

Baxter Renal Education Centre - Kew

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

Baxter Renal Education Centre – Kew is an independent healthcare location operated by Baxter Healthcare Limited. The service has five beds which include two double bedded rooms, two twin rooms and a single room. The double and twins rooms are allocated to patients and their relatives, or carers that are admitted into the centre for training. Facilities include a training room and relaxation room.

The centre offers education in renal replacement therapy in peritoneal dialysis (PD) and home haemodialysis (HHD) to patients nationally in the UK. The service also offers home based training to patients that lived outside London and were unable to attend the centre. The centre also offers home haemodialysis and home parenteral nutrition training for hospital staff. The centre is a self-contained residential unit where patients and their relatives or carers are trained and supported on how to perform and manage their dialysis treatment effectively at home. Training usually lasts approximately two to four days. The service provides dialysis training for patients and their relatives over the age of 18 years on home based therapies.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 23 May 2017, along with an unannounced visit to the centre on 5 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. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There were effective systems in place to ensure patient safety. All staff were aware of their roles and

Summary of findings

responsibilities in ensuring patient and their relatives or carer safety. There were effective cleaning schedules as well as maintenance and fire drill programmes in place.

- The centre was visibly clean and there were arrangements in place for infection prevention and control. There was no reported incidence of infection.
- Patients' records were written legibly, secured and stored appropriately by staff. Staff had access to relevant patients' records which ensured patients training and education was planned and not delayed.
- Staffing levels were maintained by management to ensure patient safety and care.
- The centre had a business continuity plan in place in the event of major incidents.
- There were training, induction and competency assessments in place. Staff training compliance was 100%.
- The centre had effective processes in place to ensure patient consent for training was obtained.
- Staff worked effectively and collaboratively with the referring NHS hospitals and renal team to support patient training and their treatment.
- Patients training and care were provided in line with evidence-based guidance, national and local policies.
- Staff participated in a journal club where new evidence was discussed and shared with colleagues.
- Staff received annual appraisals and competency assessments.
- Staff treated patients with respect, dignity and compassion and ensured their privacy was maintained.
- Patients spoke positively about the service, staff and training received.
- Staff were trained to support patients and this included having difficult conversation with them.
- Patients were provided with comprehensive information and had access to support networks including Kidney Patients Association and peer support.
- Staff understood the impact of dialysis treatment and worked especially hard to make the patient and their loved ones training experience as pleasant as possible and meet individual patient needs.
- The service was planned and delivered to meet the needs of various patients in the local community and UK.
- The location of the current non-clinical, Baxter Renal Education Centre – Kew was established as a stand-alone centre from the hospital setting in response to patients' feedback. As patients previously felt they were coming to the acute hospital setting for their training and would prefer to train in a non-clinical environment that was similar to their home setting.
- The unit provided a flexible appointment system that ensured patients' preferred dialysis training needs were met and could be adjusted to meet their work commitments or social needs. Training was available for patients at the centre or in their own home. Training was available at the centre on a one to one or group session basis.
- The service had the facilities to provide care and education on dialysis treatment for patients with learning, mobility, hearing or visual impairment to facilitate their training needs.
- Patient transport was organised by the centre through their taxi services.
- There was no waiting list at the time of inspection and there were no cancellations of the service within the last 12 months.
- There was evidence of strong local and national leadership, with accessible managers.
- The service sought feedback and engaged effectively with patients and staff.

Summary of findings

- There were various innovations by the services to improve patient outcomes and their dialysis training. This included the development of an assessment tool and use of the confidence thermometer to aid patients training.

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

- Incidents reported at the centre were not investigated effectively.
- There was no infection control lead at the centre. Staff we spoke to were not sure who their infection prevention and control lead was. Following the inspection, the provider told us that the centre manager was the infection control lead.
- Staff did not always monitor the medicine fridge temperatures to ensure they were not outside of the normal range.
- There were no effective processes in place for audits of medicines management within the centre. Medicines were not always reviewed and stored appropriately by staff. We found expired dressing packs during the inspection.
- The risk register was not updated to reflect identified risks.
- Staff were not always informed of the outcomes from the clinical governance meetings.

Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Dialysis Services

Rating Summary of each main service

- There were effective systems in place to ensure patient safety. The clinic was visibly clean and there were arrangements in place for infection prevention and control. Staffing levels were maintained by management to ensure patient safety and care. There were training, induction and competency assessments in place. Staff training compliance was 100%.
- Staff treated patients with respect, dignity and compassion and ensured their privacy was maintained.
- There was evidence of strong local and national leadership, with accessible managers.
- The service sought feedback and engaged effectively with patients and staff.

Summary of findings

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Baxter Renal Education Centre - Kew

Services we looked at

Dialysis Services

Summary of this inspection

Background to Baxter Renal Education Centre - Kew

The Baxter Renal Education Centre is an independent healthcare provider that opened in Kew in 2006 and was supported by Baxter Healthcare Limited through an education grant. Training for patients and their relatives or carers was offered as an added value service to the NHS by Baxter. The training was free for all NHS patients attending the centre; and there was no charge to the referring NHS trust. The service was provided under a service level agreement for each referring NHS hospital. The centre serves and accepted patient referrals from any NHS hospital in the UK. The centre did not accept any privately funded patients.

The current manager has been in post since 2003 and registered with CQC since October 2010.

The service is registered for the following regulated activity; treatment of disease, disorder or injury.

The service has been inspected four times using our old inspection methodology. The most recent inspection took place in 5 June 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Our inspection team

The team that inspected the service was comprised of a CQC lead inspector, Isimat Orisasami, another CQC inspector, and two specialist advisors with expertise in dialysis. The inspection team was overseen by Nick Mullholland, Head of Hospital Inspection.

Information about Baxter Renal Education Centre - Kew

The centre has five en suite bedrooms that provide home dialysis training, home based parenteral nutrition training and education to patients and their relatives or carers. The centre was developed in partnership with the NHS as Baxter identified a need to support the NHS to train patients to manage their own care. This was due to the increase in demand for dialysis patients who preferred home haemodialysis or peritoneal dialysis treatment. The purpose of the centre was to provide training to patients referred from the NHS, in a residential home from home setting, to self-manage their treatment on peritoneal dialysis, haemodialysis or intravenous (IV) therapies. Baxter has supported a residential training centre since 1991 but this centre is the first stand-alone unit away from a hospital site.

Patients were admitted to the centre as a resident to learn about their therapy before being discharged home, once they are confident to manage their treatment. Clinical responsibility remains with the referring renal unit

at all times and while the centre is training the patients onto their prescribed therapy. The centre also provides this training service for patients and relatives within their own homes across the UK using a team of six field based specialist training nurses. We looked at provision of service in the community but were unable to visit patient in their home to assess their care.

The centre is open 24 hours a day from Monday to Saturday, as patients stayed overnight during their training. However, the nurses are on duty from 7am to 9pm Monday to Wednesday and 7am to 5pm Thursday and Friday. It provides specialist training, education and support for patients aged 18 and over to self-care and manage their own treatment at home. The service provided dialysis training to 300 patients between March 2016 and March 2017. The total number of peritoneal dialysis sessions in the last 12 months, for adults age 18 to 65 years, was 47,000 and 23,000 for adults aged over 65 years of age.

Summary of this inspection

The centre is registered to provide the following regulated activity:

- Treatment of disease, disorder, or injury.

During the inspection, we spoke with four staff including; registered nurses, reception staff, and the manager. We spoke with five patients and one relative. We also received nine 'tell us about your care' comment cards which patients had completed prior to our inspection. We observed how patients were cared for during their training sessions. We reviewed eight sets of patient records and associated documents during our inspection. We also received feedback from the stakeholders about their views of the service.

There were no special reviews or ongoing investigations of the centre by the CQC 12 months prior to this inspection. The service had been inspected once, and the most recent inspection took place on 5 June 2013, which found that the service was meeting all the standards of quality and safety it was inspected against.

Track record on safety from March 2016 to April 2017:

- No reported never events.
- No reported incidences of healthcare acquired MRSA.
- No reported incidences of healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- No reported incidences of healthcare acquired Clostridium difficile.
- No reported incidences of healthcare acquired E-Coli.
- No reported complaint.

Services provided at the centre under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance

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 rate dialysis services.

We found the following areas of good practice:

- There were effective systems in place at the centre to ensure patients safety. All staff were aware of their roles and responsibilities in ensuring patient and their relatives or carers safety. There was an effective cleaning schedule as well as maintenance and fire drill programmes in place.
- The clinic was visibly clean and there were arrangements in place for infection prevention and control. There were no reported incidences of severe or serious infection.
- Patient records were written legibly, secured and stored appropriately by staff. Staff had access to relevant patient records which ensured patients training and education was as planned and not delayed.
- Staffing levels were maintained by management to ensure patient safety.
- The centre had a business continuity plan; staff were aware of their roles and responsibility to ensure patients and their relatives or carer safety in the event of a major incident.
- There was training in place to ensure staff competency. Staff training compliance was 100%.

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

- Incidents reported at the clinic were not investigated effectively.
- Staff did not always monitor the medicine fridge temperatures to ensure they were not outside the normal range.
- Medicines were not always stored appropriately and we found some expired dressing packs.

Are services effective?

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

We found the following areas of good practice:

- The centre had effective processes in place to ensure patient consent for training was obtained.
- Staff worked effectively and collaboratively with the referring NHS hospitals and renal team to support patient training and their treatment.

Summary of this inspection

- Patient training and care was provided in line with evidence-based guidance, national and local policies.
- Staff participated in a journal club where new evidence was discussed and shared with colleagues.
- Staff received annual appraisals and competency assessments.

Are services caring?

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

We found the following areas of good practice:

- Staff treated patients with respect, dignity and compassion and ensured their privacy was maintained.
- Patients spoke positively about the service and staff.
- Staff were trained to support patients and how to have difficult conversations with them.
- Patients were provided comprehensive information and had access to support networks such as the Kidney Patients Association and peer support groups.
- Staff understood the impact of dialysis treatment and worked especially hard to make the patient and their loved ones training experience as pleasant as possible and meet individual patient needs.

Are services responsive?

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

We found the following areas of good practice:

- The service was planned and delivered to meet the needs of various patients in the local community and the UK.
- The new centre, Baxter Renal Education Centre – Kew was established as a stand-alone centre from the hospital setting in response to patients' feedback. As patients previously felt they were coming to the acute hospital setting for their training and would prefer to train in a non-clinical environment that was similar to their home setting.
- The unit provided a flexible appointment system that ensured patients' preferred dialysis training were met and could be adjusted to meet their work commitments or social needs. Training was available for patients at the centre or in their own homes. Training was available at the centre on a one to one or group session basis.
- The service provided care and dialysis training for patients with learning disabilities and mobility, hearing or visual impairments to facilitate their training needs.
- Patient transport was organised by the centre through their taxi services.

Summary of this inspection

- There was no waiting list during the inspection and no cancellation of the service in the last 12 months.

Are services well-led?

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

We found the following areas of good practice:

- There was evidence of strong local and national leadership, with accessible managers.
- Patients were positive about the service, staff and training received.
- The service sought feedback and engaged effectively with patients and staff.
- There were various innovations by the services to improve patient outcomes and their dialysis training. This included the development of an assessment tool and use of the confidence thermometer to aid patients training.

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

- The risk register was not updated to reflect identified risks.
- Staff were not always informed of the outcomes from the clinical governance meetings.

Detailed findings from this inspection

Notes

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 centre had a system in place that guided staff on reporting, recording, investigating and monitoring incidents. Staff reported incidents through their online and paper reporting system. We noted that non clinical incidents and accidents were recorded in their accident logbook and discussed during staff handovers. We reviewed the accident book records and noted there was low number of incidents reported at the centre by staff. We noted that one accident was reported in the last 12 months. This incident was reported in January 2017 and was related to a patient fall. We noted that this incident was not investigated effectively. Staff gave examples of incidents they had reported in the past; for example a faulty drainage bag. However, we noted that the faulty bag was not recorded in the incident log reviewed. We noted that staff working as community nurses completed an incident form and called the unit to report incidents to their manager or colleagues when this occurred.
 - Staff told us they received outcomes of incidents reported. Incidents and their learning were shared with staff at staff meetings and handovers. We saw evidence to show that the patient fall that occurred in January 2017 was discussed with staff.
 - Senior staff told us near misses were recorded in the clinical governance dashboards. However, they had not had any near misses at the centre.
- The service reported no never events for the period from May 2016 to May 2017. A never event is a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death but neither need have happened for an incident to be a never event.
 - The centre reported no serious or clinical incidents from May 2016 to May 2017. Serious incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.
 - Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and 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. Staff had access to a policy relating to the duty of candour, which outlined actions to be taken when something went wrong. Staff were aware of the duty of candour policy and when it should be used, however they have not had to use this. Staff gave us examples of where it would be used.

Cleanliness, infection control and hygiene

- The centre was visibly clean, tidy and well maintained. However, we noted dust on a shelf in the clinical room where wound dressings, equipment's and medicines fridge were stored. Staff told us the cleaning of the centre was subcontracted to an external provider. We saw evidence that the regular cleaning schedule was maintained.

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- The service provided staff with personal protective equipment (PPE) such as gloves, aprons and face visors. We observed that staff used the PPE appropriately including the face visors to protect against bodily fluid sprays.
- Handwashing and sanitising facilities were in place for staff and visitors in the unit. Hand sanitiser were available in the training room and patients bedrooms.
- The service had an updated and reviewed organisation protocol for 'infection control universal prevention' in place that guided staff on handwashing, skin, gloves, apron, eye protection, masks, sharps, spillage, cleaning, waste and mucous membranes.
- We observed posters around the centre that detailed the effective six steps to hand hygiene technique for staff, patients and visitors. We saw that staff were compliant with hand hygiene and bare below the elbows practices. However, the centre did not complete any hand washing or infection prevention and control audits for staff. Following the inspection, the provider informed us that staff completed competency check-list for all patients and one of the competencies was hand washing technique.
- We observe that staff used appropriate aseptic techniques effectively during the training session to attach patients to their dialysis machines. Staff we spoke with told us they followed the aseptic non touch technique (ANTT) guidelines for the dialysis line management.
- Virology testing, C.difficile (Clostridium Difficile), MRSA (Methicillin Resistant Staphylococcus Aureus) and MSSA (Methicillin Sensitive Staphylococcus Aureus) infection screening was completed by the referring NHS hospital or dialysis unit before patients were referred and accepted at the centre. Staff told us if they suspect a patient or relative or carer had an infection they would refer the patient back to their referring unit and decontaminate the centre. Staff we spoke to told us the hospital contacted the centre and gave feedback if they had any issues with peritonitis.
Peritonitis is an inflammation of the peritoneum, the thin layer of tissue that lines the inside of the abdomen. Peritonitis is a common and serious complication of peritoneal dialysis.
- For the period of May 2016 to May 2017, the centre reported no cases of healthcare acquired infections such as C.difficile, bacteraemia, MRSA or MSSA. The centre took actions to minimise risks of cross infection by using aseptic non touch technique and use of PPE during training procedure.
- All equipment used in the centre was disposable except the dialysis machine, which was decontaminated after each use. This system helped reduce the risk of cross infection.
- Domestic and clinical waste bins were available in the training room for segregation and disposal of waste.
- Staff we spoke to told us they received training on infection prevention and control (IPC) during their induction. We noted that some staff attended an aseptic non touch technique conference during November 2016 as a refresher to ensure their skills, knowledge and competence. However, some staff told us they had not received a refresher course on ANTT since their induction. The manager told us they were confident with staff competence on IPC as they observed staff daily at work and also shadowed the community education practitioners monthly.
- There was no infection control lead at the centre. Staff we spoke to were not sure who their infection prevention and control lead was and some staff assumed it was their manager. Following the inspection, the provider told us that the centre manager was the infection control lead.
- During inspection, we observed that a wipe was used for cleaning patients exit site during their training session. This was not recommended by the manufacturer as it was normally used to clean medical devices and not human skin. The wipe contained 70% alcohol and had the potential to be a skin irritant. There were some numbers of protocols on dressing change used in the centre from various trust during training procedures. We reviewed some of the NHS trust protocols on dressing change that were used by the centre. We noted that two of the NHS Trust protocol indicated the use of the wipe while another trust indicated the use of saline.

Environment and equipment

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- The training room, patients' bedroom and relaxation areas were tidy and the corridors were free from obstruction. This allowed prompt access to patients.
- Each bedroom had an en suite bathroom, television, chair, wardrobe and wheel chair access. We noted some of the rooms were not spacious and staff told us they rearranged the furniture in the smaller bedroom to accommodate a patient that used a wheel chair when needed.
- There was a safe, secured and appropriate storage of equipment during the inspection.
- Patients spoke highly of the quality of the environment. They felt safe at the centre during the day and at night time. Patient specific comments included "the centre is a homely and welcoming place and staff were cheerful", "Training is in a very good facility" and "environment is very comfortable".
- The centre and equipment were generally in good state of repair. There was a washing machine, microwave and fridge noted in the kitchen area. We observed that the stock room appeared clean and tidy with shelving for all equipment and fluids.
- All staff were trained on the use of the equipment and machines in the centre.
- Patients' dialysis machines were delivered to the centre prior to their training for use during their stay. Following training, patients took their dialysis machines and equipment home.
- We observed that the equipment and dialysis machines were serviced and maintained regularly under their service level agreement. Equipment and machines were repaired by the Baxter repair services. Machines were cleaned and decontaminated as normal. Staff told us the dialysis machine conducted a self-test and alerted staff and patients if there was a problem. Staff told us they also had a 24 hour on call service if they had faulty equipment. This was repaired or replaced immediately or within hours. Patients and the centre received a swap of the dialysis machine if faulty within 24 hours and the quickest was within 45 minutes.
- We noted that the community nurses also had a stock of equipment and materials that they could replace for the patients at home if needed.
- Staff were aware of the escalation process for the reporting of faulty equipment. The centre had six spare dialysis machines they could use if a machine became faulty. We noted these machines were cleaned daily to ensure they were ready and safe to use during emergencies.
- We observed an old haemodialysis training machine which staff told us was currently not used as they had no patients on haemodialysis training. We observed that a dialysis machine pump charger that was charged in the clinical room had not been safety tested. The centre manager told us the dialysis machine for the battery was no longer used and that Baxter home care had been informed.
- The resuscitation and emergency equipment were checked daily by staff and was found to be safe to use.
- We noted that the window ledge in the patients' bedroom on the first floor had no 'safety catch' which increased the risk of patients jumping or falling out. Staff told us they were aware of the risk and had informed the landlord of the property. Staff told us they also carried out assessment of all patients accepted into the unit and during their stay to ensure they were not suicidal or at risk of falls which reduced the risk. We saw that the centre had a risk assessment in place to assess patients risk of falls during admission at the centre. We saw that staff completed risk assessment for patients admitted to the centre during inspection.
- The floor of the training area and centre was carpeted and this present an infection prevention control issue even though they had protocols in place for managing stains and spillage. Staff informed us the floor was carpeted because patients wanted to train in an area that was similar to their home environment and not a hospital setting. Staff told us carpet was deep cleaned once a year and spillages are cleaned when they occur. We observe that the carpet floor was not considered a risk by the provider and not included in their risk register. There were no plans to replace the carpet at the time of inspection.
- Staff are required to complete monthly and bi-annually water testing to ensure the water used during dialysis training was free from contaminants. We reviewed the records for the period of May 2016 to

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May 2017 and noted a lack of compliance with testing. Their system for testing water was ineffective and a risk to patients and which was not in line with guidance on monitoring the quality of treated water and dialysis fluid. There was no record of the water testing for the periods of September 2016, October 2016 and January 2017 to March 2017. We noted that for the period of November 2016, the water testing was conducted three times which included the bi-annual testing. The last test was conducted in April 2017. We observed that the missed water testing were not reported as incidents and included on their risk register. There had been no reported incidents of contamination.

Medicines management

- The service had policies in place that included a self-medication policy, self-administration policy and controlled drug policy. This provided guidance to staff on their roles and responsibility around patient medicine. The patients administered all their prescribed medicine themselves which was in line with their policy.
- Patients who required long term parenteral nutrition were trained by staff on how to carry out intravenous (IV) feeding and administer IV fluids independently as part of their training before been discharged home. We noted staff had guidance for the use of IV drugs.
- Staff we spoke to told us the medication administration record (MAR) charts were only used when patient were only prescribed antibiotics.
- The service did not have prescribing responsibility over the patients and therefore had no patient group directions (PGDs) in place. PGDs are written instructions commonly used in the health service and they permit the supply of prescription-only medicines to specific groups of patients, without individual prescriptions.
- Medicines were stored in the patient's room and in medicine fridges. We observed that there was a medicine cabinet in each patient bathroom. Staff were required to monitor the temperatures to ensure medicines were stored appropriately. We noted there was no record of the patient bathroom temperature been checked to ensure medication in the cabinet were stored appropriately.

- We were not assured that medicine fridges temperatures were monitored appropriately. We noted that the laminated sheet on a medicine fridge where staff documented the temperature checks was dated 19 and 20 September. There were no paper logs of the fridge temperature. This showed that the last documentation of the fridge monitoring was last year. Staff told us they checked the fridge temperature but did not record it. They said that the medicine fridge alarm triggered if it was out of range. Staff told us the fridge temperature should be between two to eight degrees centigrade. We noted that the medicine fridge temperature was two degree centigrade during inspection. We saw that patients' medication, for example insulin was stored in the medicine fridge. We saw that staff completed the fridge temperature for that day before the end of inspection. Also, during the unannounced inspection we observed that staff had completed the fridge temperature for the period of 23 May 2017 to 5 June 2017 and the readings were within the normal range.
- Medicines were not always stored appropriately. We noted that medicines and all intravenous (IVs) fluids including solutions for dialysis seen during inspection were all in date. However, we found 12 expired wound dressing pack stored in an incorrect wound dressing box. Expired dressings do not guarantee sterility and may present a possible infection risk. We also noted a wound dressing pack stored outside its box and we were not able to confirm its expiry date and batch number. We highlighted our concerns to staff and the expired wound dressings pack were disposed of immediately.

Records

- Patients' records were held both electronically and in paper format. Staff told us they kept patients paper records for 10 years in a locked cupboard in the receptionist office before they were destroyed. This was in line with the Caldicott principle that guides staff on handling of patient information that is identifiable.
- The service received patient' referrals through an encrypted email from their referring hospital or dialysis unit. The referrals were then printed off and stored in the office. Staff told us the referrals included information about patient blood results and infectious

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status. We observed patients records were secured and kept appropriately in a locked cupboard in a fire proof room once patients were discharged home to protect their confidentiality.

- Staff had received training on information governance. The service conducted an information governance audit and results showed staff were compliant with their policy and maintained patient confidentiality.
- We were told that the community nurses who worked off base at home had a lockable cabinet; this was fire proof to ensure patients' records were safe and confidential. Community staff told us they carried patient data securely in their car when they travelled to train patients and their relatives in their home. Staff we spoke with told us the community nurse brought their cabinet to the centre once a year as part of their audit process.
- We reviewed eight patient records during the inspection. All records were legible and signed by staff.

Safeguarding

- Staff were aware of their roles and responsibilities for escalating safeguarding concerns. All safeguarding concerns were reported to the local authority and the patients referring hospital or dialysis unit.
- The centre had a safeguarding policy in place that guided staff on how to raise concerns. However, we noted that the policy was not detailed and did not highlight what constitutes abuse or the categories of abuse.
- Staff told us they would escalate safeguarding concerns such as female genital mutilation to their manager immediately before making a referral. Staff told us if a patient raised a safeguarding issue like abuse they would speak to patients before reporting to the manager.
- Staff gave examples of where they had acted appropriately to ensure patients and staff safety and prevent further abuse. For example, a patient was removed from their training session as they acted inappropriately. Staff told us they felt the patient posed a risk towards other member of staff and patients. Staff told us this was escalated to centre manager and referring trust.

- All staff had completed the level 3 adult safeguarding training. Staff we spoke to told us their annual safeguarding training focused mainly on adult safeguarding but embedded case studies on safeguarding children. The training covered female genital mutilation. Staff told us they are aware of how to recognise and raise concerns on safeguarding children. Also, children were not accepted or trained in the centre and the community nurses rarely encountered children when they visit patient home. The service reported that their community staff had not encountered any child during training in the last 12 months at any patient house.

Mandatory training

- Staff mandatory training included manual handling, basic life support and safeguarding vulnerable adult level 2, fire marshal and automated external defibrillator (AED) use. The training was completed either face-to-face or thorough an electronic learning programme. We reviewed the staff training matrix and saw there was 100% compliance with all mandatory training. The community nurses received additional training on information governance, FGM awareness and a driving update with a driving company online.
- We noted that infection prevention and control training was completed during staff induction. We saw that staff attended an aseptic non touch technique conference during November 2016 as a refresher to ensure their skills, knowledge and competence.

Assessing and responding to patient risk

- The service admitted new cohort of patients every week and carried out risk assessment prior to and during admission at the centre.
- The centre had an escalation policy in place to guide staff when a patient deteriorated or became sick. There was guidance in place for the management of sepsis. Staff knew how to assess, respond and manage risks of deterioration to patients. Staff told us they called for an emergency ambulance for patients that were unwell. Staff completed risk assessments and blood pressure assessments during patients' admission to the centre. Staff gave examples where they had assessed a patient who had become unwell and had a temperature. Staff told us they assessed the patient using the national early warning score (NEWS)

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system. Staff called the ambulance service for emergency support. The service did not use PGDs and the patient used their own paracetamol before they attended the emergency department at the local hospital.

- We noted that the community staff were aware of how to assess and respond to patient risk. The community nurses received support from colleagues for joint visits if there were safety concerns. Staff were aware of their 'red flags' system and processes. Staff called the unit if they felt something was not working in regards to patient treatment, or felt something could be better. We noted that the community nurses spent the first part of their visit speaking with the patient and assessing their surroundings to identify potential risks.
- Staff gave examples of where actions had been taken to ensure the patient and staff safety following their assessment.
- Staff told us the most common problem that patients presented with was hypoglycaemia; this is low blood sugar levels. We saw that the centre had a clinical pathway to manage hypoglycaemia and hyperglycaemia (high sugar levels). Staff told us as part of their induction and assessment they had in depth discussions with diabetic patients about past episodes of hypoglycaemia or hyperglycaemia, which were then highlighted to all staff during their handovers.
- We reviewed patient records during the inspection. Staff completed the fluid balance sheet to ensure patients were compliant with their fluid restriction. We saw that staff documented patient allergies, weight, safeguarding risk, diabetes status and most recent blood tests which ensured they could track their care and provide appropriate training treatment. Patients' folders also contained baseline documents, receipt and removal of medication, patient competency evaluation records, record of delivery supplies, referral forms and discharge summary. We noted that staff documented when there were patient issues during the day or night shift. Staff completed risk assessments during patients' home visits and the follow up appointment. The risk assessment included the home environment safety and cleanliness which highlighted any safeguarding issues.

- The centre accepted patients that were medically stable and attending the centre from patients home and not hospital. Staff told us they did not train patients that were still hospitalised, or had an infection or blood borne virus to reduce safety risks to other patients.
- We observed that the fire exits were clearly marked and patients were not allowed to smoke within the building. Patients were allowed to smoke outside the building. However staff told us they allowed patients to smoke in the garden area after 10pm and not to go outside the centre to ensure their safety. This was because only the receptionist was available on site at night.
- There was emergency resuscitation equipment, fire extinguishers, first aids, oxygen cylinder and defibrillator in the training room to be used during emergencies. We noted the defibrillator pads were all in date and checked daily by staff.

Staffing

- The centre employed three clinical practice educators that worked in the centres and six clinical practice educators that worked in the communities throughout the UK. All clinical practice educators were registered nurses. The centre had an overnight receptionist that also acted as the housekeeper. There was one nurse post and one administrator post vacancy in the 12 months before the inspection. We saw that the service filled staff vacancies as they arose.
- There was no staff sickness reported for the service during the period January 2017 to May 2017.
- The centre did not use an acuity tool due to their unique service. Three nurses were available to cover the teaching sessions daily on each shift. The staffing ratio was three staff to five patients.
- On call cover at night was provided by one of the clinical practice educators. The community nurses also had access to the on call staff for advice and queries about patients care and treatment.
- We noted that the centre did not use any agency or bank staff for the period of January to May 2017. Staff told us they rarely used bank or agency staff. The centre used bank or agency staff to cover the night receptionist when they were on holiday. The manager

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helped to cover shifts when staff were on annual leave or off sick. Senior staff told us they were able to call the community team if they were short staffed or if necessary.

- Staff we spoke with told us they were adequately staffed and a specific comment included “staffing level is good” and “we are very lucky”.
- There were no medical staff at the centre as clinical responsibility for patients remained with their referring hospital during their training period. Staff directed any clinical patient concerns to the referring hospital and consultant through the telephone. Staff contacted the local hospital or called 999 service outside the normal hospital hours for medical support.

Emergency awareness and training

- Staff had completed emergency awareness training and understood what to do during emergencies. All staff were fire marshal trained. Staff received fire training every three years and the training record showed 100% staff compliance.
- The service conducted a fire drill once a year and fire evacuation twice a year to ensure staff skills and competence. The service had a fire inspection certificate and carried out weekly fire alarm testing. We reviewed the fire testing record and saw that staff were compliant with the weekly fire testing for the period of May 2016 to May 2017. We saw that staff completed individual fire risk assessment for patients.
- The centre had an adverse event policy and procedure in place for major incidents that included the loss of heating, power supply failure, staffing shortages, water supply failure and IT failure. Staff were aware of the major incident plan. Staff told us in case of an emergency incident and they had to close the unit or staff were unable to cover the training. They would send patients home and refer them back to their dialysis unit or hospital for training and treatment. The centre had agreement in place with the referring hospital that patients would be transferred back if there were no staff available.

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

- Policies and procedures were developed in line with national guidance, standards and legislations such as renal association guidelines and International Society for Peritoneal Dialysis (ISPD) guidelines. We saw and staff told us they accessed and used the National Institute for Health and Care Excellence (for nutritional support for patients, chronic kidney disease and sepsis. Staff used and were familiar with the renal association guidelines and ISPD guidelines.
- Staff we spoke to were familiar with their organisation policies and told us this was covered during their induction training. Their policies were available on the intranet and via a hard copy at the centre. Staff we spoke to including the community nurses told us they had access to policies remotely. We saw that staff had access to each referring trust protocols on dressing change as part of their referral process. These protocols are stored on each patient file while admitted at the centre. We saw that there was a checklist that ensured staff followed the evidence based care and treatment policy from their referring trust for each patient.
- The service had updated procedures in place for staff that guided them on patients’ dialysis training. These procedures included and were not limited to ‘home parenteral nutrition disconnection procedures –changing needle free connector’, ‘home parenteral nutrition connection procedure’ and ‘home parenteral nutrition connection procedures and medicine.
- The centre participated in clinical research, audit and development of assessment tools. These were evidence based and had helped improve patient care. We noted that some of the research findings had been presented and shared at dialysis conferences.

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- We saw posters of audits, research and projects displayed within the centre which informed staff, patients and visitors of patient outcomes and result.

Pain relief

- Patients self assessed and managed their pain relief while admitted at the centre. Staff further assessed this when the patient expressed they were in pain. Staff we spoke to told us they liaised with the patients referring hospital or dialysis unit if there were any concerns with pain management.
- Patients we spoke with told us the nursing staff asked if they were in pain and felt their pain control was well managed.

Nutrition and hydration

- Patients' hydration and nutritional needs were assessed by their referring hospital prior to their admission at the centre. Staff also assessed and had discussion with patients and their relatives on their nutritional needs.
- Staff recorded patients' weight during admission as part of their assessment process.
- Staff provided patients with written information and guidance that was related to their diet and fluid management. The centre did not have access to the dietitian as patients were still under the care of their dietitian from their referring trust.
- The centre provided food and drinks to patients while admitted at the centre. However patients and their families were required to cook their own food to encourage their independency and assess their safety at home. The centre received a weekly delivery for patients' drinks and foods which were mainly microwaveable meals. Patients' food was stored in the patient fridge and freezer at the centre. Patients and relatives were encouraged and allowed to bring their own food except meat and eggs.

Patient outcomes

- The service participated in a joint audit with a local NHS hospital to assess the time of therapy of peritoneal dialysis (PD) for patients' that trained at the centre compared to those that trained in the hospital. The result showed that patients that trained in a group environment at the centre had better outcomes on

therapy compared with those trained in the traditional way at the hospital. Results showed that patients training at their own pace, in a conducive environment and using an appropriate educational style facilitated patients dialysis training This indicated that effective dialysis treatment training may result in better patient compliance and overall sustainability of their therapy.

- The centre carried out an audit for the period of July 2016 to January 2017 on their newly modified peritoneal dialysis assessment tool. The assessment tool was used for assessing the impact of patients' age and diagnosis on their functional and cognitive ability. The tool assessed patients on five aspects, which included cognitive function, manual dexterity strength, comprehension, language, auditory and processing. The centre carried out the audit of 104 patients that had been referred for initial dialysis training over a period of six months using the assessment tools. The result confirmed a measurable decline from the age of 60 in the patients' ability of cognitive processing, co-ordination and ability to recall new information when learning how to perform PD. The centre reported 19.2% of those over 60 were able to achieve the highest score of five which indicated they had good functional and cognitive ability. Also 42.3% of patients under 60 scored the top score five which indicated they had good functional and cognitive ability. The result showed 30% of patients over 60 could have benefited from being referred for continuous ambulatory peritoneal dialysis (CAPD) rather than automated peritoneal dialysis (APD). We noted that the audit highlighted the importance on the use of assessment tools to assess patient over 60 years of age before making a treatment decision and reduce the costs of patients referred back to their hospital for additional support.
- The centre participated and developed a 'follow up to success' project that was an independent patient education centre's retraining model for peritoneal dialysis (PD). The centre instigated "Follow up Training" days for patients six to eight weeks after starting new therapy. This consisted of a review of dialysis procedure, hand positioning when connecting, hand washing and a fun interactive quiz which assessed their retention of knowledge related to their dialysis. The results showed that patient

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numbers grew and improved having adopted the follow up training model within the unit. The number of PD patients' transferred to haemodialysis (HD) at 12 months decreased to 54% and patient numbers increased by six. Result showed no patients transferred from PD to in centre haemodialysis (HD) following the implementation of the 'follow up training'; therefore, the follow-up project was useful and ensured patient continuity in their home with PD treatment. We noted that the centre had continued to use this model for all new patients that had been trained in PD.

- The centre conducted a retrospective audit over a 24 month period for dialysis patients that accessed the centre. The audit aimed to determine if the location and approach of patient training either in a purpose built, off site peritoneal dialysis (PD) patient training centre or in a conventional clinic setting, had any impact on the peritonitis (infection) rates amongst similar patient groups. **Peritonitis is an inflammation of the peritoneum, the thin layer of tissue that lines the inside of the abdomen.** The centre benchmarked the findings with participating NHS trusts that took part in the audit. A total of 58 patients started PD therapy in the unit during the 24 month period. The result showed the peritonitis rates were 1 episode every 44 patient months (1:44 patient month) in the hospital group while there were no episodes in the centre group, despite training more patients.
- The centre audited the outcomes of home dialysis patients who had trained at the centre through their 90 days audits programme. This included transfer to in-centre HD and infection rates. Result showed improved outcomes compared with patients who had trained within the NHS system.
- The centre carried out a local audit of the effectiveness of the patients and relatives at discharge and at six weeks follow-up. The result showed 30% uptake of the six weeks invite to come back to the centre to assess how patients were doing following their training. Staff told us that patients do not come back due to other appointment, social commitment, holidays or hospital admissions. Patients received a certificate following their training sessions and

follow-up appointment. The key performance indicator showed 90% of respondents rated their confidence level as five out of six on the confidence rating question.

- The service collected data regarding patient transport at the centre compared to the NHS hospitals to monitor patient outcomes. Result showed that the centre consistently performed better than the NHS hospitals.

Competent staff

- Staff had an induction and competency pack. Staff could access training through e-learning and were offered some face-to-face training.
- Staff completed three months induction training at the beginning of their post. Staff received information from the human resource department and attended a 'welcome to Baxter' two day event where they learnt all about the organisation. Staff were shadowed by competent and experienced staff during their induction period before been signed off by the manager. The induction programme included competencies staff should familiarise themselves with, which included glucose safety, prescription management, water, dialysers, bloodlines and consumables. Staff were also required to spend time with the technical service department, operations, home care delivery, community practice educators and customer service department as part of their induction. Baxter operated a six month probation period and new staff had regular meetings and formal review at three month and six month to ensure staff had met necessary job requirement.
- Staff were provided with range of development workshops and training programmes to improve their competence such as communication with impact and harnessing your impact and presentation skills. Staff attended the British Renal Society as part of their mandatory training to develop their presenting skills.
- Staff had set competencies they were assessed against. Staff participated in self-directed learning worksheet, dialysis machine assessment booklet, quiz and assessment checklist to ensure their competence.

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- The medical director completed monthly supervision and support for the registered nurses. Staff told us their supervision were referred to as 'check ins'.
- Staff had a monthly informal one to one with their manager and had the opportunity to discuss their career progression. Staff told us their meeting covered how they were feeling, raising concerns, any issues and how the centre was running. We noted that the management and staff did not keep a record of the one to one meetings. Staff told us these sessions ensured they maintained their standards and the teaching, training and information given to patients and their relatives was consistent.
- Staff also completed continuing professional development (CPD) for their development, which was monitored by their manager.
- We noted that two of the educators had completed their renal training course whilst the other educators were registered nurses with teaching backgrounds.
- All staff were trained and competent to use the home haemodialysis machines and peritoneal dialysis machines.
- Staff started and participated in a journal club to discuss evidence based research and guidelines through a conference call. Staff spoke positively about this club and how it has helped develop their knowledge and practice.
- Staff attended regular staff meeting where they discussed clinical practices or had educational training. We noted that the community nurses were told in advance about staff meetings and training. Staff told us they discussed incidents and adverse events with each other. We reviewed the staff meetings for the period of January 2017 to May 2017 and noted that the agenda included teaching week, surveys, workshops, patient bookings and discharges, therapy applications, food and patients going out for the evening.
- Staff had completed their nursing revalidation. Staff told us they received revalidation support from their manager and had received colleague support through

peer discussions and group reflections to reflect on their practice. Staff told us reflective conversations were completed with another nurse before been signed off by the medical director.

- All new employees had their references checked and we saw evidence that all staff had their enhanced Disclosure and Barring Service checks (DBS) checked by the human resource department. We saw evidence that all nurses had current Nursing and Midwifery Council (NMC) registration and identity check confirmed.
- Staff received relevant clinical updates and research by email and during handovers.

Multidisciplinary working

- The service worked closely with the NHS hospitals and the medical teams within Baxter.
- Staff reported good communication and effective working relationships with the NHS referring centre. They contacted each other monthly and discussed patients care and areas for improvement where necessary. Staff gave us examples of good working relationship and where they had contacted the referring hospital regarding patient care. A staff member we spoke to told us they contacted a patient referring hospital the previous day due to concerns and queries regarding a patient's prescription. The staff told us the hospital staff were really helpful and resolved the issue within a couple of hours.
- The nurses and receptionist told us they had good working relationship, helped each other a lot and had good engagement and collaboration. Staff also reported good working relationship with their medical director to improve patient care, treatment and outcomes.

Seven-day services

- The unit was open from Monday to Saturday. Training sessions took place usually on Monday to Thursday. Staff conducted patient follow-ups on Thursday, Fridays and Saturdays. The centre carried out training for NHS staff on Thursday to Saturday when patients were not admitted at the centre.

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- The centre had the capacity to increase the number of patients training during the week and was able to admit more patients towards the end of the week if required.

Access to information

- All relevant information needed to deliver effective care and treatment was available to staff through either electronic or paper records. Records consisted of patient risk assessment, consent form, dialysis treatment and blood results. Staff told us they received relevant information needed for patients training when referrals were received from the referring hospital or dialysis unit.
- Patients discharge summaries were emailed to individual hospitals following patients training and discharge from the centre. Staff we spoke to told us that if the hospital wanted detailed information of a patients training, a paper copy was sent via post.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were fully aware of their roles and responsibility in relation to the requirement of consent. Patients were asked to complete a consent form during their admission process before commencing their dialysis training. The consent forms were filed in the patient record.
- Staff told us they previously had training on mental capacity and Deprivation of Liberty Safeguards (DOLS) but had not received an update. Staff we spoke to told us they had not had any patients or their loved ones with learning disability or mental health issues. Staff told us it was unlikely to have patients at the centre that were subject to deprivation of liberty safeguards (DOLS) or Mental Capacity Act (2005) due to their acceptance criteria and available support. Patients would have been assessed at the referring hospital.

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

- The service sought feedback from patients and their relatives about the care and training received. Patients commented they were happy the centre gave them the opportunity to be independent and able to care for their chronic condition at home. A patient commented that “although it was a training centre but I would always love to come back and visit the team again”.
- Throughout our inspection, patients and their relatives spoke highly of the high level of care received. Patients told us they had received “perfect care” and were “shocked about the good care” and respect received from staff during their stay at the centre.
- Specific comments made by patients and their relatives included “well looked after”, “very good and friendly staff”, “treated with high standard of care and respect”, “great staff and training environment would highly recommend”, “wonderful and cheerful staff”, “treated with care and respect”, “very impressed with staff”, “all staff members are caring and polite”.
- During our inspection we observed staff treated patients and their relatives or carers in a caring, friendly, kind and compassionate manner. Staff interacted appropriately with patients and showed empathy when delivering care to them.
- We observed that patients’ dignity was maintained during training, and staff ensured patients and their relatives or carers privacy were maintained. We noted that specific training such as attaching catheters was conducted in the patients’ bedroom following their group sessions.

Understanding and involvement of patients and those close to them

- Patients and their relatives told us staff communicated with them in a way that allowed them to understand their dialysis treatment and training. Specific comments included “staff provided all the answers I wanted”, “valuable information given during the course”, “presentations were first class”, “explanation and demonstration very informative”, “gave me a lot of information and how to deal with my dialysis treatment”, “very thorough support and training”.

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- Patients gave positive feedback on staff competency such as “friendly staff with great knowledge and training skills”.
 - Patients gave positive feedback about their induction to the centre. Patients and their relatives told us they received an hour individual induction from staff about the service, wound-site dressing, fire alarm and orientation of the building and about their training. Specific comments received from patients included “well orientated”, “good shared experiences”, “induction very detailed”, “good quality of training”, “questions always answered”. A patient commented that a particular staff member went above their call of duty with their explanation and was a real asset to the service.
 - We observed the group training session for patients and their relatives for 40 minutes during the inspection. Staff used visual aids and demonstrations during the teaching and training sessions to help with patients understanding and learning. We noted high quality teaching methods during the session and the group was interactive; this ensured patients and relatives involvement. The educators used multiple methods for training. They also recapped what patients and relatives learnt during training which resulted in good feedback and improved understanding. Patients were given supportive information in a booklet to aid their training; this also covered fluid restriction to help manage patients’ treatment.
 - The 2016 patient satisfaction surveys result showed 87% patients rated their teaching session as excellent, 12% rated teaching session as very good and 1% rated as good. The service also performed well on the ‘teaching area’ covered during training, with 73% rated as excellent. There was 34% response rate from the patient satisfaction survey.
 - Staff told us they had to explain to patients, during their training, that they were all on different prescription, therefore will be on different medication. These ensured patients did not compare their treatment with others and to prevent conflict.
- loved ones. Staff supported patients to be independent and to maintain normal life as much as possible. Patients and their loved ones were encouraged to go out in the evening after their training in order to visit popular places in the local area.
- We observed that staff gave patients and their loved ones time, opportunity and support to discuss their treatment and dialysis training.
 - We noted that staff were trained on how to support patient emotionally should they experience physical or emotional distress. Patients gave good feedback about the service and told us about the benefits received from their training at the centre. Comments about benefits included “peer support”, “home from home” and “staff support is quick”. Staff we spoke with told us they ensured they gave emotional support to the patients’ relatives and carers during their stay at the centre, as they were often nervous and did not know what to expect. Staff told us following their discussion and the support given, they saw relatives and carers were relaxed and not nervous.
 - Patients spoke positively about the peer support they received from other patients and relatives admitted at the centre during their week. During inspection we observed that patients and relatives sat and ate together in the lounge and dining area and discussed their experiences and gave each other support. The patients and relatives also went out together in the evening to visit popular places in the area. Patients and staff told us by the end of their week training, patients and their relatives had developed a friendship and support network among themselves. Specific comments from the centre patient survey included “very helpful to talk to other patients in the same situation”, “best thing was learning in a group with other people”.
 - Patients and relatives who required counselling and psychologist support were referred back to their referring hospital and dialysis unit.
 - We noted there was no formal patient support group at the centre. Staff told us this was because different hospitals had different ideas about what they wanted for their patients. Therefore, patients accessed their referring unit’s patients group. However, the centre had discussions and provided support for patients

Emotional support

- Staff understood the impact of chronic kidney disease and dialysis on a patient’s wellbeing as well as their

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during their follow-up. We noted that the community nurses also followed up on patients seen at the centre that needed a little support or confidence following their training at the centre.

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.

Service planning and delivery to meet the needs of local people

- The centre was contracted to complete dialysis training for patients and their carers or relatives by the patient's referring trust or dialysis unit in the UK. The centre had service level agreements with each individual patient's NHS trusts that referred patients to them. The training was free for all patients attending the centre; and there was no charge to the referring NHS trust.
- Baxter Renal Education Centre-Kew was established as a response to patient feedback about the facilities of the previous dialysis centre. Patients wanted to train in an environment that was similar to their home and not the hospital.
- Patients who required home dialysis treatment were assessed by their local NHS trust or dialysis unit for suitability for dialysis training at the centre before referral. The centre had the capacity to expand the number of patients attending training when necessary.
- The centre mainly trained patients onto peritoneal dialysis and were able to train patients on home haemodialysis and home parenteral nutrition as necessary.
- The centre consisted of two floors. The patient training room was located on the ground floor while the patients bedrooms, kitchen and relaxation room were

located on the first floor. Entry to the building was secured and patients arriving to the centre were required to be let in through a secure door from the patient car park.

- Training sessions were planned in the morning and afternoon so that patients and their relatives or carers could spend time in the evening together in the relaxation room and/or visit the popular places near the centre.
- There were sufficient free car parking spaces for patients and their relatives who drove to the centre.

Access and flow

- The centre received referrals from hospitals and dialysis units in the UK for patients that wanted to train on home peritoneal dialysis or haemodialysis.
- The centre had admission and exclusion criteria for patients in order for them to be accepted for dialysis training. The centre accepted patients that were independent or required minimal support with the help of a carer. The referring dialysis unit or hospital were required to assess all patients' mental capacity before admission. This was to ensure patient had capacity and were suitable to train at the centre. The service accepted patients with hepatitis b for their training, however did not accept patients that had infections such as MRSA, MSSA or C.difficile.
- Patient referrals and allocation for training was on a 'first come first served' basis. The centre did not book patients more than three weeks in advance and they ensured they had one acute slot available for patients that had an unplanned start to dialysis and required at short notice admission. If there was no available space, patients and their carers were put on the cancellation list, or offered training at home by their community educators. The community nurses were allocated one patient for training per week.
- The centre had five residential places available for training each week. However, they could take up to seven places for training, if two patients and their relatives or carers could travel daily to the centre.
- The service had a restriction of one relative or carer to a patient. However, some patients could also travel to the unit if they preferred. During our inspection, we noted that a patient who lived close to the centre

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travelled daily for their training, however we noted the patient's relative was able to stay at the centre for the training as they lived far away. The community clinical practice educators (nurses) trained patients and their carer or relatives at their home. There were many reasons for training at home, which included patient preference, distance to the centre or if there was no available slot or room at the centre during the week of the training.

- Patients had orientation, teaching and training on the dialysis machine on their first day of admission. Patients were allowed to put themselves and connect themselves on to the dialysis machine on the evening of the second day. The aim was for all patients to be familiar and confident in using the dialysis machine for their treatment before being discharged at the end of the week.
- The service had a seven day operating licence from the local council and could discharge patients on a Saturday when necessary. Staff told us they often reserved Fridays and Saturdays for patient follow-ups. Patients that were discharged home from the hospital on a Friday and required urgent training would be admitted the following Tuesday. This was to ensure patients were fit and well rested following their discharge from the hospital before commencing training.
- The centre had a 15% increase in the usage of the dialysis training in 2016 and aimed for a 10% increase in usage during 2017. Staff were confident they could achieve the 10% increase this year if they utilised their diary appropriately. Staff told us if they were very busy they admitted patients during the week on Wednesdays and discharged patients on Saturdays.
- The centre's target was to train 300 patients and relatives to manage their dialysis treatment at home per annum, however, they exceeded their target. Last year they trained 327 patients.
- Patients received an appointment card for six weeks follow up on discharged. Staff we spoke to told us they ensured one of the nurses met patients at home following their discharge from the centre during the following week. This was to ensure patients were followed up and settling well with their home dialysis treatment.

- Staff we spoke to told us there had been no cancellation of the service in the last 12 months. They had a cancellation year ago when there was snow outside and was unsafe for patients. Staff told us they had to delay and rebooked some of their sessions.

Meeting people's individual needs

- The centre had facilities for patients with disabilities including car parking, a lift and toilets with wheelchair access. Hand rails and stair lift were seen on the hallway to support transfer patients on the wheelchair on the stairs.
- The service provided one to one training with patients with hearing impairment. Staff told us they did not have a hearing loop in the training room and the room can be noisy for patients using hearing aids. Therefore, patients with hearing difficulty were taken to another room for a quiet place to train. The centre had picture guides to support patients that were hard of hearing or could not read. Information and instructions were also made available for patients on audio cd to take home and use following their training. Staff told us some patients did not disclose the fact that they had a hearing impairment, but through their assessment before and during training, they were able to identify this.
- The centre does not offer training to patients living with dementia or learning disabilities. The staff we spoke to told us the centre only accepted patients with limited literacy skills as they do not have the facilities and provision to cater for people with learning disability and dementia. Patients with limited literacy skills were required to have their carer or relatives admitted with them during their training for additional support.
- The service provided training for patients with limited literacy skills and their carers or relatives. Staff we spoke to told us they had resources to help support patients and their relatives learning. Patients and their relatives could use the dictaphone provided to record and play back the session whilst at the centre and when back at home. Books were also used as training materials during their teaching and training sessions.

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- Training was done in groups, however there was flexibility to have individual training if a patient or relative request this, or staff had to give additional support.
 - The service accommodated the cultural and religious needs of patients and their loved ones. Staff told us they did not always receive information regarding a patient's religious and cultural background and needs before admission. However, they always discussed this with the patients and relatives during their induction and assessment. Patients were encouraged to use their own bedrooms as a prayer room and if not they were directed to their local mosque, church or temple.
 - Translation services were provided by the referring NHS hospital as part of their service level agreement. Staff had delivered training to a patient using a translator and it went well.
 - We noted that the centre arranged and paid for patients taxis transport to the centre and back home for patients how did not drive or did not have their own transport. The centre had a contract with a taxi service. Staff and patients we spoke to told us there was no delay with the taxi transport service.
 - We noted that television, video recorder, fan, sofa, cushion, dining, books and magazines were in the relaxation area. The area was neat and well decorated and had a relaxed home environment atmosphere. The room were decorated with plants and had pictures on the wall.
 - Food was provided for patients to meet their dietary, cultural or religious needs. The centre provided kosher and vegetarian food. Patients and relatives were encouraged to bring their own cooked meals to the centre.
 - A drinking fountain was available at the centre for patients, their relatives and carers.
 - Patients and relatives received a welcome booklet ahead of their arrival or on their first day at the centre. The booklet included opening days and time, details, and experience of staff working in the centre, information on phones, meals and visiting times. The booklet also had information on the availability of Wi-Fi including the passwords and bedroom facilities. Patients were also advised on the afterhours training activities and attractions they we able to visit outside of the centre. The booklet also included details of the training sessions from day one to three, which prepared patients and carers as to what to expect.
 - The centre had access to the Kidney Patient Association under the National Kidney Federation that provided support to patients and their relatives through social events. We noted the centre provided patients with the Kidney Patients Association newsletter. The newsletter seen provided latest updates on transport systems, conferences, detection of acute kidney injury and dietetic advice.
 - Patients were able to recognise staff easily. There was a notice board with staff pictures and roles identified placed in the reception area.
 - Staff we spoke with told us patients felt they were coming to the acute hospital setting for their training and would prefer to train in a non-clinical environment. The management decided to move the centre to a new location that was not within a hospital so patients could train in an environment that was similar to their home setting. The new centre, Baxter Renal Education Centre – Kew was established as a response to patients' feedback.
 - From 1st August 2016 onwards, all organisations that provide NHS care were legally required to follow the Accessible Information Standard. The standard aim is to ensure that people who have a disability, impairment, or sensory loss are provided with easy to read information and support to communicate effectively with health and social care providers. The centre had been accredited by the Information Standard since August 2016 and received re-certification in July 2017.
 - We observed that the centre employed male and female staff, which matched the clients that accessed the service.
- ## Learning from complaints and concerns
- There was a clear process in place for the management of complaints. Staff were able to explain the action to take when they received formal and informal complaints.
 - The service reported that no complaints had been received for the period of May 2016 to May 2017. An

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informal complaint had been received in the past relating to how a nurse taught a patient during their training. Staff told us they tried to discuss and resolve the complaint to ensure the patients learning and experience was better. The complaint was also investigated to ensure the complaint was not related to a personality trait or preference.

- We observed a poster displayed at the centre that included their complaints procedure.
- Information on how to make a complaint was highlighted in the information booklet given to patients during admission. Patients we spoke to were aware of how to make a complaint.

Are dialysis services well-led?

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.

Leadership and culture of service

- There was a clear leadership structure in Baxter organisation and that was applied locally in the centre.
- Baxter Healthcare Limited organisation structure had a UK organisational structure, which included a UK medical director supported by two medical managers, renal director, pharmacist lead, senior medical affairs and the clinical training manager.
- The Clinical training manager was the lead and manager of the Baxter Renal Education Centre-Kew who reported directly to the medical director of Baxter UK. The centre manager was supported by the national clinical coordinator and clinical practice educators (nursing staff) and administrators. We noted that the local leaders had the appropriate skills and knowledge to lead and manage the service.
- Staff knew how to raise concerns through the whistleblowing policy. Staff told us they felt comfortable to approach and raise concerns, particularly patient safety issues with their manager, during their team meetings or one to ones. They also felt comfortable with raising issues with senior management within the organisation.

- All staff reported they felt supported by the managers and organisation when incidents or other issues occurred. Staff reported there was a no blame culture when things went wrong.
- All staff were aware of the need to be open and honest with patients. Staff felt the organisation and centre had a culture of openness and honesty, and was open to ideas for improvement. Staff told us they would recommend Baxter as a place to work.
- Staff were passionate about their work and the care given to patients. Staff told us they were proud of the quality time they spent with patients during their training. Staff were also proud of making a difference to the lives of patients and their relatives or carers by empowering them to take control of their dialysis treatment at home. Staff told us they received lovely thank you cards from patients and received lots of positive feedback. This made staff proud of their jobs and the positive impact they had on the life of their patients and relatives.
- Staff told us they felt the organisation and centre was a great place to work, they were happy they had a small team which ensured staff were able to support each other. Specific comments included “such a nice atmosphere”, “leadership great”, “leadership is good”, “manager has a good sense of humour”, “service is managed so well”, “everyone was really nice and friendly”, “centre has a really good feel about it”.
- We noted the organisation promoted women in leadership through various programs and forums. The centre was accredited as a disability confident employer.

Vision and strategy for this this core service

- Baxter Renal Education Centre (BREC) vision was to provide high quality, individualised effective training and education to patients managing their own care with the purpose of enabling them to stay well on their chosen therapy.
- BREC's mission was to provide the best possible education for dialysis patients and their families at all times.
- The centre had shared values that included respect, integrity, teamwork and empowerment. We noted the values were developed from the employee and

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business values of the organisation. We noted that not all staff were familiar with the centre values. Some staff told us their vision and values were “patient first”, “making sure as many patients could self-care with dialysis at home”.

- Staff told us their strategy was fitting as many patients as possible, and safely into the training to sustain life. Also making sure patients felt safe and educated; however, we noted there was no formal strategy in place for the centre.
- During the inspection, we noted the centre philosophy was displayed for visitors and patients to see. Staff we spoke to were aware and familiar with the centre philosophy.

Governance, risk management and quality measurement

- The corporate clinical governance committee met monthly to discuss all clinical issues relating to the patient facing services that Baxter Healthcare provided across the UK and Ireland. This included the centre facility and home based training as well as Baxter’s homecare service such as renal services, parenteral nutrition and intravenous (IV) therapies area. Staff told us the clinical governance meeting was held either face to face or via conference call; the manager received the minutes of the clinical governance meeting. The standing items on the agenda were reviews of the complaints and incidents dashboard, root cause analysis, the risk register, updates from the information governance lead, medication safety officer, device safety officer and other updates as required. All risk and concerns at the centre were discussed at corporate level. Staff told us the centre was considered a low risk area of the overall patient facing service that the organisation provided; there had not been a patient complaint or incident since the dashboard was instigated in January 2016. Staff told us as a result BREC rarely features in any minutes from the clinical governance committee. The committee were assigned different actions, which they had to feedback during their meeting before mutual agreement.
- Staff told us they did not receive clinical governance meeting updates and outcomes from their manager. Staff told us they were concerned that the national committee did not understand the local risks. We noted that the clinical manager was part of the committee and attended the regular clinical governance meetings. We asked for number of documents from Baxter’s to show how governance and risks were managed and they refused to give it to us. We were not provided with the minutes of the clinical governance committee.
- There were 26 risks included on the risk register which included cardiac arrest, acute anaphylaxis, patients becoming hypotensive, building problems such as electrical failure, ‘patients infused incorrect dialysis fluid not prescribed’, patient device malfunction and hypoglycaemia. We saw nothing on the risk register related to the local risk of the service identified during inspection such as window restrictor, carpet floor and water testing. Falls and skin cuts which were all highlighted in their incidents log were not identified as risks or added to the risk register. The overall system governance at times appeared ineffective, for example five times the water systems had not been tested and no subsequent action were taken by leaders to address this. We noted that the risk register did not highlight when the risks were added or the last reviewed date. We saw nothing in the risk register to assure us that actions were taken in a timely way. Senior staff we spoke to told us the risks on the risk register were all potential risks and had not yet occurred. Staff told us the risk were reviewed monthly at the clinical governance meeting which was attended by the manager. Following the inspection, the provider informed us the window restrictor and risk of patient slipping off their bed had been added to their risk registers.
- We received mixed responses from staff about the centre risk and risk register. Staff were aware that there was a risk register but do not know how to access this. They were unaware as to what the identified risks were. Staff told us the risk register could also be updated by the nurses. We were not assured staff were aware of risks and incidents that related to the centre and organisation.
- Staff had a lone worker policy and nurses working on their own in the community had access to their 24

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hour line service to support and ensure their safety. If there were concerns with the patients, community staff contacted the centre and the safeguarding team at the referring hospital.

Public and staff engagement

- Baxter Renal Education Centre completed patients experience surveys at the end of the patient training and 'how you feel survey' later when they were at home. Majority of the feedback from patients were positive and also identified areas where the service could do better. We noted the service took the patients feedback on board and also utilised ideas from their suggestion box. Some feedback received from patients and relatives on areas to improve included the heating and mattress. A patient commented they would have preferred a shorter training session for those patients who had done dialysis before.
- Baxter has an annual "Best Place to Work" survey which was completed by staff across all Baxter services worldwide each year to improve the employee experience. The surveys were anonymous and the results were filtered regionally and then to individual countries. The survey results were only filtered to the UK and not available for the Baxter Renal Education Centre; therefore, we were not provided with the result as it contained confidential information that related to the non-clinical and commercial branch of the Baxter organisation.
- Staff we spoke to told us the organisation developed a new project called the "My Manager Cares" following the areas of improvement identified through the patient survey. This new programme was designed to provide managers with tools and training in three areas that included valued differences, driving engagement and giving feedback. The organisation aimed to reinforce their managers' accountability and recognise role models in their organisation through the project.
- The centre and staff received awards for their service. The centre promoted and awarded staff that were innovative and gave them credit for their hard work.

We saw examples of staff that had been put forward by the centre manager for their organisations award. The centre received a renal leadership recognition award for uncompromised dedication to quality.

- The Baxter Renal Education Centre held a meeting for their community and centre staff twice a year. Staff were recognised for their outstanding work and were involved in team building activities during these meetings. Staff told us they also held dinners together twice a year.

Innovation, improvement and sustainability

- Staff gave us examples where changes had been made to the service. Staff told us that previously patients did not start their dialysis on Mondays. Some patients were not comfortable and confident and felt pressurised towards the end of the week. Staff told us the team supported patients and worked with patients for them to start dialysing on Mondays after their teaching session. Staff told us this was effective as it helped get the 'fear factor out of the way' and both staff and patients felt this was a positive move.
- There were plans to build another renal education centre in the North West of England due to the demand and need for home dialysis treatment.
- The patient follow up reunion days were initiated to recheck patients trained at the centre around four to six weeks following discharge. This was to check the patient's technique and how they had been managing at home since training. This enabled the training team to audit the effectiveness of the initial training.
- The centre developed the photographic picture guides for performing automated peritoneal dialysis to help patients who had limited literacy skills or who do not read English. The guides had photographs of the steps involved in setting up and connecting to the peritoneal dialysis machine.
- The centre provided individual audio CDs for patients with limited literacy skills or those that found the pictorial guides confusing. The audio instructions contained step by step verbal instructions and was given to the patient to take home.
- The centre developed the confidence meter in the form of a speedometer with a dial and indicator to show each patient's confidence levels each day.

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Patients indicated their level of confidence at the start and end of each training day. This helped the training team to highlight those individuals that struggled with confidence and maybe required a one to one training or separate session with them in another room.

- The centre developed a peritoneal dialysis assessment tool in response to an ageing population; they found more elderly frail patients that started dialysis had not necessarily been assessed to determine which

method of peritoneal dialysis would suit them individually. This assessment tool enabled the nurse to easily identify skills and cognitive ability which were rated as a score. This score then identified which therapy would be most appropriate for each patient.

- The centre had been recognised and rewarded by external organisations such as Pharmaceutical Marketing and Health Investor for their service and training.

Outstanding practice and areas for improvement

Outstanding practice

- The service is innovative and had developed various assessment tools and materials to support patients learning, dialysis treatment and training.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure compliance with the water testing and treatment used for dialysis treatment and training at the centre.
- The provider must ensure window restrictors are installed to ensure patients and their relatives' safety and minimise the risk of falls.

Action the provider **SHOULD** take to improve

- The provider should ensure they follow their policy and the NMC guidelines in regards to safe storage of medicines.

- The provider should ensure incidents are reported and investigated effectively.
- The provider should ensure that the risk register is reviewed and updated regularly to reflect local risks.
- The providers should ensure staff receive updates from the clinical governance meeting that affects their clinical practice.
- The provider should ensure the carpets are replaced and meet the Department of Health, Health Building Note 07-01: Satellite dialysis unit guidance.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>We had concerns around the system and governance processes at Baxter Renal Education Centre. The water testing was not completed as required and there was no action plan in place to address this. The system for testing water was ineffective and a risk to patients and not in line with guidance on monitoring the quality of treated water and dialysis fluid. The service must address this including:</p> <ol style="list-style-type: none">1. Ensure there is effective system in place to assess, monitor and improve the water testing at the centre.2. Taking action to improve the water testing and monitoring among staff.3. Ensure water testing is added to the risk register and reviewed regularly. The risk register should reflect local risk identified at the centre during inspection <p>This was a breach of Regulation 17 (2)(b)(c)</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>We had concerns that windows restrictor were not installed on the first floor which increase the risk of patient falls. This was not in line with The Health and Safety Executive 2012 guidance (HTM55) and Department of Health Building Note on having suitable control measure such as: fitting adequate window restrictors to prevent falls. The service must address this including:</p>

This section is primarily information for the provider

Requirement notices

1. Ensure window restrictors are installed to identified windows at the centre. This is to ensure patients and their relatives' safety while training and minimise the risk of falls.
2. Ensure that the windows were in line with the Department of Health Building Note 00-10 Part D Windows and associated hardware.

This was a breach of Regulation 15 (1)(b)