened in 2014. It provides haemodialysis services for adult patients from a local partnership NHS trust who are living with chronic kidney failure. The service has 20 dialysis stations including four isolation rooms.

The nurse-led centre is supported by renal consultants employed by the local NHS trust who contract the service. The nursing director for Diaverum Facilities Management Limited has overall responsibility for the centre's nursing staff. The centre primarily serves adults from the local trust. It also accepts referrals for adults who may be visiting the area, for example, on holiday.

The centre's manager was new in post and was not registered with the CQC, however their application was with the CQC registration team. Kings Norton Kidney Treatment Centre is registered to provide the following regulated activity: Treatment of disease, disorder or injury.

Kings Norton Kidney Treatment Centre had been inspected for the first time in April and May 2017. Following this inspection there were requirement notices issued which have now been met.

We inspected the centre using our comprehensive inspection methodology. We carried out an unannounced inspection of the centre on 17 October 2018.

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector,a second CQC inspector, an assistant inspector, and a specialist advisor with expertise in renal dialysis. The inspection team was overseen by the Head of Hospital Inspection.

Information about Kings Norton Kidney Treatment Centre

During the inspection, we visited treatment areas where dialysis took place. We inspected non clinical areas of the centre, such as the water treatment and storage area, the staff room and consulting rooms. We spoke with 18 staff including; registered nurses, health care assistants, dialysis assistants, medical staff, a clinical and operational manager. We spoke with 13 patients. We reviewed 10 sets of patient records.

There were no special reviews or investigations of the centre ongoing by the CQC at any time or during the 12 months before this inspection. The centre had been inspected once previously April and May 2017. The April and May 2017 inspection found that the centre was not meeting all standards of quality and safety it was inspected against:

The provider must ensure that conversations in the centre's consulting rooms cannot be overheard by people in the waiting area, to ensure patients are treated with dignity and respect.

Summary of this inspection

The provider must review its compressed gas storage arrangements to ensure cylinders are stored safely in accordance with The Department of Health: Medical gases. Health Technical Memorandum 02-01 (2006).

The provider must ensure its clinical waste bags are labelled in accordance with the Department of Health's Health Technical Memorandum 07-01: Safe management of healthcare waste.

The centre's manager must ensure their yearly clinical competencies are completed and they review any staff competencies they signed off in 2016 and 2017.

Activity (September 2017 to September 2018)

- There were 14,153 outpatient total attendances in the reporting period; of these 100% were NHS-funded.

The centre employed a clinic manager, one clinical manager, a practice development nurse, eight and a half-registered nurses, five health care assistants, two dialysis support workers, and one receptionist, as well as having its own bank staff.

Track record on safety

- There were no recorded never events
- No recorded serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- Two incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- Four complaints

Services provided at the hospital under service level agreement:

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

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?

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The service managed most patient safety incidents well. Staff recognised most incidents and but did not always report them appropriately. We were not always assured that the service always learned or improved practice because of incidents.
- The service did not always control infection risk well. Staff did not always use control measures to prevent the spread of infection.
- The service could not assure us that they prescribed, gave, recorded and stored medicines well. Patients may not have received the right medication at the right dose at the right time.
- The service had suitable premises, however did not always have the equipment to look after them well.
- The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

However

- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service provided mandatory training in key skills to all staff and had a system in place to make sure everyone completed it.
- The service planned for emergencies and staff understood their roles if one should happen.

Are services effective?

Are services effective?

Good

We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Summary of this inspection

- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- Staff could not assure us that they gave patients enough food and drink to meet their needs and improve their health.

Are services caring?

Are services caring?

Good

We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

Are services responsive?

Are services responsive?

Good

We rated responsive as good because:

Service delivery to meet the needs of local people

- The provider planned and provided services in a way that met the needs of local people.

Summary of this inspection

- People could access the service when they needed it. Waiting times from treatment were and arrangements to admit, treat and discharge patients were in line with good practice.
- The service took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Are services well-led?

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The leadership team did not have a formal strategy to set out priorities and delivering good quality sustainable care.
- There was no shared vision for what the service wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The service did not have a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The systems were not always effective for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

However:

- The new leadership team aimed for a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The provider engaged well with patients, staff, and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The new leadership team were committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.
- The provider had recruited new managers with the right skills and abilities to run a service providing high-quality sustainable care.

Requires improvement

Dialysis Services

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

Are dialysis services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. They did this by providing training and regular updates in the systems and processes which helped to keep people safe.
- We reviewed the staff training matrix which confirmed all but two members of the team, one new starter and one on long term sick, had completed their mandatory training requirements. Mandatory training included infection prevention control, health and safety, fire safety, hand washing and specialist training specific to the patient group, for example, dialysis equipment and medicines management. Staff told us most of the mandatory training was via eLearning, however some modules, such as basic life support (BLS) were delivered face to face. All staff had completed basic life support training as a minimum, which was updated every year.
- The practice development lead had an effective computerised training system to ensure staff had a local and corporate induction which included a range of mandatory training. The lead used a matrix to keep up to date with staff compliance. There was an electronic system that gave an alert when staff had failed or passed their eLearning. If a member of staff failed on a few occasions before passing, the lead would have a one to one with that staff member to determine whether they required opportunities to develop their mandatory competency.
- All staff had a contemporaneous mandatory training record on following standard operating procedures to minimise the risk of infection, electrolyte imbalance, symptomatic dialysis-related hypotension and/or accidental venous needle/line disconnection.
- Staff had access to sepsis protocols, training and tools to safely access patients while receiving treatment. All nursing staff received annual sepsis recognition and escalation training. This was evidenced in staff records. Staff used a sepsis flowchart but there was no specific dedicated sepsis box. The nurses we spoke with understood sepsis screening and used NEWS scoring as a means of observing and monitoring for suspected sepsis. The policy and procedures for managing sepsis were adapted specifically for this service by the partnership NHS trust. This meant it was adapted from an evidence base and met the needs of the specialist patient group to keep them safe.

Safeguarding

- Staff demonstrated varied understanding of safeguarding. Some staff had an in-depth knowledge and were aware of who, why and when they may need to make a safeguarding referral. Other staff had a more limited understanding but they knew to raise concerns with senior staff. All staff we spoke with understood the importance of maintaining patient safety and protecting patients from harm and abuse.
- Staff had access to safety and safeguarding systems and processes. There were posters in the staff room

with details of who to contact in the event there were safeguarding concerns. All staff, except one who was on long term sick had completed a level two safeguarding children and adults course. The practice development nurse was level 3 trained and the safeguarding lead for the service was trained at the higher level 4. This was in line with intercollegiate guidance.

- All staff we spoke with told us they had not made many safeguarding referrals from this centre. Staff and patients told us some patients were aggressive towards staff. This was addressed directly with patients and the referring trust were informed. Some of the patients told us they felt this could be addressed further to protect others using the service.
- All staff completed PREVENT training, the aim was to identify and stop vulnerable people being drawn into terrorism.
- All patients who attended the centre were over the age of 18. We did not see any children (under 18), such as patients' children, onsite at the time of our inspection. Staff told us that children never came on site.
- Where patients regularly chose not to attend dialysis sessions; this was monitored and reported on. Staff contacted a patient who had not attended their scheduled session in the first instance to find out their reasons for non-attendance. When the patient could not be contacted; social services, next of kin and the police were informed to conduct welfare checks on that patient.
- The service catered for a diverse demographic. The staff group were made up of people from diverse backgrounds. Patients who used the service were protected from discrimination and harassment in relation to protected characteristics under the Equality Act 2010. Staff received equality and diversity training as part of their two-week induction training programme.
- All staff were recruited through the service head office. To ensure staff were safe to work with the patient group, they had a local and corporate induction before they commenced their roles. Staff could work with patients following recruitment checks, for example, Disclosure and Barring Service checks, two recent references and qualification checks.

Cleanliness, infection control and hygiene

- The systems for assuring high levels of cleanliness, infection control and hygiene were not always effective. Although the service had a checking system to ensure standards were maintained, there were gaps on the cleaning log on two shifts over two different days. This meant there was no way of knowing that cleaning had been carried out on those shifts to ensure the right level of cleanliness was maintained. However, domestic staff were employed to maintain standards of cleanliness and hygiene. There were clean and dirty utility rooms with systems to prevent and protect people from a healthcare-associated infection.
- We sample checked cleaning logs for the dialysis machines. Of those machines we checked; all but one record from a total of six showed that appropriate cleaning had been undertaken between patients. One record showed that two cleans should have been conducted between patients; including elements such as wiping the bed down, but they had not been carried out. This could have increased the risk of infection.
- Staff did not always follow good practice when disposing of sharps. Staff could access two sharps bin per bay to dispose of needles, and other sharp implements. The bins slide-back lids were open and were large enough to fit a hand in there and meet contaminated sharps waste. There were blood smears on the lid and around the edges of four sharps bin. This could represent a risk of cross contamination.
- Staff did not always practice good infection prevention and control which were important in maintaining a safe environment for patients by reducing the risk of the potential spread of disease. Three members of staff were seen to risk cross contamination by incorrectly disposing of sharps. For example, one nurse was seen to use their feet to manoeuvre the sharps bin following a disconnection procedure, the bin could have been knocked over increasing the risk of needle stick injury and infection.
- The centre had four side rooms to treat patients who were an infection risk. For example, this centre dialysed patients with blood borne viruses such as

Hepatitis B and HIV and treated patients who lived further away for this reason. Specific machines were allocated for use with patients with specific blood borne viruses to reduce the risk of contamination.

- Staff used single use tourniquets to prevent the spread of infection. Patients were given their own tourniquet which they kept in an individual box also containing their patient card used to record their pre- and post-dialysis weight.
- The centre was visibly clean and tidy. An external company provided a deep clean every day between 21.00 and 23.30 hours. Staff carried out cleaning duties throughout the day. The centre was checked once a month to assure standards of cleaning were being met. A janitor had been employed but was not in post at the time of inspection to provide further assurance that standards of cleanliness and safety were met.
- Staff, patients and visitors were encouraged to use infection prevention control procedures. There was a hand basin in reception for patients and visitors to use before entering the clinical areas. There were posters displaying five steps to hand hygiene above hand basins to remind people how to wash hands effectively. There was hand-sanitising gel at every entrance, nurses' station and treatment area. We saw staff and visitors using them to maintain standards of cleanliness. Every treatment station had a hand basin, and we saw staff washing their hands in line with the World Health Organisation 'five moments for hand hygiene' guidelines. All hand wash basins on the premises were operated by 'no-touch' sensors, and had paper towels and soap.
- Staff did not always wear appropriate personal protective equipment to create a barrier between people and germs. A patient allocated to a side room with a communicable disease, was attended to by a nurse without appropriate personal protective equipment. One nurse was seen to leave and enter the building with their personal protective equipment on and then continue to treat patients, this could represent a contamination risk.
- Staff were trained to use aseptic non-touch technique to minimise risk of infection when connecting and disconnecting patients from their venous access device. We observed one nurse who did not use aseptic technique. The nurse touched the medicine, then touched the hub of a needle prior to connecting a patient, then touched the lines and 'clean tray' with contaminated gauze on it. One nurse was seen to risk possible contamination during the disconnection process. This nurse did not practice safely to prevent cross contamination from pathogens which involved applying the strictest rules to minimise the risk of infection.
- Hand hygiene audits were carried out every week. The target for hand hygiene was 90%. We looked at documentation that evidenced nursing staff had met this target for October. This information was entered in to the hand hygiene audit report which was shared with partnership NHS trust. Nursing staff were made aware of the audit results and had received refresher training if required.
- Nursing staff cared for central venous catheter devices appropriately. This was demonstrated by auditing the process. The central venous access audit results which were consistently 100%.
- Patients were provided with sheets for dialysis chairs for hygiene purposes. A new sheet was used for each patient. We saw staff clean each chair and associated machinery following every use. A contracted laundry service was employed to launder the sheets.
- The centre used single use dialysis membranes to reduce the risk of infection and contamination. Dialysis membranes help to remove harmful products and excess water from the blood.
- The centre screened patients for all blood borne viruses. Patients who had transmittable infections, for example hepatitis B and HIV, were cared for in isolation rooms. Patients in isolation rooms had a dedicated member of staff who covered these rooms only during a shift. The centre used colour coded equipment in the isolation rooms to prevent cross contamination between patients.
- The centre had a policy and a process to assess and manage patients returning from holiday. Patients returning from low risk countries had blood samples analysed at the NHS trust's laboratory. Patients who returned from higher risk countries were treated in isolation at a different centre, arranged by the NHS trust, for three months following their return to the UK.

Staff arranged for patients to be seen at other centres if they were travelling. Patients were reviewed for suitability by the consultant as fit to travel and patient information was shared to ensure safe continued treatment with another provider.

Environment and equipment

- The service had suitable premises and equipment and looked after them well. The premises and facilities were designed and maintained to keep people safe. There was a secure plant room, clean and dirty utility rooms. Oxygen Cylinders were in date and stored correctly. There was a technician accessible upon request to support the monitoring and maintenance of those services. For example, to carry out haemodialysis machine testing annually.
- There were arrangements for managing water, disposal of waste and clinical specimens. There was a locked treatment plant room with restricted access to ensure only authorised staff could access it. This room was appropriately managed and maintained. Water samples were taken every month to be sent for testing. We looked at records for July, August and September 2018 and saw evidence of regular testing. This included daily water testing to ensure it was safe to use. The results were shared with staff who attended quality assurance meetings. There were robust provisions in place for decontamination of equipment. We looked at records which demonstrated compliance.
- Staff told us there had been a water leak the day before we visited. We looked at records and saw it had been reported and reviewed by the maintenance engineer. The engineer promptly attended and fixed the leak.
- The centre had an electronic set of scales which was appropriate for use with patients using wheelchairs and bariatric patients. However, there were no 'back up' scales should the scales fail. Instead staff would request a set of scales to be delivered from elsewhere which meant if this happened; patients may not be weighed to establish correct weights and provide adequate treatment whilst waiting for the alternative scales to arrive.
- Staff recognised and reported any failures in equipment and medical devices. Additional maintenance checks were carried out by the maintenance staff and recorded. Equipment was regularly serviced, including chairs and beds and dialysis machines.We looked at records for 16 chairs, all of which had been serviced with renewal dates scheduled for November 2018.We looked at servicing records for four beds; serviced August 2018 and due for renewal in August 2019.All dialysis machines had been serviced in 2018 and this was displayed on machines and in records.
- The resuscitation trolley was serviced and appropriately maintained. We looked at the trolleys and saw that all supplies were intact with the right expiry dates. The trolleys contained all the appropriate kits and equipment. For example, anaphylaxis kits, oxygen cylinders that were full and secure.Checks were carried out daily and recorded. We looked at recorded for September and October 2018 and they were completed with no omissions.
- We checked a random sample of consumable goods in the stock room and found all to be in date and well stored. The stock room temperature and humidity levels were monitored and recorded daily, except for Sundays when the clinic was shut. We checked the checks for the previous month and found these to be completed appropriately.
- Patients had sufficient space to ensure they safely received haemodialysis and to allow rapid staff access in case of an emergency. There were privacy screens if patients requested them and a nurse call system.
- Staff did not always dispose of clinical waste appropriately. There were accessible and appropriately coloured clinical and non-clinical waste bins. One of the external clinical waste bins was not labelled and or locked, all other bins were locked. This meant they did not comply with the Department of Health's Health Technical Memorandum 07-01: Safe management of healthcare waste by always keeping it secure and labelled.
- The dirty utility room had a blood fridge to store blood samples for testing or sending away. Although there were no blood samples stored at the time of our inspection; the temperature monitoring log did not demonstrate the fridge was maintaining a consistent temperature.

- Supportive equipment, such as pressure relieving cushions, were available to patients who had a risk of developing pressure ulcers.

Assessing and responding to patient risk

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff completed risk assessments to identify and manage risks to patient safety. These included falls assessments, moving and handling assessments, venous needle dislodgement assessments and pressure assessments. We saw three recorded falls for patients August and September 2018.All three were incident reported with root cause analysis and learning.
- Staff completed the risk assessments when the patient first commenced dialysing and were regularly reviewed. When staff identified that a patient was at risk, for example, of developing pressure ulcers, they recorded an action plan to mitigate this risk and reviewed the patient at least monthly.
- Staff assessed whether patients had allergies, or a lack of known allergies, which was recorded in all but one of the 10 patient records looked at.
- Nurses conducted observations including blood pressure and temperature checks before connecting patients to the dialysis machines, after connection and at the end of the session. We observed nurses undertaking these checks and, where required, conducting more regular checks on patients.
- Dialysis machines automatically alarmed if any problems were identified; for example, raised or lowered blood pressure, or if there was a problem with access to the patients' blood. When alarms sounded, staff responded quickly and checked the machines or the problem before silencing the alarm. We observed this in practice and patients told us that staff usually responded to the alarms quickly.
- Where concerns were identified with a patient, such as low blood pressure, nurses could initiate the completion of National Early Warning Score (NEWS) observations; a nationally recognised way of identifying deteriorating patients. We saw that dialysis support workers dialysis support worker noted physiological and behavioural changes to patients; such as a patient becoming pale and quiet. The dialysis support workers escalated any concerns to nurses and continued to check on the patient's wellbeing.
- Staff did not always follow their deteriorating patients' policy. Staff told us that if patients deteriorated significantly; for example, if they started to bleed excessively or if a low blood pressure didn't raise with support, then they would ring an emergency ambulance to take the patient to hospital. We saw records to support this. However, on one occasion, a patient deteriorated and patient transport ambulance was called rather than an emergency ambulance. This meant the patient had a significant delay in receiving appropriate treatment and care. In this instance the patient died soon after. Staff did not carry out any investigation or reviews to establish if there were any lessons learned or possible changes in practice to improve outcomes.
- Staff relied on familiarity with patients as a means of identification. Staff told us if a new patient started dialysis, nurses would check identification by asking the patients' personal details such as date of birth before connecting them to a machine or undertaking treatment. We checked ten patient records, only two of which had photo identification which would be a way of positively identifying a patient. We looked at the medication administration procedure dated July 2014 and was due for review in April 2017. The document said checks should be performed immediately prior to medication administration: right medication, in the right dose, to the right person, by the right route, at the right time. The nurses did not verify or check identification at the time of connection to the dialysis machines. This meant they were not following procedure and might increase the scope for drug administration errors.
- We saw two nurses checked intravenous medications for the afternoon slotted patients and the patients were not present. The medication was checked by two nurses and placed into the patients' folder and left unattended at the patient's bed space.Other patients who entered the bay could have access to the patient's folder. When the nurses connected the

patient on to dialysis, at the point of administering the medication they did so without checking the patients name, dose etc. This left room for administering the wrong medication to the wrong patient. It also could have represented a data protection risk if patients could access other patients notes.

Nurse staffing

- The centre employed one whole time equivalent clinical manager, one whole time equivalent clinical development manager, one whole time equivalent deputy manager, two whole time equivalent senior staff nurses, six whole time equivalent staff nurses and one half whole time equivalent staff nurse, two whole time equivalent dialysis support workers and five whole time equivalent health care workers. Nurses were responsible for the overall care of patients receiving dialysis. Dialysis support workers were trained and supervised to deliver care and treatment such as cannulation, and connecting and disconnecting patients to and from dialysis machines. Healthcare assistants supported with observing patient receiving treatments and understood management of stock duties in addition to supporting the cleaning of the environment.
- The centre was not fully established with nurse staffing; there were two whole time equivalent staff nurse vacancies and one healthcare assistant vacancy. There was a recruitment drive to improve staffing. There were two new starters at the time of our inspection, these staff were required to work on a supernumerary basis for a period to ensure their competency. Nurse staffing was on the location risk register and had been escalated to provider level and regularly reviewed. Bank staff and new starters had been recruited to backfill these posts. This meant there was some mitigation during the recruitment process.
- The centre was nurse led, and as such no medical staff were employed. However, consultants from the referring trust attended regularly to undertake appointments with patients. All patients were under the care of a renal consultant at the referring trust and staff at the unit could access advice and support at any time from the medical team.
- Three new registered nurses were appointed in September and October. One newly appointed clinical manager started in post in August 2018 and one clinic development manager was appointed October 2018.
- Management could access bank staff to keep people safe. Bank staff were staff employed substantively by the provider and had all the appropriate checks in place before they could work at the centre. These staff were used to provide consistency and familiarisation with systems, processes and patients.

  We looked at bank and agency usage for the past 6 months, from April 2018 to September 2018:

Month	Bank usage in hours	Agency usage in hours
April	202.5	8
May	125	0
June	222	32
July	369	98
August	216.5	216
September	292	111
Totals:	1427.00	465.00

- All nursing staff engaged in a daily handover to ensure they were up to date with patient information. We attended a handover. It was led by the nurse in charge. Some of the content discussed included patient consent for flu vaccines and checks that refusals were documented. Patient medications were discussed. Blood testing and results, including treatment effectiveness were discussed and referrals to the consultants, if appropriate. Staff followed handover by attending each patients bed space and checking that dialysis treatment had been started with the correct prescription and identify any issues that required resolving. This was good practice.

Medical staffing

- Two medical consultants who visit the clinic at least five times per month. If a patient became unwell, staff could access an on call renal registrar from a local NHS Trust Staff could also contact the consultant during office and out of hours. This was applicable to all

hours that the clinic was open from 07.00 to 23.30 hours. This meant there was access to medical cover when required; within and outside normal working hours.

- Staff communicated with all medical professionals involved in patient care. We saw this documented in medical records. For example, letters from GPs and from consultants at the referring trust advising on clinical changes and updates.

Records

- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- During the inspection we reviewed ten patient records. These were paper based and kept securely at the centre in lockable cabinets. Nursing staff also input into electronic patient records which could be accessed by staff, including consultants, at the referring trust. The paper records viewed were well maintained and all were organised consistently.
- Each patient had a dialysis card which they used with the electronic scales. This card kept a record of the patients' weight to ensure treatment given was appropriate.
- There were copies of letters from GPs and from consultants at the referring trust advising on clinical changes and updates stored within paper records. Information from the clinic to the referring trust, such as blood test results, were communicated via the electronic patient record system.
- Staff completed a paper based pro forma dialysis assessment following each patient's session. This was adapted according to the type of connection point a patient had. For example, we saw an arteriovenous fistula (AVF) assessment form specific to this connection type, and a central venous catheter (CVC) assessment form. AVF's and CVS's enabled a patient to be connected to a dialysis machine. This assessment provided a clear overview of any patterns occurring during treatment, such as problems with an AVF.
- A written summary of each patients' dialysis session was input onto the electronic patient record following treatment. We observed this process being completed by nursing staff; and noted the information contained within this summary was concise and clear.
- We saw two of the ten patient records contained a photograph of the patient; having a photograph provided an additional form of visual identification and to help keep patients safe.
- Staff did not always ensure patient records were securely stored. Patient records were sometimes left unattended at the patient bedside. Other patients could access and misuse this information without consent which could be a breach of patient confidentially or represent a risk to the patient's health.
- We observed that staff discussed patient medication changes at handover, and communicated to the hospital team and others involved in the patients care if appropriate via email, letter and telephone. Related documentation could be found in patient files.

Medicines

- Staff did not always follow local procedures when administering medications. Nursing staff should follow Nursing and Midwifery Council (NMC) standards for medicines management. This includes being certain of the patients' identity, checking the allergy status of the patient and expiry date of the medicines.
- The local medication administration procedure was dated July 2014 and was due for review in April 2017. This meant the guidance document for staff was out of date. The document said checks should be performed immediately prior to medication administration: right medication, in the right dose, to the right person, by the right route, at the right time.
- We saw that two nurses checked patient details, dose and signed appropriately. Then the medicine was left inside the patient folder, until the point that medication was dispensed. We saw on at least two occasions that staff did not carry out identity checks immediately prior to administering medication. This meant they were not following their own procedures or meeting NMC standards to avoid medication administration errors.

- Medicines were stored securely and were temperature controlled; at room temperature or in a fridge, depending on the manufactures guidance. The centre had two fridges to manage in the event of one fridge being out of range. The temperatures were checked daily, except for Sunday when the centre was closed. We checked the temperature log for the previous two weeks and found two dates had not been recorded as being checked; however, all others were completed. Staff told us that when the fridge temperature was noted to be out of range; they first checked for problems; if a fault was identified, the alternative fridge would be used and engineers called.
- Staff managed prescription charts appropriately. We reviewed four prescription charts contained within patient records. They had been reviewed within the last three months. There were two staff signatures in each paper prescription chart for the administration and checking of dialysis related medicines. Non-dialysis medications were listed. This meant that there was a system in place to keep patients safe.
- Patients were able to access the 'flu' vaccination via the centre. One nurse had a patient group direction (a written instruction for the administration of a specific medicine to a group of patients by a health care professional who is not a medicine prescriber) to administer these. In addition, Hepatitis B vaccinations were offered to all eligible patients.
- There were no local audit processes to identify and improve on medication errors. Medicine error incidents were recorded in a 'communication book' for all staff to review and learn from. The centre did not employ a pharmacist to audit prescription charts, medicines or errors which might mean additional learning from incidents.

Incidents

- The service managed most patient safety incidents well. Staff recognised most incidents and reported them appropriately. However, we identified a serious incident that had not been recorded or reported which was a statutory requirement. There was limited assurance that the service always learned or improved practice as a result of incidents. Ten incidents were randomly selected for review. Some of the incidents did not have a manager's comment to share outcomes or learning. This might mean there were missed opportunities to improve practice.
- One patient had deteriorated while in treatment at the service. Patient transport were requested however, there were delays and the patient was taken by alternative transport. The patient later died in hospital. There had been no local investigation to establish if there were any lessons to be learned from the incident. There were no local debriefs or protocols for staff following serious incidents. The managers offered support to staff if they needed it and shared information with staff in the communications book. The incident had not been notified to CQC as an incident.
- Staff reported incidents using an electronic system. All staff we spoke with, including regular bank staff, knew how to access the system and could demonstrate how it was used. We looked at incidents from September 2017 to September 2018 and saw 710 incidents had been reported. We looked at the number of clinical incidents where there was no harm, low harm, moderate harm, severe harm or death. None of the incidents reported were categorised as severe harm or death. The top five reported incidents were shortened treatment, other, missed treatment, vascular access problems and hypotension.
- We looked at one serious incident that had been recorded in September 2018 related to a needle dislodgement. The patient was known to move about a lot which caused the needle to dislodge. The patient did not complete their dialysis session. A root cause analysis was completed and lessons were learned. Staff revised the needle taping process and adapted their practice to reduce the incidence of dislodgement. The feedback from the incident was shared with the partnership NHS trust.
- There were no incidences of MRSA and two incidences of MSSA. MRSA stands for methicillin-resistant Staphylococcus aureus; a bacterial infection that can be hard to treat. MSSA stands for methicillin-susceptible Staphylococcus aureus. a

strain of bacteria that responds well to medicines. We reviewed the related root cause analysis reports for the two MSSA incidents and found appropriate investigation and learning had taken place.

- Staff used a 'communication book' as a way of sharing information about incidents and any learning from these. We reviewed this book; and tracked back over the last six months. We saw updates following incidents were added; along with any identified themes in incidents such as specific patient aggression. We observed this book being used as part of the twice daily handover. Staff also told us they read the book individually when they came on shift to ensure they were up to date.
- Staff were able to tell us about action taken following incidents which had been reported. For example; following repeated unacceptable behaviour displayed by a patient; staff told us this was addressed locally and also by the referring trust. Staff told us since this action, the patient's behaviour had become more appropriate towards both staff and other patients.
- Whilst staff we spoke with were not familiar with the term 'duty of candour'; they understood the principles of this and explained when they may apply it.

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

Good

We rated effective as **good.**

Evidence-based care and treatment

- Staff understood care should be evidence based to maintain high standards. Patients received haemodiafiltration, in line with the terms of the contract with the trust. A small number of patients received traditional haemodialysis when they could not tolerate haemodiafiltration.
- Patients' weight, temperature, pulse and blood pressure were taken at the beginning and end of dialysis. This was recorded in patient records. Staff monitored patients during the haemodialysis session. This meant that dialysis therapy was in line with clinical practice guidelines published by the UK Renal Association and accredited by the National Institute for Health and Care Excellence.
- Patient blood samples were taken monthly for analyse by the laboratory at the partnership NHS trust. The results were accessible by staff electronically. This meant that the most recent test results could be used to inform changes to treatment plans.
- Patient data was reported to the UK Renal Registry by the partnership NHS trust. This information was used by the UK Renal Registry Renal Association who provided independent audit and analysis of renal replacement therapy in the UK and used to improve patient outcomes.
- Patients with complex needs such as learning disabilities, severe mental health conditions, significant mobility problems or more advanced dementia were treated at the partnership NHS trust where specialist support was more readily accessible.
- Staff used a haemodialysis sepsis screening tool in partnership with the referring renal department at the partnership NHS trust dated March 2018 with a review date for March 2021.The tool was to support clinical staff working within the centre to assess and manage patients for suspected sepsis. The policy followed NICE published recommendations and Renal Association Guidelines January 2015.These was adapted for use with community dialysis centres. The centre could access the partnership NHS trust consultant nephrologist and team of nurse specialists and the on call renal acute out of hours service to escalate sepsis concerns. This meant there was an appropriate pathway and tool specially adapted for patients using a community setting with suspected sepsis.

Nutrition and hydration

- Two dieticians who were based at the referring trust attended the centre weekly; one day each. This was to provide face to face appointments with patients who required nutritional support.

- The centre provided a cup of tea (no coffee - which is good practice) or water and biscuits per dialysis session to those patients who could consume these. Patients were welcome to bring their own refreshments such as sandwiches, snacks and drinks.
- Nursing staff recorded how much fluid the patient had taken whilst at the centre. However, on one occasion we noted that this was completed without the member of staff checking how much the patient had consumed. We spoke to staff about this who reported that they based their assumption on what the patient had been given as a refreshment. We checked with the patient and on this occasion, they had not consumed any of their drink. This patient also reported that they had had to correct staff on several occasions regarding their permitted fluid intake.

Pain relief

- Staff assessed patient's pain needs in advance of their treatment. Patients could have pain relief as needed. Pain relief for patients using dialysis was in the form of a local anaesthetic prior to treatment.

Patient outcomes

- There was participation in relevant quality improvement initiatives, such as local clinical audits, benchmarking, and approved certification scheme (ISO 9001). Managers told us that all staff were involved in activities to audit, monitor and use information to improve outcomes. We saw that audits were a standard item for discussion in the staff meetings and at quality meetings. For example, we saw reference to infection prevention control audits in September 2018 meeting minutes. We saw staff discussed how to improve the audit process and performance. This meant that audits were being discussed regularly and used to improve practice.
- Staff carried out monthly audits on all patients looking specifically at risks, bloods, waterlows and take home prescription audits. These audits were part of the continuous quality improvement process that focussed on specific issues or aspects of care and clinical practice. This meant there was a process of measuring a clinical outcome against standards.
- Managers attended quality assurance meetings monthly as multi-disciplinary team. The meetings were attended by the provider leadership team, senior clinical staff and the partnership NHS trust. We looked at meeting minutes from April 2018 to September 2018 and saw there were standard agenda items that included patient number compared to actual sessions, patients who did not attend, death reviews, complaints, water quality and the risk register.

Competent staff

- All new staff completed an orientation programme. We saw each new starter had a documented orientation worksheet to follow to ensure they were competent to carry out tasks in their new role at the centre. For example, the staff had an assigned mentor and their training programme which included safeguarding children and adults, health and safety, fire safety, operation of medical equipment, infection prevention control. Staff told us they undertook yearly competency assessments.
- There was a system to ensure staff were competent to carry out their role. Staff competencies were recorded with review dates. For example, we looked at medicines management competencies for registered nurses and saw that all registered nurses had completed except a new starter and a nurse on long term sick.
- Dialysis support workers and health care assistants worked under the supervision of trained nurses. This meant there were qualified staff to oversee standards of work carried out by unqualified staff.
- All new staff were allocated a mentor to support them in the first few months of their employment to ensure they were competent in their roles. The practice development nurse met with staff for one-to-one meetings, appraisals, coaching and mentoring, and supported nurses in their revalidation. The registered manager told us that prior to her taking up post, staff supervision and appraisals had not been formally structured. A schedule of formal, structured supervision and appraisals had started in September 2018.
- The manager told us one of the mentors had an accredited renal nursing qualification. All the mentors were experienced registered nurses; however, it is good practice to have a specialist qualification when working with this patient group. The remainder of

nursing staff were qualified and experienced, however, had not been supported in achieving a relevant, accredited qualification to ensure they were qualified to a specialist degree to support the patient group.

- The practice development nurse carried out clinical supervision with staff as part of their competency and annual training programme. This meant that staff had an opportunity to reflect on their practice with a member of the team responsible for their competencies and to support learning and development.
- Staff performance was assessed and managed using competency observations, through compliance with training including eLearning, supervision and incident reporting.Staff who were not meeting standards were supported in either additional training, practical learning or mentoring. For example, if a member of staff repeatedly failed their online learning courses this triggered the practice development nurse to consider if they required further one-to-one training.
- Qualified nurses understood the principles of the medicines used, such intravenous iron infusions and anticoagulants. There were one off competency-based assessments at local orientation and one-off assessment to ensure staff were kept up to date. We looked at staff competency documentation which included competency checks in administering medication. Staff were assessed in their understanding of the medication, the side effects and how to intervene and how to follow all infection control measures when administering the medicine.

Multi-disciplinary working

- The service held monthly multi-disciplinary team meetings to review patients. In addition to staff from the centre, attendees included staff from the partnership NHS trust, access nurse, dieticians who worked with patients, consultants and the dialysis co-ordinator. This meant there were a group of professionals from different clinical disciplines who made shared decisions regarding recommended treatment of individual patients.
- All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. We saw evidence of these staff working together to encourage dis-engaged patients to undertake their prescribed sessions of dialysis.
- Staff from the centre and partnership NHS trust met regularly either at the centre during consultations and meetings and offsite at formal meetings to quality assure the work they were doing together.
- Staff worked closely with involved organisations to manage patients discharged from the service. Discharge was undertaken only when necessary ongoing care was in place. The centre worked closely with the patient and other related organisations to ensure pathways and processes were in place.
- The consultant nephrologist from the partnership NHS trust attended clinical reviews of the patients and was kept fully up to date with patients' conditions including their blood results. Clinicians could access this information on a computerised system or hard copy.

Seven-day services

- Patients had access to the service six days a week. Staff worked with the partnership NHS trust for those patients who required care outside normal working hours and patients were afforded flexibility to meet their personal preferences.

Health promotion

- Patients could access a range of guidance documents available in the reception area on welfare support, kidney donation, blood transfusion andguidance notes relating to dialysis. Staff discussed each patient at the quality assurance meetings to explore additional health needs and referral requirements, for example, podiatry or dieticians.

Consent and Mental Capacity Act 2007

- Staff ensured patients had consented to their treatment. We sampled ten patient records and found all contained signed consent forms, including initial consent to undertake dialysis treatment, consent for blood samples to be taken and screened, and ongoing consent to dialysis treatment completed yearly.
- Two of the 10 patient records also contained information that reported the patients did not speak

English and required interpreter services. We reviewed both patients' consent forms and saw that a patient signature was present; but there was no evidence that an interpreter had translated the information. In addition; there were no additional signatures to indicate a family member or advocate had translated. When we asked staff; they confirmed that interpreters were not booked to translate consent forms. This meant that the patient could not make an informed choice about their care and treatment. We raised this concern with the management team at the centre on the day of inspection. They told us both patients had an interpreter who attended for a consultant visit within the next month. Management told us they would ensure the consent forms were re-completed using an interpreter.

- There were posters outlining the Mental Capacity Act located in staff areas. Staff told us that patients generally had capacity to consent to treatment. If a patient's capacity was thought to changed, for example, through declining health or an infection, staff would refer to the referring trust for assessments. This centre treated patients who were safe to be dialysed at a satellite centre; therefore, all patients were deemed to have capacity.
- Staff demonstrated a good understanding that it was the patient's choice to make decisions related to their treatment, even if the decision seemed unwise. Staff told us some patients chose not to attend sessions, or asked for their session to be shortened. Staff encouraged patients to make decisions that would benefit them. If a patient declined, staff offered alternative sessions either at this centre or at the referring trust. When patients regularly chose not to attend, staff worked with the referring trust and the patient's GP to encourage patient engagement. Where patients were on site and wishing to reduce or forego their treatment; staff asked them to sign a form to confirm the patient had made this decision themselves.
- We saw examples in patients care files stating the patient required the support of the translation support service. Interpreters were sourced for appointments with consultants from the local trust. One patient's record clearly indicated that their first language was not English. An interpreter had not been used to countersign completion of consent forms which meant that patient may not have understood what they were consenting to.

Are dialysis services caring?

Good

We rated caring as **good.**

Compassionate care

- We spoke with thirteen patients who were predominantly positive in their views of staff treating them with kindness and compassion. They told us that staff were respectful and helped patients to maintain their dignity whilst undertaking treatment. There were privacy screens available should a patient request this; although we did not see any in use at the time of inspection.
- Three patients named a specific member of staff as being consistently caring, approachable and kind. We observed this particular member of staff and found they regularly checked patients' welfare; and engaged positively with patients. Staff told us they encouraged and enabled celebration of special events, such as patient birthdays and national events such as the Royal Wedding.
- Patients and staff were seen to have positive relationships during our visit. We saw that staff kept up to date with the patients' daily lives; and encouraged discussion. Patients told us that generally; the centre staff were friendly and approachable.
- When patients received treatment in open or shared bays, privacy screens were provided in the event of an emergency to maintain the person's dignity during any emergency treatment or when required to maintain privacy at any other time.
- Patient therapy sessions lasted up to 4.5 depending on patients prescription. During this time, all patients had individual entertainment systems, TV and headphones during their therapy sessions.

Emotional support

- Where staff identified patients required additional emotional support; they could refer patients to the renal psychologist based at the partnership NHS trust. We saw examples of where staff had noticed behavioural changes in patients; and as a result, had sought to gain a deeper understanding of the patients' needs. Staff recorded and shared the information in a communications book and at handover to other staff were aware of the patients' needs; and of any referrals to support services made.

Understanding and involvement of patients and those close to them

- Patients told us that staff explained the dialysis process when they first commenced treatment at the centre. Where necessary, staff re-explained what they were doing at the patients' request.
- All patients told us that they felt listened to by staff and answered their questions. We saw this demonstrated on the patient noticeboard, where patients had raised concerns and how staff at the centre had responded to those concerns. For example, concerns relating to patient transport.

Are dialysis services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- The space, size and configuration of the centre was appropriate to meet the needs of the specialist patient group. There were sufficient bed space and bays to afford patients seat and bed space. The space was configured to afford patients some privacy and enough space for staff to access patients during general and emergency care.
- The layout of the building meant that patients with mobility needs could access all areas if they were wheelchair bound.This included access to toilet and side rooms.
- There was sufficient parking space and friends and family could attend if they wanted to.
- Patients were referred from the partner NHS trust based on geographical location and individual need and there was flexibility and choice for patients based on their personal preferences.
- Patients were afforded flexibility, choice and continuity of care. There were a full range of haemodialysis shifts available to maximise for patients i.e. working patients, religious and cultural needs, and family responsibilities. Dialysis slots could be amended to suit patients' personal needs, for example, those patients with slots on a Tuesday, Thursday and Saturday could have those days adapted if they wanted a weekend off.

Meeting people's individual needs

- Assessments were conducted with patients to ascertain any social or other needs. For example, patients were asked about their lifestyle outside of dialysis to ensure treatment fitted in with this. However, we did note that in two patients' assessments it was recorded they required interpreters for any formal communications. We found that although interpreters were booked via the referring trust for consultant appointments; staff either asked family to translate, or used basic English and body language to communicate. Whilst this may be appropriate for simple queries, such as regarding drink choices; we also observed this was done at times where it was not appropriate such as when gaining consent to treatment or care.
- When patients wished to use the toilet during dialysis; we saw staff facilitated this and had processes to enable an efficient disconnection and reconnection to dialysis machines.
- Toilet facilities were accessible for people with additional needs, for example, wheelchair use and dementia friendly colours, for example, contrasting colour toilet seat for easy identification.
- All staff we spoke with told us that in general, the service did not treat patients with complex needs such as learning disabilities, severe mental health conditions, significant mobility problems or more advanced dementia. Patients who had more

complicated requirements were treated at the referring trust where access to direct support was more readily accessible. There were several patients who used wheelchairs or had some mobility restrictions. We saw that the equipment used supported patients with such needs, and staff were on hand to provide assistance when required.

- A named nurse (a specific nurse allocated to each patient) was responsible for managing holiday dialysis for their specific patients. Patients told us when they had requested information on how to access holiday dialysis; information had been provided and support offered. There was a policy and procedures to support patients on holiday and for patients holidaying locally and required the service.
- There were three nurses trained to vaccinate patients against flu. Consent forms were completed before patients care commenced and we saw this during our visit. GP's were informed following vaccinations. We saw data which showed uptake of the flu vaccination was low at 18%.Staff told us vaccines were not always available which delayed the number of patients vaccinated.

Access and flow

- Patients went through the local partnership NHS trust pathway. Patients should be as local to the service as possible. Managers told us that this did happen. The satellite co-ordinators, based at the partnership trust assessed suitability and arranged a visit to the centre to meet the team to familiarise them with the service in advance for suitability.
- Patients were assessed and referred from a partnership NHS trust daily, depending on nurse availability. Criteria for acceptance was confirmed and agreed with the centre staff. Patients with complex needs; for example, patients who were bedbound were not accepted and would be dialysed at the partnership NHS trust. Capacity only to accept patients on a one to four nurse ratio. Where the centre could not meet the nurse to patient ratio, they would not accept patients.
- Nursing staff undertook patient blood tests monthly to check for treatment outcomes; and also for blood borne viruses (BBV). These samples were sent to be tested externally; however, where an urgent test was required, facilities were available to process the blood on-site to enable quicker access to appropriate treatment.

Learning from complaints and concerns

- We looked at four complaints the centre had received between September 2017 to September 2018.One was for staff attitude, one was in relation to reported racism and two were for stock management. Each had been reviewed, informally managed and closed. Examples of complaints were placed in the centre 'communication book' which was reviewed during handover sessions and individually by staff during their shifts. We saw that learning from complaints was shared this way; for example, following a complaint regarding a breach of data protection.
- Patients told us they were not specifically aware of the centre's complaint policy or how to make a formal complaint. However, they reported they felt comfortable to raise issues with staff if required.

Are dialysis services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership

- Staff reported feeling supported by the management team. Despite the clinic managers both being very new in post at the time of our inspection; staff told us they felt comfortable to approach the managers for help and support where necessary.
- The centre had an operational and clinical lead on site. They worked together sharing the skills and expertise to ensure they had the skills, knowledge, experience and integrity needed to run an effective service for those working in and using the service.
- The leadership team were new in post. They told us they had an open-door policy and all staff we spoke with told us the leaders visible and approachable.
- The leadership team worked closely with the partnership NHS trust. They liaised regularly using a range of communication methods. For example,

telephone, email, one-to-one meetings and at a minimum monthly quality assurance meeting. We saw this evidenced in our discussions with staff, the NHS consultant on site and recorded in documentation.

Vision and strategy

- The new leadership team told us about the providers' global values which put the patient at the heart of the service. The vision and values were displayed on the staff noticeboard and we were told the new leadership team were hoping to carve new local vision and values and involve the team in doing so.
- The new leadership team were unable to provide us with a strategy for achieving the priorities and delivering good quality sustainable care. This meant there was no formal documented management process used to analyse the service, set priorities, and to focus resources.

Culture

- Staff spoke of a good team work environment, they told us they felt respected and valued and spoke of supportive colleagues.
- Staff told us the culture was centred on the needs and experience of people who used the centre. Staff told us they felt positive and proud to work in the organisation. Staff were praised by leaders when they were recognised as adding value to the patients and team.
- Staff told us, and we saw recorded in documentation, that staff were encouraged to be open and transparent in response to incidents. Leaders and staff understood the importance of staff being able to raise concerns and learn from concerns raised. However, not all incidents were investigated, for example, the patient referenced earlier who had deteriorated and then later died. Managers told us that because the patient death was not related to their treatment; they did not need to investigate. This meant there was no learning from this incident that might improve the way they manage deteriorating patients in future.

Governance

- There were governance structures in place. However, the leadership team did not always have oversight of the risks. Staff did not always follow policies and procedures to keep patients safe. For example, administering medications in line with their policy, following their infection prevention control procedures or managing and recording fluids.
- The practice development nurse had an effective system for managing staff competencies, training, development, learning and improvement. Staff were clear about their roles and to whom and what they were accountable for. We saw this evidenced in the work the practice development nurse carried out with staff and within the systems and processes used to manage, monitor, review staff and their contribution to good quality care for patients.
- Staff across partner agencies, including the referring partnership NHS trust worked well together, with clear pathways and lines of accountability. There were regular internal and external meetings. The consultants, specialist staff and technical support worked with the centre to ensure joint working to carry out good quality care.
- The leadership team communicated with commissioners on a regular basis. They attended monthly quality assurance meetings which included consultants, the partnership trust, and leadership team and regular local multi-disciplinary team meetings to review patients on a schedule and systematic basis.

Managing risks, issues and performance

- The leadership team had a systematic audit cycle which involved staff at all levels. Audits were reviewed to manage risks, issues and performance. We saw evidence of this in practice, in meeting minutes and other documentation. All audit information was reported to the partnership trust monthly to ensure standards were being met and performance issues were managed for improvements.
- Audits indicated good outcomes. We saw this recorded in documentation, however, we still saw poor infection prevention control practice among some staff and staff did not always follow local protocols, for example in medications administration.

- There was a risk register with a colour coded matrix to identify those risks that required immediate action and those that were tolerable though appropriate mitigation. The risk register was a live document and reviewed regularly.
- Staffing in clinical areas was identified as a risk. This outlined the high use of bank staff and was managed appropriately by ensuring there was a recruitment drive to fill vacancies. Bank staff were used in preference to agency staff usage, which was rare. All bank staff had a local induction, their competencies signed off to manage risks and ensure performance was of a safe and effective standard.
- The practice development nurses and the nursing director attended a bi-monthly medical advisory board meeting. There were four practice development nurses nationwide who met, discussed risks and issues and shared learning and best practice.

Managing information

- Staff did not have access to effective arrangements to ensure that data or notifications were submitted to external bodies as required. For example, the leadership team did not comply with their statutory requirement to inform Care Quality Commission when there was a patient death. This meant they were in breach of the regulations.
- Patients signed paperwork to state they agreed with the principles of the General Data Protection Regulation (GDPR) when they commenced dialysis. However, not all patients with English as a second language had translation services signatories in documentation to demonstrate that patients understood what they were signing.
- There was an electronic records system that all staff could access patient information. The system was accessible only to those allocated with a password and log in. Staff were aware of data protection and keeping their passwords and log in safe and secure. Bank staff were allocated secure access only when they had completed their induction and their competencies were signed off.
- 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.

Engagement

- To empower patients and get them engaged in their treatment, the provider introduced a phone application. This would have given patients 24-hour access to their medical data. The tool also included non-medical features to increase the user experience. Patients could enter how they were feeling at the same time each day and rate their general condition. All patients we spoke with told us they did not know about the app which meant although it was technology to engage patients, they were not using it.
- Patients provided regular feedback. We saw this evidenced on the 'you said, we did' board. There were examples of patient concerns shared and changes made as a result. For example, patients had raised concerns about the reliability of patient transport. The leaders met with the patient transport service to discuss and provided feedback on the notice board to patients outlining the outcome and contact details for the ambulance service and the Patient Advice and Liaison Service (PALS) who offered confidential advice, support and information on health-related matters to make formal complaints.

Learning, continuous improvement and innovation

- The centre employed a practice development nurse who ensured there were systems in place to support staff in continuous learning and improvement. There was no evidence of local research programmes. However, the centre had achieved accreditation (ISO 9001). This was a quality management system to focus on the important areas and improve efficiency.
- Staff were involved in local audits as a means of continuous improvement and learning. The practice development nurse carried out unannounced spot checks and CQC style inspections to ensure staff were complying with standards and to identify areas for learning and improvement.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure staff observe infection prevention control and appropriate use of personal protective equipment to ensure risks of cross contamination are prevented.
- Ensure staff follow local procedures relating to administration of medication to check the identity of patients to avoid medication errors.
- Ensure serious incidents are recorded and investigated appropriately to uncover the factors that lead to patient safety events and help to deliver safer care.
- Ensure statutory notifications are completed and sent to the Care Quality Commission as set out in the regulations.
- Ensure external clinical waste bins are labelled and locked to avoid access by unauthorised people.

Action the provider SHOULD take to improve

- Ensure loose leaf patient information is stored securely in folders to avoid scope for access by unauthorised people and medication errors.
- Ensure staff record fluid intake based on direct observations rather than making assumptions.
- Ensure fire doors are not propped open to meet fire safety regulations, prevent the spread of fire and smoke and keep people safe.
- Provide patients with English as a second language with a translator to help them understand information that is being relayed about their treatment.
- Formally identify patients by keeping an up to date photograph of the patient as an additional form of visual identification to help keep patients safe.
- Support qualified nurses to achieve specialist accredited qualifications.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 – Safe care and treatment – 12(2)(g) The proper and safe management of medicines.** Staff did not administer medication in line with medicines management protocols or best practice: Staff relied on familiarity with patients as a means of identification. This meant they were not following procedure and might increase the scope for drug administration errors. Staff did not follow procedure or meet Nursing and Midwifery Council standards in safely administering medications by confirming with the patient their details immediately prior to administering medication. Staff left medicines bedside unattended which meant there was scope for medication errors. **Regulation 12 – Safe care and treatment–12(2)(a)(b) Assessing the risks to the Health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks** Staff did not always follow process or instruction when assessing and escalating deteriorating patients. Staff were instructed to urgently transport a deteriorating patient to accident and emergency. Staff did not follow this instruction and patient transport was significantly delayed. **Regulation 12 – Safe care and treatment – 12(2)(h) Assessing the risk of, and preventing, detecting and controlling the spread of infections** Staff did not always use appropriate personal protective equipment to reduce the risks of cross contamination.

This section is primarily information for the provider

Requirement notices

Staff were trained to use aseptic non-touch technique to minimise risk of infection when connecting and disconnecting patients from their venous access device. This meant staff did not always practice safely to prevent cross contamination from pathogens which involved applying the strictest rules to minimise the risk of infection.

Staff did not always dispose of contaminated sharps waste appropriately, for example sharp side down. There were blood smears on the lid and around the edges of four sharps bin. This could represent a risk of cross contamination.

Staff did not always ensure external clinical waste bins were labelled and locked to avoid access by unauthorized people.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services Managers did not complete statutory notifications to ensure that Care Quality Commission was notified of the deaths of people who used services so that where needed, Care Quality Commission could take follow-up action.