

# Crawley Kidney Treatment Centre

## Quality Report

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Crawley Kidney Treatment Centre is operated by Diaverum UK Ltd. The centre provides haemodialysis for stable patients with end stage renal disease and failure. Dialysis units offer services which replicate the functions of the kidneys for patients with advanced chronic kidney disease.

The centre opened in 2001 and has been in its present location since January 2015. The facility is a standalone unit within an industrial park operating 24 dialysis stations (comprised of 20 stations in the general area and four side rooms which can be used for isolation purposes).

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 7 June 2017, along with an unannounced visit to the centre on 16 June 2017.

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

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

### 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 keep patients safe. This included appropriate management and reporting of incidents, effective cleaning schedules and maintenance programmes. All staff were aware of their roles and responsibilities in ensuring patient safety.
- Effective processes were in place for the provision of medicines. These were stored and administered in line with guidance and staff completed competencies according to Diaverum UK policy to administer medicines correctly.
- Patients' medical and nursing records were secure. Staff had access to all relevant records ensuring patients' care was as planned and not delayed.
- Staff worked collaboratively with the referring NHS trusts to monitor and assess patients regularly. Patients received a verbal explanation. Patients and their GP's were provided with written updates on their condition and treatment plans. These were provided to them a minimum of monthly.
- Staffing levels were maintained in line with national guidance to ensure patient safety. Nursing staff had direct access to a consultant nephrologist who was responsible for patient care. In emergencies, patients were referred directly to the local NHS trust and the emergency services called to complete the transfer.
- Staff were aware of their roles and responsibilities to maintain the service in the event of a major incident. Patients were able to continue their treatment at alternative centres.
- All policies and procedures were based on national guidance and compliance was monitored through an effective audit programme.
- Patients' pain and nutrition were assessed regularly and patients were referred to appropriate specialists for additional support as necessary.
- There was a comprehensive training and induction programme in place to ensure staff competency.

# Summary of findings

- There were processes in place to ensure effective multidisciplinary team working, with specialist support provided by the referring NHS trusts.
- There were effective processes in place for gaining patient consent for treatment.
- Patients were treated with respect and compassion. Staff took care to maintain patient dignity and confidentiality when delivering care and treatment.
- The service met the needs of the local population and the needs of individuals attending for dialysis.
- The centre encouraged patients to self care through the 'shared care' programme.
- Staff were familiar with and worked towards the organisational vision of providing the best possible care for renal patients.
- There were effective processes in place to monitor risks associated with the service and individual patients. Quality assurance meetings occurred regularly and included the referring NHS trusts and specialists.
- There was evidence of strong national and local leadership, with accessible and responsive managers.
- All staff and patients were positive about the service.

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

- No staff had received specific training to recognise sepsis in patients despite the patients being a high risk group. This was not in line with national guidance.
- Best practice guidelines advise two registered nurses check at the point of administration of intravenous medicines. We saw the sodium chloride (0.9%) prepared by staff was not checked by a second nurse.
- The provider did not have plans in place to implement the Workforce Race Equality Standard (WRES) requirement.

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

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
<b>Dialysis Services</b>		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.

# Summary of findings

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# Crawley Kidney Treatment Centre

**Services we looked at**

Dialysis Services

# Summary of this inspection

## Background to Crawley Kidney Treatment Centre

Crawley Kidney Treatment Centre operated by Diaverum UK Limited is a partnership between two local NHS trusts: Brighton and Sussex and Epsom and St Helier, primarily serving the community of Crawley, West Sussex. The service opened in 2001 and has been in its present location since January 2015.

The centre had a registered manager in post since January 2015. At the time of the inspection, a new manager had submitted an application to be registered with the CQC.

The service has not been previously inspected.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in renal dialysis. The inspection team was overseen by Vanessa Ward, Inspection Manager.

## Information about Crawley Kidney Treatment Centre

Crawley Kidney Treatment Centre is a unit that provides dialysis for patients with chronic renal failure. Diaverum UK Limited ('Diaverum') is contracted to complete dialysis for local patients under the care of nephrologists at two local NHS trusts: Brighton and Sussex and Epsom and St Helier. All patients attending Crawley Kidney Treatment Centre ('the centre') receive care from a named consultant at the trusts, who remain responsible for the patient. Diaverum have support and close links with the trusts who provide medical cover, pharmacy support, transport coordination and regular contact with a dietician. The clinical teams attend the centre regularly and assess patients in preparation for monthly quality assurance meetings.

The centre operates Monday to Saturday with a maximum capacity of 144 patients. Fifty eight sessions are provided every Monday, Wednesday and Friday and 40 sessions every Tuesday, Thursday and Saturday. Opening hours are 6.30am to 11.30pm Monday, Wednesday and Friday; and 6.30am to 7pm Tuesday, Thursday and Saturday. Reception is staffed Monday to Friday 8am to 4pm.

The centre has 24 dialysis stations (comprised of 20 stations in the general area and four side rooms which can be used for isolation purposes). Facilities include a reception and waiting area, three consulting rooms, staff room and a meeting room.

The centre is registered to provide the following regulated activities:

- Treatment of disease, disorder, or injury.

During the inspection, we visited the treatment areas where dialysis took place, and the other non-clinical areas of the centre, such as the maintenance room, and water storage area. We spoke with seven staff including; registered nurses, dialysis assistants, health care assistants, reception staff, and senior managers. We spoke with four patients. We also received six 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 13 sets of patient records.

There were no special reviews or investigations of the centre ongoing by the CQC at any time during the 12 months before this inspection. This was the centre's first inspection since registration with CQC.

# Summary of this inspection

In the 12 months before our inspection, there were 6240 dialysis sessions carried out for 18-65 year olds and 8736 sessions for people over 65 years of age. Forty patients aged between 18 and 65 years and 56 patients aged over 65 years of age were NHS funded and treated at the centre. An average of 294 treatments sessions were delivered each week.

The centre does not provide services for people who are on holiday or patients under 18 years of age. Both male and female patients are treated in the same areas at the same times.

The centre does not employ any doctors. The centre employs 3.6 whole time equivalent (WTE) registered nurses (two full time, two part time and two on a zero hours contract). There are six WTE dialysis assistants (three full time and five part time). In addition the centre employs 4.6 WTE health care assistants (three full time and two part time).

Access to the facility is by established routes with bus stops in close proximity. Most patients use hospital arranged transport to and from the centre. Ambulance access is available and a designated drop off base is available at the entrance. A small number of patients use private transport and designated parking is available.

Track record on safety in 12 months before inspection:

- No never events.
- No incidences of healthcare acquired MRSA.

- One incidence of healthcare acquired Methicillin – sensitive staphylococcus aureus (MSSA).
- No incidences of healthcare acquired Clostridium difficile.
- One incidence of healthcare acquired infection caused by other bacteraemia.
- No incidences of pressure ulcers, urinary tract infection (UTI) and hospital acquired venous thromboembolism(VTE).
- Two incidences of patient falls.
- 51 complaints received.

## **Services provided under service level agreement:**

- Clinical and or non-clinical waste removal.
- Maintenance of medical equipment and environment.
- Pathology and histology.
- Maintenance and service of dialysis chairs.
- Water treatment system maintenance.
- Laundry services and provision.

Other services were carried at the location and included pre-dialysis consultations, education sessions and phlebotomy services. These clinics were run by the local acute NHS trusts. Daiverum offered administrative support and phlebotomy upon request.



# 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 for recording and escalating incidents both internally and externally. There was a positive safety culture, which was inclusive of all staff.
- Staff were compliant with mandatory training and there was a reliable system to monitor this.
- Staff were aware of their roles and responsibilities in the escalation of safeguarding concerns.
- The centre and equipment used were visibly clean, with evidence of effective cleaning regimes and schedules in place. Audits were completed to ensure compliance with local policy and procedure. All staff were observed using effective precautions to maintain patient safety and reduce the risks of infection.
- All equipment was maintained according to the manufacturer's guidance. Equipment was standardised across the organisation with an adequate supply to cover maintenance or breakages.
- There were systems and process in place to safely manage the ordering, storage and administration of medicines.
- Patients' medical and nursing records were held securely, with direct access to all relevant records at each area where treatment was provided.
- Staff worked collaboratively with the referring NHS trusts to monitor and assess patients regularly. Staff completed regular risk assessments and patient reviews to ensure they were suitable to continue treatment at the centre.
- Medical advice was available during opening times, with direct access to the appropriate consultant or renal team at the referring NHS trust.
- Nursing staffing levels were maintained in line with national guidance to ensure patient safety.
- Staff were aware of their roles and responsibilities to maintain the service in the event of a major incident. Patients were able to continue their treatment at alternative centres.

However, we also found the following issues that the service provider need

to improve:

# Summary of this inspection

- No staff had received training to recognise sepsis in patients despite the patients being a high risk group. This was not in line with national guidance.
- We saw the sodium chloride (0.9%) prepared by staff was not checked by a second nurse. Best practice guidelines advise two registered nurses check at the point of administration of intravenous medicines.

## Are services effective?

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

We found the following areas of good practice:

- All policies and procedures were based on national guidance.
- Patients' pain and nutrition were assessed regularly and patients referred to appropriate specialists for additional support as necessary.
- The unit had a comprehensive annual audit schedule with clear actions taken as a result.
- The service monitored key performance indicators. These demonstrated the service performed similarly to other dialysis centres.
- All staff completed a detailed competency pack on commencement of post. Staff had the skills, knowledge and experience to ensure safe patient care.
- There were processes in place to ensure effective multidisciplinary team working, with specialist support provided by the referring NHS trusts.
- All staff had access to all relevant information for patient care and treatment.
- The mental capacity of patients and, in addition, the equality and diversity of patients and staff were respected and monitored.
- There were effective process in place for gaining patient consent for treatment.

## Are services caring?

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

We found the following areas of good practice:

- Patients were treated with respect and compassion.
- Nursing staff gave patients adequate time to ask questions and provided written information regarding patients' conditions, treatment plans and support networks.
- Nursing staff provided patients with information and contact details of support networks, which included the Kidney Patients' Association and social care.

# Summary of this inspection

## Are services responsive?

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

We found the following areas of good practice:

- The centre had been built to provide local dialysis patients with a treatment centre nearer to their home. Patients were assessed for suitability to attend the centre and had the opportunity to visit before finalising the placement.
- Patients' initial treatments were commenced at the NHS trusts and once stabilised patients were transferred to the centre. This process varied according to the patient's response to treatment.
- The centre had 10 patients on the waiting list at the time of inspection.
- The centre was fully equipped to provide safe treatment for patients with translation needs, or those living with mobility, hearing or visual impairment needs.
- The centre encouraged patients to self care through the 'shared care' programme.
- The centre received 51 complaints in the past year. There were systems to ensure that patient complaints and other feedback was investigated, reviewed and appropriate changes made to improve treatment of care and the experience of patients and their supporters.

## 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 national and local leadership, with accessible and responsive managers.
- Staff felt valued and there was a positive culture. We observed team working and staff respecting each other.
- Staff were familiar with and worked towards the organisational vision of providing the best possible care for renal patients.
- The centre had effective systems in place to monitor risk and quality, using a dashboard to evidence performance and identify trends or areas of development.
- Staff and patients were positive about the service.

However:

- The provider did not have plans in place to implement the Workforce Race Equality Standard (WRES) requirement.

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Safe

Effective

Caring

Responsive

Well-led

## Are dialysis services safe?

### Incidents

- The centre had an effective system in place for recording, investigating and monitoring incidents. Staff were fully aware of the roles and responsibilities in the recording of incidents, both internally and externally.
- No never events were reported by the centre in the 12 months before inspection as none had occurred.
- The centre reported no deaths, serious incidents, pressure ulcers, urinary tract infections (UTI) and hospital acquired venous thromboembolism(VTE) in the 12 months before inspection as none had occurred.
- Diaverum had a procedure for the reporting of incidents (due for review October 2017). An electronic incident reporting system was used and staff demonstrated a good understanding of how to use the system. Feedback from incidents were discussed at meetings and minutes of meetings confirmed this. Staff told us the organisation encouraged them to report incidents to help the whole organisation learn. Staff were able to give us examples of incidents that had been reported.
- All incidents were investigated by the centre manager. Data showed 645 incidents were reported between March 2016 and February 2017. The majority of incidents related to missed treatment by patient choice (31%), patients decision to interrupt treatment after 15 minutes (29%), dialyser and/or blood lines changed due to clotting (15%) and vascular access problems and complications (8%). The high numbers of incidents reported suggested a good reporting culture.

- The dissemination of information regarding incidents and lessons learned was through electronic communications and staff meetings. We reviewed a sample of the centre's clinical incidents, patient's notes and root cause analysis and saw evidence that staff had applied the duty of candour appropriately.
- The centre reported two falls as duty of candour notifications in the 12 months before inspection. 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 were able to describe the basis and process of duty of candour. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The centre apologised and informed people of the actions they had taken. We saw operational staff understood their responsibilities with regard to the duty of candour legislation and we found the responsible manager ensured the duty was considered and met when investigating safety incidents. We saw copies of the letters sent to those affected and correct processes followed.

### Mandatory training

- Diaverum had an effective mandatory training programme. All staff were required to complete a programme of mandatory training appropriate to their role. Training was completed either in face-to face or by an electronic learning programme. No staff we spoke with described difficulties accessing these electronic training packages.
- We saw the staff records for mandatory training. The centre manager kept an electronic record which

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recorded the training required, and its completion dates. The manager described how the system was used to ensure staff remained up to date. We were provided with the annual timetable of training for the staff working in the centre which was colour coded, for example showing red where training was overdue, amber if the training was due soon, and green if the training was within date.

- The training programme was comprehensive and contained all the training subjects that would be expected. For example, data protection, anaphylaxis, infection prevention control, aseptic non-touch technique (ANTT), medicines management, fire safety and cardiopulmonary resuscitation (CPR) were completed every year and 97% of staff were up to date. Topics covered every two years included safeguarding, Control of Substances Hazardous to Health (COSHH), personal protective equipment (PPE) and data showed 95% of staff had completed the training. Training which was completed once included code of conduct training.
- As part of their mandatory training, appropriate staff completed a number of competencies when they started their employment at the centre. This included water education and treatment and the administration of catheter locking solutions and specific medicines.
- Practical skills were competency based and practical training included clinical skills such as ANTT, medicines' management, care of fistulas (a connection of an artery to a vein) and dialysis catheters.
- Equipment and facilities training covered all machinery such as hoists, dialysis chairs, resuscitation trolley, glucometers and the centrifuge (fast sample processing). These topics were completed at the commencement of employment and updated as required by Diaverum policy.
- All trained staff completed the national basic dialysis programme on induction. This comprised 16 modules of practical and e-learning. Subjects covered included renal function for managing a cardiac arrest,

hypotension (low blood pressure) and hypoglycaemia (low blood sugar). The dialysis assistants completed the same course except for the last module (managing symptoms on dialysis).

## Safeguarding

- There were systems, processes and practices in place to keep patients safe from avoidable harm. Staff were aware of their roles and responsibilities for escalating safeguarding concerns. They were able to explain the main types of abuse, and knew how to access the centre's policy for safeguarding patients.
- Staff told us they had not had to report or escalate many safeguarding concerns but were aware of the escalation process. All safeguarding concerns were reported through the local NHS trust safeguarding team who contacted the centre with any feedback from investigations.
- The service lead for safeguarding vulnerable adults and children was the Diaverum director of nursing. Locally, the centre manager had been the only person to raise concerns.
- The centre did not treat patients under the age of 18 years, and did not therefore complete safeguarding children training in accordance with national guidance. Staff told us they would seek advice from the local NHS trust safeguarding team in the event of concerns.
- Diaverum had a safeguarding adult's policy and procedure which specified the process and responsibilities of staff.
- The procedure stated all staff received training as part of the induction process and then every two years. Data showed us staff had received training at induction and all staff had completed the update course at the time of inspection. Staff were trained to safeguarding adults' level 2 and the centre manager trained to level 3.

## Cleanliness, infection control and hygiene

- There were clear infection prevention and control policies and hygiene plans for staff to follow. All staff we spoke with told us they were aware of the procedures. The centre manager was the lead for infection prevention control.

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- The centre reported four cases of healthcare acquired infection in the 12 months before inspection. Data showed there was one case of Methicillin – sensitive staphylococcus aureus (MSSA) and one other bacteraemia. No cases of Methicillin-resistant staphylococcus aureus (MRSA) and blood borne viruses were reported as none had occurred.
- Patients were screened every three months to monitor virology bloods, MRSA, MSSA and any other healthcare acquired infection according to national guidelines. We were told a zero target where practicable was aimed for and variances acted upon in accordance with Diaverum and referring NHS trusts' policies and procedures.
- Four side rooms were available for patients identified as being at risk or those with potential infectious conditions. The centre had strict guidance on the segregation and monitoring of patients. Due to the possibility of blood borne viruses, patients were required to be isolated upon admission and returning from temporary dialysis in another centre or country. Patients were tested every two weeks and all results were treated as potentially positive until the result was known. This was in line with national guidance.
- We saw patients identified as at risk were allocated the same equipment and rooms for each session to prevent risks of cross infection. Rooms were observable from the main nurse's station.
- All the areas we visited in the centre were visibly clean and tidy and we saw there were good infection control practices in place.
- Diaverum's general infection control policy, 2016 stated all centres must provide adequate supply of running water and a dedicated sink for hand washing at minimum one per 10 stations with non-refillable liquid soap, non- hand operated taps and paper towels.
- We saw there were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. We saw information was displayed demonstrating the 'five moments for hand hygiene' near handwashing sinks. Sanitising hand gel was readily available throughout all areas.
- During the inspection we saw staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care.
- Monthly hand hygiene audits were completed. We saw the audits for March, April and May 2017. Over the three months overall compliance was 96% for all staff. An action plan was devised for non-compliant staff who were provided with individual training. Feedback from the audits were discussed at handovers and staff meetings.
- We saw personal protective equipment was available for all staff and observed staff use it appropriately. This included face visors to protect staff from the possibility of blood sprays.
- Infection prevention and control and Aseptic Non Touch Technique (ANTT) was part of mandatory training for staff to complete every year. Aseptic techniques are methods designed to prevent contamination from microorganisms; they involve actions to minimise the risks of infections. We saw all staff had completed the courses at the time of inspection. Personal protective equipment (PPE) was part of mandatory training for staff to complete every two years. We saw all staff had completed the course.
- We observed suitable aseptic technique processes when staff were connecting patients to, or disconnecting them from dialysis machines.
- Diaverum had a schedule for the process for cleaning of patient care equipment. This included the cleaning and disinfection of the interior fluid pathway and the exterior surface of the dialysis machine. The schedule listed all the equipment, the type of cleaning required and frequency. For example, dialysis chairs were to be cleaned with suitable wipes and cloths using approved cleaning agents. This was to happen after every dialysis treatment. In addition, on a weekly basis the base, brakes, back and wheels were to be cleaned. We saw staff performed disinfection of dialysis machines between each patient and at the end of each day. Single use consumables such as blood lines were used and disposed of after each treatment.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This

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demonstrated compliance with health and safety sharps regulations 2013, 5(1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the labels on sharps bins had been fully completed which ensured traceability of each container.

- During the inspection we saw all seating used within the patient areas was covered in a material that was impermeable, easy to clean and compatible with detergents and disinfectants. This was in line with HBN 00-09 section 3.133 for furnishings.
- The centre did not have carpets in clinical rooms. The flooring was seamless and smooth, slip resistant, easily cleaned and appropriately wear-resistant. This was in line with HBN 00-09: Infection control in the built environment, 3.109.
- We saw the cleaning schedules of the building and facilities. These were maintained, with evidence of regular cleaning documented. The cleaning of the building was subcontracted to an external provider. The contractors had regular meetings with the centre manager to ensure satisfaction with the service.
- A monthly audit was completed to inspect the level of cleanliness in all clinical and non clinical areas. We reviewed the results for April 2017 (93%), May 2017 (94%) and June 2017 (92%). All areas noted as non compliant included an action to be taken. For example, in April 2017 it was noted some bases of dialysis chairs had evidence of dust. The cleaners were instructed to ensure all bases were dusted on a weekly basis. In addition, the April 2017 audit showed the exterior of the microwaves were not being cleaned. The audits for May and June 2017 showed this task was being completed in an appropriate and timely manner.
- There was a large water treatment room, which was monitored remotely by the manufacturer. This enabled them to identify any issues with supply, effectiveness or treatment or leaks. In addition to the remote monitoring, staff had telephone access to the manufacturers for emergencies.
- Water used for dialysis needs to be specially treated to prevent risks to patients. Staff were able to describe the management of the water systems for the

presence of bacteria and pH (used to specify the acidity or alkalinity of a solution) levels and were able to explain the procedures required should a water sample test positive.

- Staff carried out daily water tests to monitor the presence of chlorine in the water in line with the UK Renal Association clinical practice guidelines. The daily checks carried out in May, April and June 2017 were all within safe ranges.
- Water testing was completed monthly to ensure the water used during dialysis was free from contaminants. This was in line with guidance on the monitoring the quality of treated water and dialysis fluid. We saw the record log which recorded the testing and the results. Staff were aware of the processes for obtaining samples, and actions to take if results showed some contaminants. We looked at the records between January and May 2017 and saw there had been no reported incidents of contamination.

## Environment and equipment

- The centre had three consulting rooms which could be used for patient assessments, private conversations and treatments. The centre complied with all 'Renal Care Health Building Note 07-01: dialysis unit requirements', including appropriate waiting areas, storage, dialysis station size and access to facilities such as toilets.
- The environment and equipment met patients' needs. The centre provided 20 dialysis stations and four isolation rooms. Each dialysis station had a reclining chair, dialysis machine, table and nurse call bell. All equipment was numbered to ensure it remained in the same location. There was plenty of space around each station to allow for patients, staff, and equipment.
- Emergency equipment was located in the main treatment area by the nurse's station. The resuscitation trolley contained all the required equipment including a defibrillator, to manage a medical emergency such as a cardiac arrest. We saw the trolley was secure and fully stocked and ready for immediate use. All equipment needed was available, as indicated by an equipment list. All consumables were in date. There was a system for checking these

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daily and we saw the fully completed records of checks. Staff checked the trolley on the days the department was open. The records clearly stated 'not in use' on the days the centre was not open.

- Fire extinguishers were serviced appropriately under a service level agreement (SLA) and were in prominent positions. Fire exits were clearly sign posted and exits were accessible and clear from obstructions.
- All patients had access to the nurse call system and we observed that systems were working at the time of inspection.
- Alarms on the machines would sound for a variety of reasons, including sensitivity to patient's movement, blood flow changes or leaks in the filters. We saw the alarms were used appropriately and not overridden by staff or patients. When alarms sounded we saw nursing staff check the patients and the lines before cancelling the alarms.
- The centre had three (one was faulty and awaiting repair) spare dialysis machines. A fourth machine was allocated for isolation purposes. All Diaverum centres used the same type of equipment; therefore another centre could provide equipment in an emergency.
- We saw there was adequate equipment to enable regular servicing and maintain full service. All dialysis machines were under manufacturer's warranty and maintained according to guidance. The manufacturer's attended the centre at regular intervals to complete routine servicing. In addition, reported faults were actioned in a timely manner. All equipment checked was logged electronically with a record sent to the centre manager detailing works completed. Staff were aware of the escalation process for the reporting of faulty equipment.
- We asked for evidence of the replacement programme for dialysis machines which should be replaced every seven to ten years or between 25,000 to 40,000 hours of use according to Renal Association guidelines. All of the machines had been replaced in December 2015 with new machines. We looked at five machines and saw they had been in use for less than 7,000 hours.
- All staff were trained on the equipment in use. Either Diaverum or external providers completed this as necessary. We saw equipment training records showed 100% compliance for all staff.
- All single use equipment was labelled accordingly, and disposed of after use.
- We saw the blood glucose machines were calibrated daily and the results were documented according to manufacturer's instructions. The machines are required to be calibrated periodically because there are variances in the test strips used which can make the results different between batches.
- The stock room appeared clean and tidy with shelving for all equipment. Fluids were stored on pallets off the floor. Stock was provided weekly and staff told us there were adequate supplies to ensure the service could continue if a weekly stock delivery was delayed.
- We saw the ambient temperature of the treatment area was recorded daily, and there had been no incidents where the temperature had been outside the recommended temperatures.
- Waste in the clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- Filled bin bags were removed to a secure unit outside of the building awaiting collection. We saw the clinical waste bags did not have tags or labels on them. HTM 07-01 states 'all clinical waste to be tagged or labelled in a manner that identifies the individual producer'. We highlighted our concerns to the manager who informed us an order had been placed for appropriate labels for this purpose. At our unannounced inspection we saw all clinical waste was appropriately labelled with tags and paper stickers to identify the individual provider according to guidelines.
- We had concerns in relation to some aspects of food hygiene and safety. The fridge in the kitchen, used to store patients food, and the fridge in the staff room were required to have temperatures recorded daily when the centre was open. Records showed in May 2017 the fridge in the kitchen was outside the



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recommended maximum temperature (8°C) on six occasions and the staff room fridge on five occasions. We saw when the fridge temperatures were out of range staff had not raised this through their reporting mechanisms.

- We highlighted our concerns to the centre manager regarding actions not being taken when fridge temperatures were out of range. The centre manager explained they were not aware of this and immediately checked the temperatures and reported to the maintenance department. We asked how they would ensure staff would action discrepancies in the future and we were told all staff would receive communication by email; this would be mentioned at the handover and would be an item on the agenda of the monthly team meeting. We saw this was discussed at the handover.
- At the unannounced inspection we saw the thermometers for the kitchen and staff room had been changed to ensure an accurate temperature was recorded. We saw the provider was in the process of providing training for all staff on food storage and handling. Included in this training was the appropriate action for staff to undertake when anomalies were noted when recording temperatures.

## Medicine Management

- Diaverum had a medicines management policy. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of medicines. However, the policy stated it was reviewed in April 2017 but did not state specifics regarding the document history as part of this review.
- The centre did not use or store any controlled drugs (CD's), medicines that are liable for misuse and have additional legal requirements regarding their storage, prescription and administration. The centre manager had lead responsibility for the safe and secure handling and control of medicines.
- There were a small number of medicines routinely used for dialysis, such as anti-coagulation and intravenous (IV) fluids. Medicines were stored in a large treatment room, which was secured with a keypad access door.
- We saw medicines cupboards and fridges were clean and tidy. We found all the items stored were within date and there was a system of monthly expiry date checks by registered nurses. We saw the completed monthly audits of the expiry dates for April, May and June 2017. These confirmed all stock was checked to ensure it was in date and recorded any medicines returned to pharmacies. Both referring trusts were designated a separate sheet.
- Medicines which were temperature sensitive were monitored closely. The medicines management policy gave guidelines for staff for action to take in the event temperatures were outside the required ranges. We saw the fridge and ambient room temperatures were recorded daily, and had been maintained within the recommended parameters.
- We saw sodium chloride (0.9%) stock, as a prescribed medicine, was stored in a locked temperature controlled cupboard. Guidelines state sodium chloride (0.9%) should be stored at room temperature (25°C). However, we saw supplies for each session were removed from the temperature controlled cupboard and left on a trolley in the treatment area which was not temperature controlled, until required for use for the patient. The temperature in the clinical area was not monitored and on the day of inspection we saw the temperature in the area was 27 °C.
- We highlighted our concerns regarding the storage of sodium chloride (0.9%) in the treatment area to the manager. At our unannounced inspection we saw the centre had changed practice and the sodium chloride (0.9%) was kept in the temperature controlled locked cupboard until required. Staff told us discussions were in process to devise methods for storing emergency supplies appropriately for easy access.
- The pharmacy departments from each referring NHS trust supplied medicines to the centre. Ordering of medicines occurred on a monthly basis or more often if required. Both trusts used internal couriers to deliver medicines to the centre. This meant a secure system of transportation of the medicines was in place. Upon arrival at the centre, the registered nurse would check the medicine against the order form to confirm it was correct. We saw the stock forms were kept at the centre.

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- Prescriptions were written by the consultants at the two referring NHS trusts. Medicines were reviewed at the quality assurance meetings for each patient. We saw prescription charts were clearly written, showed no gaps or omissions and were reviewed regularly.
- We saw staff ensured a patients identification was confirmed before all medicines were administered. This was achieved by confirming the patients name and date of birth.
- We saw sodium chloride (0.9%) was listed on the prescription charts 'sodium chloride 0.9% for injection 1000ml IV'. The sodium chloride was administered, as part of routine practice, as a 'prime' or 'bolus infusion'. Two nurses explained normal practice at the centre was to provide an online bolus infusion of sodium chloride (0.9%) if patients had a low blood pressure episode while on dialysis. This was recorded on the electronic record system.
- Nursing and Midwifery Council (NMC) standards (standard 1: methods) for medicines management state registered nurses must only supply and administer medicine products in accordance with specific processes including the use of patient medicines administration chart (prescription chart) or patient group directions (PGD). A PGD is a specific written instruction for the supply or administration of a licensed named medicine to specific groups of patients who may not be individually identified before presenting for treatment.
- We observed the PGD for one of the referring NHS trusts. The PGD stated medicines were to be administered by registered nurses only and included anticoagulant injections and named brands for adrenaline, antihistamine and corticosteroids.
- We saw both registered nurses and dialysis assistants administered medicines. Guidelines state a dialysis assistant can administer medicines providing they are appropriately trained, experienced and competency assessed. The responsibility remains with the registered healthcare professional (the nurse) as they are delegating the task and it is the nurses duty to ensure the dialysis assistant is sufficiently trained and competent to do the task. It is also the nurses responsibility to ensure that reasonable foreseeable harm does not occur to the patient in the event that the task is delegated. We saw the dialysis assistants had completed competencies for the administration of specific medicines.
- We saw staff prepared sodium chloride (0.9%) appropriately for three patients. However, we saw this was not checked by a second nurse on two occasions. Although it is not a legal requirement to have two registered nurses check at the point of administration, it is seen as good and safe practice when administering IV medicines. Standard 20: IV medication of the NMC medicines management states: 'wherever possible, two registered nurses should check medicines to be administered IV, one of whom should also be the registered nurse who then administers the IV medicine'. In addition, number 23 of the Diaverum procedure for medication administration, quoted standard 20 of the NMC medicines management for administering IV medicines.
- We saw medicine management was part of mandatory training for all clinical staff. This was updated every year and consisted of a two part on line course involving theory and a test . Training records showed us all staff had completed the update course at the time of inspection. Staff competencies in medicines management were completed every three years as according to Diaverum training and development policy and NMC medicines management guidelines.

## Records

- Patients' records were held both electronically and in paper format. Diaverum electronic record system recorded information downloaded directly from the dialysis machines and data recorded by nursing staff. We saw the electronic records detailed dialysis sessions by date and time. This meant any changes in treatment, any problems occurring during the session and any treatment changes could be easily identified. The electronic data was shared with the appropriate referring NHS trust. This meant the relevant consultant had access to the patient records at all times.
- The referring trusts had their own electronic systems. All staff who delivered patient care had an honorary contract in place with the referring trust, allowing access to their system. The trust's electronic system

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formed the main frame for access to all patient information and was visible to the multi-disciplinary team. Staff told us the system operated effectively as all people involved in delivery of the patient care had access, could do referrals, follow up and monitor progress of the patient.

- The paper records included the dialysis prescription, patient and next of kin contact information, and GP details. There were also nursing assessments, medicine charts, and patient consent forms. Paper records were colour coded according to the relevant referring trust. All seen were completed legibly and accurately. The individual patient file was kept by the patient during their dialysis session. When not in use, the active patient files were kept in a locked cupboard by the nurses station and inactive files kept in a secure storeroom.
- Paper and electronic records were available for all clinic appointments and quality assurance meetings. This meant the multidisciplinary team had access to the most up to date patient records when reviewing their care and treatment.
- We looked at 13 sets of patient records which were well maintained and easy to navigate. They were generally compliant with guidance issued by the NMC, the professional regulatory body for nurses. The records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received. All were completed with appropriate assessments, signatures and consent.
- Each patient was assessed and a care plan completed on admission to the centre. This established individualised goals for the patient and indicated the interventions required to be achieved. We saw the care plan was reviewed annually or more often if indicated by the patients' status, as according to Diaverum policy.
- The organisation's medical records policy (2016) defined the contents required in patient care records to ensure consistency. This included the patients' medical history and care plans. The policy coincided with the medical records initiation and maintenance policy. This incorporated the maintenance of medical records, discharge processes and the retention of medical records. The policy stated all data from

treatments must be entered onto the electronic system by staff by the end of each shift. In addition the medical records checklist should be used to perform regular audits of medical records.

- During our unannounced visit, we checked patient records and we viewed one 'do not attempt cardio-pulmonary resuscitation' (DNACPR) form. This complied with national guidelines. We saw all decisions were recorded on a standard form, signed by an appropriately senior clinician and evidenced that there had been discussion with the patient or relative. The form was kept in the front of the patient's notes.
- We saw patient records and dialysis prescriptions were audited every month. Data provided showed the audit of dialysis prescription for both quarter one and quarter two 2017, overall were 91% compliant. Audits for patient records for quarter one and quarter two showed the centre was overall 97% compliant. For any variance to the target to be achieved, an action plan was implemented. For example in quarter one 89% of records showed all entries were clear and easy to read. In quarter two the audit showed this had improved to 100%.
- Communication with the patients GP and any other service outside the trust network was carried out by the renal consultants.
- We saw information governance was part of mandatory training for all clinical staff. The annual training included data protection and Caldecott guardianship (the use of confidential health and care information). We saw training records showed us all staff had completed the update course at the time of inspection.

## Assessing and responding to patient risk

- Only stable patients were dialysed at the centre; if someone was acutely ill with renal problems they were treated at a main NHS hospital. This was to ensure patients who required additional support received their treatment at the local NHS trust where a nursing ratio was increased to ensure patient safety. In the year before our inspection, no patients had been transferred to an acute trust. This was less than the national average.

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- We found no staff had received training to recognise sepsis in patients despite the patients being a high risk group. This was not in line with National Institute for Health and Care Excellence (NICE) guidance NG51: sepsis recognition, diagnosis, and early management. Sepsis is a life-threatening illness caused by the body's response to an infection. We were told Diaverum was in the process of training staff in the recognition of sepsis and use of the national early warning score (NEWS). This monitors patients clinical observations, such as blood pressure and pulse. However, this training had only recently been implemented and all staff were required to be trained before using in practice.
- Staff followed the referring NHS trust sepsis guidelines, with any patients thought to be unwell. Nursing staff told us they would not commence dialysis if they suspected sepsis. They were referred directly to the NHS trust for an urgent medical review. Staff showed us and explained the sepsis pathway which was displayed on the wall in the treatment area.
- Nursing staff called the emergency services to assist with any patient who rapidly deteriorated during their dialysis session, for an urgent transfer to the local NHS trust. Staff told us the paramedic services were quick to respond.
- However, other effective systems were in place to assess and manage risks of deterioration to patients. Nursing staff used comprehensive risk assessments to review patients on a regular basis. We saw patient records showed a minimum of weekly risk assessments, which were repeated more often if required. This enabled staff to identify any deterioration or changes in patients physical condition.
- Nursing staff completed a full patient assessment based on the activities of daily living to identify the patient baseline condition on referral to the centre. The assessment included past medical history, mobility assessment, skin integrity assessment and dialysis access assessment. This information was used to plan treatments and attendance at the centre.
- Patients had clinical observations recorded prior to commencing treatment. This included blood pressure, pulse rate and temperature. The nurse reviewed any variances prior to commencing dialysis, to ensure the patient was fit for the session.
- Patients' blood pressures were recorded at regular intervals during their dialysis. Alarm settings were adapted for each patient, allowing any variance to the patients' normal readings to be highlighted to nursing staff.
- Patients weighed themselves before treatment began. They inserted an electronic card which identified them, into the electronic walk-on weighing scales. This was to establish any excessive fluid which had built up in between treatments.
- Patients with conditions such as Hepatitis B, tuberculosis, or advanced neurological conditions such as advanced dementia were not managed at the centre. Patients who required additional support received their treatment at the local NHS trust where the nurse to patient ratio was increased to ensure patient safety.
- Patients were required to confirm identity prior to treatment and medicine administration. This was completed by the patient being asked to give their name and date of birth which was checked against the patient record, the dialysis or medicine prescription or dialysis card. In addition all patients records contained photographic identification of the patient.
- Each referring trust had a dedicated renal consultant who visited the centre every two weeks. Treatment was reviewed and changes could be made. These visits were to conduct clinics for planned patients as well as seeing patients who would benefit from a consultation.
- We saw there was adequate resuscitation equipment and it was easily accessible. Staff knew where it was located.
- All staff received training in basic life support and anaphylaxis. The course was completed every year and included practical sessions. Records showed us all staff had completed the update course at the time of inspection.

## Staffing

# Dialysis Services

- The centre employed 3.6 whole time equivalent (WTE) registered nurses (two full time, two part time and two on a zero hours' contract). There were six WTE dialysis assistants (three full time and five part time). In addition the centre employed 4.6 WTE health care assistants (three full time and two part time).
- The centre had one whole time equivalent (WTE) vacancy for a dialysis nurse at the time of inspection. Two dialysis nurses had left the service in the previous 12 months and one had joined the service.
- There were no vacancies for dialysis assistants and health care assistants (HCA's). Three HCA's had left the service in the previous 12 months and three had joined the service.
- The average sickness absence over the three months before inspection was 2.1% for registered nurses, 9.1% for dialysis assistants and 7.3% for HCA's. The national average sickness is between 3 and 4%.
- We saw the nursing rota confirmed staffing numbers were consistent and maintained the appropriate ratio. During the inspection, we saw there were three registered nurses and three dialysis assistants on duty which maintained the ratio of four patients to one nurse. These staff worked long days and were also joined by two health care assistants who worked an 11am to 7pm shift to provide assistance.
- The centre manager worked predominantly Monday to Friday supporting staff and was supernumerary (not included in the nursing rota).
- On each shift a member of staff (either the centre manager, deputy manager or a senior staff nurse) was nominated as the 'nurse in charge' who was supernumerary to staffing numbers during the week, and included as part of the rota on a Saturday. The 'nurse in charge' role was highlighted on the duty rota so staff were aware of the role prior to attending for duty. The role of the nurse in charge was to support staff, patients and ensure the safe running of the centre.
- The Diaverum policy and procedure on staff rostering outlined how the headcount and WTE numbers were to be calculated and managed at centre level. The centre manager was trained in rostering and used the headcount guidance tool to support with maintaining safe numbers. Business Continuity Plans were developed so the organisation could effectively respond to changing circumstances, for example sickness, absenteeism and workforce changes. Agency and bank nurses were used when required to maintain safe staffing levels.
- In the three months before our inspection six dialysis nurse shifts were covered by bank staff and 89 shifts were covered by agency staff.
- We saw the unit received assurances from the agency used for nursing staff. This included proof of minimum one year of renal experience, training, qualifications, disclosure and barring service (DBS) check, immigration status, professional registration and details of induction.
- The centre did not employ any doctors; a renal consultant from the referring NHS trust attended the centre every two weeks to review patients who were there that day. If doctors were needed outside of this, renal doctors at the NHS trust could be contacted by phone or email.
- Staff recognised the need for an effective handover between shifts. We saw this was attended by all staff on duty to enable them to review the patients visiting the centre on that day. The handover included any changes in treatment, condition or outcome of investigations and appointments.

## Major incident awareness and training

- All staff received fire awareness and evacuation training. The course was mandatory and completed every year. Records showed us 94% staff had completed the course at the time of inspection.
- We saw in the entrance to the centre the fire evacuation plan was displayed and the centre had a nominated fire warden for when the centre was open. The fire officer visited the centre regularly to check compliance and the environment.
- The centre had effective adverse event policies and procedures in place for the loss of heating, power supply failure, staffing shortages, water supply failure and information technology (IT) failure. Each procedure detailed relevant contact numbers; actions expected by staff of each grade and expected interactions with the referring NHS trusts services.

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- Diaverum had an internal alerting system which automatically notified senior managers of the implementation of any adverse event pathway. This was completed and accessed through email.
- We saw there was a process in place which meant when any adverse event was resolved; an investigation into the cause would be completed. If the recovery procedure was found to be inadequate, an improvement plan would be implemented. Outcomes of the investigation and any learning were shared with staff through a debriefing session.

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

### Evidence-based care and treatment

- All policies and procedures were developed in line with national guidance, standards and legislation. This included guidance from the Renal Association, National Service Framework for Renal Services and the National Institute for Health and Care Excellence (NICE).
  - Patients were assessed using risk assessment tools based on national guidelines and standards. This included falls risk assessments, nutrition scores and skin integrity assessments.
  - We saw the information technology system used enhanced the collection of data and ease of monitoring. This was largely due to the Diaverum system uploading data collected during dialysis to the referring NHS trusts databases. Similarly, staff at the centre were able to access all records at the NHS trusts; reducing time spent chasing blood and test results.
  - Staff monitored and recorded patients' vascular access on a vascular access chart. Vascular access is the term used for access into a vein, for example, a dialysis catheter. Recordings detailed the type of access, appearance and details of any concerns. Each category was given a score of nought for no issues and one for issue identified. Any patient scoring one or more were referred immediately to the local NHS trust for review and possible intervention. This was in line with NICE Quality Statement (QS72) statement 8 (2015): 'Haemodialysis access-monitoring and maintaining vascular access'.
- The referring NHS trusts were responsible for the creation of fistulas; staff at the centre were responsible for monitoring them. A fistula is a special blood vessel created in a patients arm, called an arteriovenous fistula (AV fistula). AV fistulas are regarded as the best form of vascular access for adults receiving haemodialysis. This is because they last longer, and have less risk of complications than other types of vascular access. The centre monitored the AV fistulas which formed part of the NICE Quality Statement (QS72) statement 4 (2015): 'Dialysis access and preparation'. We saw more experienced staff were responsible for cannulating patients with less established fistulas.

### Pain relief

- None of the patients we spoke with required pain relief at the time of our inspection. However, we observed staff asking patients about their pain levels.
- We saw patient's pain relief needs were assessed and managed appropriately. Patients did not routinely receive oral analgesia during their dialysis sessions; however, local analgesia was available for cannulating the patients' arteriovenous fistula or graft (AVF/G). Needling is the process of inserting wide bore dialysis needles into the AVF/G, which some patients find painful.
- Local analgesia was prescribed as a 'to be administered as necessary medicine', which enabled it to be used at each attendance to the centre. If the pain related to the patients' general condition, they were reviewed by the consultant as soon as was possible. Patients who required an urgent review for pain management were referred to their GP or the local acute trust depending on the severity.

### Nutrition and hydration

- Patients who have renal failure require a strict diet and fluid restriction to maintain a healthy lifestyle. We saw patients' hydration and nutritional needs were assessed and managed appropriately.

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- Patients were reviewed by the dietician monthly, who assessed their past medical history and their treatment plans to advise patients on the best diet for them. We saw patients were provided with written information and guidance relating to their diet and fluid management.
- Patients were weighed on arrival to the centre at each visit. This was to identify the additional fluid weight that needed to be removed during the dialysis session. This varied from patient to patient.
- Patient records showed us all patients were assessed using the Malnutrition Universal Assessment Tool (MUST) at least weekly. Any patients identified as being at risk were referred to the dietician for a review.
- Patients were offered hot and cold drinks and pre prepared sandwiches or biscuits while they were having their treatment. Patients told us they also bought their own refreshments to consume whilst having their treatment.

## Patient outcomes

- The centre did not directly submit data to the UK Renal Registry; this was undertaken by the 'parent' NHS trusts. The data from the centre was combined with the NHS trusts data and submitted as one data set.
- There was an audit calendar which detailed audits which should be completed daily (patient admissions), weekly (empty dialysis slots, patient treatment numbers and hand hygiene) and monthly (Hepatitis vaccination data, dialysis record audits and prescription delivery). The audit calendar included the report process and the online address where all records were analysed. This information was fed into the organisational database to produce a dashboard of compliance. We saw the centre met all key performance indicators.
- Clinical outcomes for renal patients on dialysis can be measured by the results of their blood tests. The blood results were monitored on a monthly basis as directed by the NHS trusts. Results were collated on the computer database used at the centre. The data was available for the centre manager and consultant to review so they could see individual patient outcomes.
- The results show how the centre performs in the achievement of quality standards based on UK Renal Association guidelines. We reviewed results of blood tests for three months from March 2017. These comprised of a number of standards, for example: two standards we looked at show how much waste products are removed from the patient and how effective the dialysis is. This shows the rate blood passes through the dialyzer over time, related to the volume of water in the patient's body (expressed as 'eKt/V  $\geq$  1.2,h') and the Urea Reduction Ratio (URR). On average just over 81% of patients had effective dialysis based on the first standard. We could not establish how this compared to a national average.
- For the URR, Renal Association guidelines indicate a target of 70%. The average URR for the patients at the centre from March 2017 was 96%. Patients with these levels of waste reduction through dialysis have better outcomes and improved survival rates.
- We also looked at the standards indicating patients' haemoglobin (Hb) was at safe levels. Anaemia can be a complication of renal failure and dialysis associated with increased risks of mortality and cardiac complications. From March 2017, the average number of patients with the NICE recommended target of Hb (100-120 g/l) was 57%. This meant the other patients had lower Hb levels. Where patients had low levels they were given injections of a stimulating agent to help their body produce more blood cells.
- Potassium levels in the blood are monitored as part of a renal association standard. From March 2017, an average of just 4% of patients had high levels of potassium (greater than 6.0 mmol/l). If potassium levels are higher than 6mmols, it can cause acute cardiac problems. This means around 96% of patients had potassium levels within acceptable ranges.
- From March 2017, we saw 90% of patients who attended three times a week were dialysed for the prescribed four hours treatment time. This is better than the minimum standard of 70%.
- In the 12 months before our inspection, the average number of patients with an arteriovenous fistula (AV fistulas) was 67%. This was below and therefore worse than the Renal Association guidance of 85%.

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Other types of vascular access used were grafts (8%) and catheters (25%). The decision for the type of vascular access used was decided by the referring NHS trusts.

- NICE quality standards (QS72- standard 6) indicates adults using transport services to attend for dialysis are collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis. The quality standard indicates dialysis providers should collect evidence at centre level to ensure the standard is being met. The provider was unable to provide data relating to this standard when requested.

## Competent staff

- Staff in the centre had the relevant qualifications and memberships appropriate to their position. There were systems which alerted managers when staff's professional registrations were due and to ensure they were renewed. These were demonstrated to us.
- All staff were supported by the Diaverum practice development nurse (PDN) and the centre manager to ensure the maintenance of standards and competence. The PDN attended the centre regularly to assist with mandatory and as required training.
- On commencement of employment, staff were given a bespoke training plan depending on their level of experience and qualifications. This included an orientation programme and competencies which were based on the national standards framework.
- All new staff were allocated a mentor, a senior nurse who had an appropriate renal qualification. The mentors trained new nurses in cannulation technique. This included a period of observation for the nurse to gain confidence. Staff told us they were encouraged to tell senior managers if they did not feel confident.
- There was a comprehensive training programme available for staff. Registered nurses and dialysis assistants were required to complete a series of mandatory clinical competencies, to support their role and responsibilities. All staff had completed the basic dialysis programme, relevant to their role, at the commencement of employment.
- Specific competencies for the administration of medicines were updated according to Diaverum

training and development policy and Nursing and Midwifery Council (NMC) medicines management guidelines. Competencies were completed at commencement of employment and then updated every three years. We reviewed five competency files of registered nurses and dialysis assistants based at the centre. We saw the competencies were last completed in 2015.

- The duty roster was created to ensure there was always a senior member of staff on duty. Therefore, staff had constant access to a more experienced member of staff. Due to working in an isolated unit, not attached to a local NHS trust, staff were responsible for the management of any untoward incident or emergency. Staff were trained to manage situations like these by the centre manager and PDN.
- Permanent and agency staff were recruited through the central human resources department. Assurances were received for all staff. This included training, qualifications, disclosure and barring service (DBS) check, immigration status, professional registration and details of induction. All agency staff used completed an induction to the centre. This included emergency procedures (fire safety, evacuation and resuscitation equipment and procedure) and equipment training in line with safe working practices. We saw evidence of this induction was kept by the centre.
- Data showed all staff had received an appraisal in the 12 months before inspection. All staff we spoke with told us they had received an annual appraisal. They told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with the NMC.
- All staff at the centre had allocated 'link roles' for specific topics such as infection control or health and safety. The link persons attended regional meetings and brought information, for example changes in practice and updates, back to the centre staff. We were told the Diaverum network enabled staff to meet regularly with other centres to capture ideas.

## Multidisciplinary working

- The two referring NHS trusts provided all specialist support for patients with the exception of nursing staff who were employed by Diaverum. Staff told us the



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renal consultants from the relevant acute NHS trusts had overall responsibility for patient care and visited the centre every two weeks to complete a clinical review of patients.

- The trust's consultants and dietician attended monthly multidisciplinary meetings at the centre. These meetings were also attended by the centre manager and senior nurse on duty. We saw the meetings followed a set format where patients' current condition, care plans, most recent blood results and medicines were discussed and recorded in the electronic patient record. Any changes were communicated to the wider team and discussed with the patient before implementation.
- Patients had access to a dietician who reviewed each patient monthly, prior to the multidisciplinary team meetings. This enabled an informed discussion about planned care and treatment. Any changes to patients' diets were recorded on information leaflets which were given to patients.
- Patients had access to a social worker advisor who visited the centre and assisted with any financial advice, benefits claims and helped inform patients of their entitlements. Patients we spoke with us told us this service was helpful.

## Access to information

- All information needed to deliver effective care and treatment was available to staff through either the electronic or paper records. Paper records consisted of all patient risk assessments, consent forms and dialysis and medicine prescriptions. Electronic records including records from the referring NHS trusts and blood test results, were accessible to all staff attending the centre.
- The consultants from the referring NHS trusts were contactable by email and phone. Staff were aware of the contact numbers and had confidence to contact the consultants if required.
- Staff working within the centre had honorary contracts with the referring NHS trusts which allowed them to access the hospital's electronic patient records (EPR). This meant staff had access to the latest information regarding patient treatment plans, blood and test results and multidisciplinary notes.

- Data collected during dialysis was automatically uploaded into the relevant trust's databases, which meant the records were contemporaneous and accurate at the time of review. The compatible information technology systems allowed all staff to access relevant information about all patients.
- Patients and their GP's received copies of their multidisciplinary notes on the day of the meeting. This included any detailed changes to treatment or medicine, which needed to be implemented.
- We saw the centre shared information to send with a patient when they went for treatment to another centre whilst on holiday. This was to ensure care and treatment would continue.

## Equality and human rights

- As part of our inspection we asked for evidence the centre met the 'Accessible Information Standard'. From 1st August 2016 onwards, all organisations that provide NHS care were legally required to follow the Accessible Information Standard. The standard aims to make sure people who have a disability, impairment, or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services.
- We found the service took into account the needs of disability, race, religion and sexual orientation. Reasonable adjustments were made for disabled service users, for example the installation of ramps, wheelchair access, toilets and moving and handling equipment. Adjustments to the service were also made for vulnerable patients, for example those living with dementia and learning difficulties.
- Patients with complex needs were assessed by the referring NHS trusts prior to making a referral to the centre for treatment to ensure they received their care and treatment in the most appropriate location. We were told the majority of patients who required additional support received their treatment at the NHS trusts where staffing numbers were higher.
- Staff and patients told us the centre was flexible in scheduling of treatment sessions to facilitate individual patients work, religious practices and social needs.

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- The Workforce Race Equality Standard (WRES) is a requirement for organisations which provide care to NHS patients. This is to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The centre employed a culturally diverse range of employees to reflect this. However, the centre did not provide plans in place to implement the WRES requirement when requested.
- We saw Diaverum had introduced equality and diversity training which was to be completed every two years. This training had been introduced in January 2017 and at the time of the inspection 63% (12 staff), including the centre manager, had completed the training.

## Consent, Mental Capacity Act and Deprivation of Liberty

- Consent to treatment means a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.
- All staff were fully aware of their roles and responsibilities in relation to the requirements of consent. We saw patients were asked for verbal consent at the start of each dialysis session and for any treatments or care during their attendance at the centre.
- We saw each patient completed consent forms for the completion of treatment and for dialysis. This consent form was filed in the patient paper records and updated annually.
- Each paper record contained photographic identification of the patient. We observed there was a positive patient identification process in place and we observed staff using this on all occasions. We looked at 13 patient records. All had photographic identification with the patient's name, date of birth, centre and NHS number.
- Staff were aware of mental capacity assessments, and how they would escalate any concerns to promote safe care and treatment. We were told patients who were suspected not to have capacity to consent to

treatment were discussed with the relevant consultant. The patients would be reviewed as a matter of urgency and a mental capacity assessment completed. In these cases the consultant would speak with the patient's family, following a best interest decision. Staff referred to implied consent, with patients attending the centre in their own free will for treatment.

- Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. The safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. Staff were aware of DoLS, but had not experienced any situation where a referral needed to be made.
- Diaverum was in the process of ensuring all staff received training with respect to the Mental Capacity Act 2005. This training was to be completed every two years by all staff. At the time of inspection 63% (12 staff), including the centre manager had completed the training.

## Are dialysis services caring?

### Compassionate care

- We saw staff treating patients in a kind and considerate manner. Patients told us staff always treated them with dignity and respect.
- Staff maintained patients' privacy and dignity. All information was treated as confidential. Special arrangements were in place to facilitate private discussions and consultations with the patient.
- Patients received treatment in shared areas. The centre did not have curtains around the dialysis stations. However, screens were available for use if a patient wanted privacy.
- Patients told us, and we observed, call-bells were left within reach of patients and were answered promptly. In addition we saw staff respond promptly to requests for assistance.
- We viewed comment cards we had sent to the centre to be anonymously filled in by patients before our inspection. Out of six cards, five were positive and one card contained negative comments. Positive comments included: "I couldn't ask for better

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treatment”, “Staff are always caring, friendly and helpful” and “At all time the staff complete tasks with consideration for the patients’ needs”. The negative comment was by a patient who considered the centre to be understaffed and the existing staff were under immense pressure and stress.

- We saw the results of the patient satisfaction survey for quarter four, 2016. Out of 97 patients 57 participated in the survey and the results were mainly positive about the service received. We saw 87% would recommend the centre. Comments left by patients predominantly focused on transport complaints (10), waiting to start treatment (nine) and complaints regarding shortage of staff (eight).
- In addition the patient satisfaction survey contained written comments by patients. These included “very pleased with all the staff and the treatment given to me”, “Thanking everybody for all the help”, “The service is very good, all the nurses are very kind” and “Apart from the transport the service is great”.
- The provider told us the service received 25 written compliments in the 12 months before inspection. The centre recorded the compliments and we saw these included monetary donations, thank you cards, cakes and chocolates for the staff.

## **Understanding and involvement of patients and those close to them**

- On referral to the centre, patients were encouraged to visit the centre for an initial assessment and a look around. On arrival, staff gave patients information packs about the centre, which detailed what to expect from the service and information on haemodialysis. Patients and their relatives were encouraged to spend time with the staff and other patients to ensure they were satisfied with the centre before agreeing to start treatment at the centre.
- Patients new to dialysis were given additional time and support by staff prior to commencing treatment. Information leaflets were used by staff to inform patients of side effects and common risks and benefits of treatment. These were discussed throughout the patients visit to the centre.
- Patients and their relatives were encouraged to participate in their treatment if appropriate. Staff

encouraged patients to take responsibility for parts of their treatment, such as weighing themselves before and after dialysis, inputting data to the dialysis machine, preparing needles and connecting dialysis lines. Nursing staff and relevant patients told us patients liked to have some control over treatment received.

- Staff told us they saw their patients frequently and they were familiar with their moods and were able to identify when patients were having a bad day or were feeling unwell. This enabled them to spend additional time with the patients as necessary to support them with their treatment or assist with any concerns they may have.
- Patients we spoke with were aware of the links between other clinical conditions and their renal failure. For example, a patient spoke to the inspection team about the management of their diabetes and the input and information received from the dietician.
- All patients were reviewed at least monthly by the consultants and dietician which enabled discussions of any concerns, medicines or treatment changes. Following each meeting, patients were given a printed summary of the discussion and any planned changes to treatment.
- We saw staff spoke openly about treatments provided, the blood test results and dialysis treatment plans. We observed patients speaking to staff about their latest blood results and what these meant and staff responded appropriately.
- We saw patients were fully informed of their blood results at each dialysis session. Patients spoke with the nurses about the impact of their blood results and whether any changes would be made to their treatment. We saw any changes made to treatments were written and given to patients to ensure they were informed of the reasons for the change.

## **Emotional support**

- The social and emotional aspect of care for the patient was managed by the relevant professionals and professional bodies. Senior staff told us the centre

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worked in partnership with a social worker and renal psychologist who were based at the renal units of the referring NHS trusts. They could arrange for relevant support for patients.

- Staff told us where any social needs were identified, the patients GP and community social services are contacted.
- Staff received regular training from trust counsellors, social workers and the conservative management team to enable them to identify patients' emotional needs. Protocols and pathways were in place which supported staff in decision making and early referral.
- Peer support groups such as the Kidney Patient Association (KPA) were actively involved and offered access to support services for the patient, family members and carers.
- The KPA also funded annual social events for both patients and families and this promoted good emotional support. Activities such as Christmas dinners, raffles, an Easter bunny run and days out were some of the activities arranged by the staff.

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

### Service planning and delivery to meet the needs of individual people

- The centre provided disabled access, wheelchair accessible toilets and a selection of mobility aids. We saw hoists were available for patients who could not transfer onto chairs or beds and wheelchairs were used to assist patients to and from their transport.
- Staff told us about adjustments which could be made for someone living with learning disabilities or who were living with dementia; they could have someone with them during treatment. We saw the centre had a specific patient handbook to provide information for those living with learning disabilities.

- If translation or interpreting services were needed, for example, for someone who was deaf and used British Sign Language to communicate; or a non-English speaker, this would be arranged by the referring NHS trust.
- There was a hearing loop available to assist patients who were hard of hearing.
- Facilities were provided to support patients comfort. These included electrically operated dialysis chairs which could be adjusted, and pressure relieving mattresses were on the chairs. Wheeled tables were positioned at each station for ease of use.
- Patients had access to a personal television and Wi-Fi during their dialysis sessions. We saw patients brought books to occupy their time. Each station had a ceiling mounted television for individual patient use.
- The centre was involved in the 'shared care' programme. This included working with a university hospital with teaching sessions over a four month period. Both registered nurses and dialysis assistants attended the course. We were told the centre had 12 patients appropriate for the self-care programme and at the time of inspection three patients were completely self-caring.
- Staff told us one of the referring trusts had started advance care planning for relevant patients. A specialist nurse and a consultant visited the centre every three months for this role. Advance care planning included the patient's individual wishes and the completing of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) if appropriate. The other trust did not have a set agenda at the time of inspection but staff told us consultants would see specific patients for this purpose if highlighted by staff.

### Access and flow

- Patients were assessed for their appropriateness to attend the centre by the two referring NHS trusts. Only chronic, long-term dialysis patients were referred to the centre for treatment. Patients attending the centre received their initial dialysis at the referring NHS trust. This was to ensure patients were stable during their treatment before being treated at the centre, therefore reducing the risk of any untoward incidents.

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- When a patient was identified as being suitable to attend the centre, a referral was completed and an assessment visit arranged. Patients attended the unit to have a look around and meet the staff. This gave staff the opportunity to complete the initial risk assessments and collect patient details and consent. Once the patient had agreed to attend the centre, the referring NHS trusts arranged transport, if required, and ensured medical notes were available. If there was no capacity to accept the referral, the patient was placed on a waiting list.
- Ten patients were on the waiting list for dialysis treatment at the time of inspection. Diaverum worked closely with the referring trusts to meet the increasing demands of patients on the waiting list. The patients were sent to a temporary centre or remained at the main hospital until a slot became available. There was constant communication between the consultants, lead renal nurse and the centre about which patients should receive priority once there was capacity.
- When emergency admissions or transfers occurred the acute team accommodated the treatment until a permanent slot was made available to the patient. However, due to high demand on the service and limited availability, patients could be expatriated for an undetermined period of time and a priority transfer list was agreed by the trust's renal service managers and the lead renal consultant. Options for increasing capacity, development of new facilities and exploring other methods of increasing capacity options (for example, home therapies and, nocturnal shifts) were reviewed periodically and capacity discussions took place on a regular basis with the referring trust.
- Staff told us they were flexible as far as possible to accommodate patient wishes and other commitments for the days or sessions they attended for treatment. For example patients who worked preferring an evening slot.
- The level of utilisation of capacity in the service for the three months before inspection was 67%.
- The service cancelled 18 planned dialysis sessions for non-clinical reasons in the 12 months before inspection. These were due to failure of the water

treatment plant. All 18 patients were facilitated with sessions on different shifts either at the centre, at another Diaverum location, or the trusts' main dialysis units.

- Data showed 132 planned dialysis sessions were delayed by the service for non-clinical reasons in the 12 months before inspection. These were all due to machine breakdown or other equipment failure.
- All appointments with the consultant or dietician were scheduled for the same day as the patient's dialysis sessions to prevent multiple attendances at the centre.
- At the time of inspection the centre was unable to accept referrals for out of area patients due to capacity.

## Meeting the needs of local people

- Dialysis services were commissioned by NHS England. Patients were referred to the centre by two local NHS trusts. Senior staff told us Diaverum met with commissioners in order to plan services for patients. This ensured the needs of local people were met.
- The centre was on one level with a reception area, clinic rooms, dialysis stations and a service corridor. Each area was secure with electronic pass access. Patients arriving in the reception were required to be buzzed in through a secure door from the car park. This area had a camera to enable staff to identify callers upon arrival. The service corridor contained all treatment storage, water room, staff room, changing facilities, maintenance room and dirty utility room.
- The building met most of the core elements of provision for dialysis patients. (Department of Health Renal care Health Building Note 07-01: Satellite dialysis unit). This included level access and dedicated parking facilities. There was space for transport services to drop off and collect patients.
- Access to the facility was by established routes with bus stops in close proximity. Most patients used hospital arranged transport to and from the centre. A small portion of patients used private transport and designated parking was available. Ambulance access was available and we saw a designated drop off base was at the entrance.

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- The transport service had defined key performance indicators that the service was evaluated against by the transport group. The patient transport service had an appointed area manager who oversaw the service level agreement and daily operation of the transport service. The trusts had designated transport teams who formed part of the transport group which involved representatives from the ambulance service, patients and the transport provider.
- The transport group were involved in transport surveys and collated feedback to patients. The group also gave feedback and recommendations to the commissioners about improvements that could be made to the service.
- The responsibility for all operations complaints rested with Diaverum operations director. These were escalated and the nursing director was responsible for all complaints escalated. The centre manager was responsible for the management of all complaints before escalation.
- We saw complaints were reviewed and formally discussed as part of the quality management review meeting. The numbers of complaints were reviewed every three months by the senior management team and board of directors.
- Verbal acknowledgement of the complaint was required within 2 days and a full response was given within 20 working days unless ongoing, then a response was given within five days of a full investigation being completed.
- The service received 51 written complaints in the 12 months before inspection. Of these, four were managed under the formal complaints procedure and these were all upheld. We reviewed these complaints and saw the centre responded in a timely and appropriate manner.

## Learning from complaints and concerns

- Patients who had concerns about any aspect of the service received were encouraged to contact the centre in order that these could be addressed. All staff were encouraged and empowered to identify and address any concerns or issues while the patient was still in the centre.
- When a patient was transferred to the service, both the patient and family received a patient booklet that included information about the complaints policy and procedure. An explanation of how complaints could be made was given to the patient. Patients were made aware of response times and how the complaints escalation pathway worked.
- The centre had a copy of the complaints policy displayed in the waiting area, in addition to information leaflets about other organisations such as the Patient Advice and Liaison Service (PALS), Kidney Patient Association (KPA) and the referring trusts complaints management system. Feedback boxes were available in the patient waiting area. These were designed for patients or family members who wished to remain anonymous.
- Where there were concerns or complaints related to the service delivered, the service encouraged transparency and openness so the service user was able to express their opinions. We saw the contact details of senior management members, who were contactable at any time, were displayed in the patient waiting area.

## Are dialysis services well-led?

### Leadership and culture of service

- Diaverum had an organisational structure, which included a managing director, supported by a director of nursing and operational manager, in addition to financial, commercial and operational clinical divisions. Staff were divided into three regions nationally and each area had a practice development nurse and a manager.
- The director of nursing, practice development nurse and operational manager from Diaverum were present during the inspection. It was clear from their interactions and knowledge of staff they had regular contact with staff of all levels.
- Leaders of Diaverum and the centre had the appropriate skills and knowledge to manage the service. The centre manager reported directly to the area manager for the south region who reported to the

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Diaverum operations director. Locally the centre manager was supported by a deputy manager, nursing staff, dialysis assistants, health care assistants and an administrator.

- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in all areas of the service. Staff told us they could approach immediate managers and senior managers with any concerns or queries.
- We were told the organisation strived for a culture of openness, candour and honesty. Leaders were visible and approachable to service users and staff, including the UK senior leadership team.
- We saw the senior nursing staff at the centre held or were working towards specialist renal nurse qualifications, held teaching certificates and had completed management courses.
- Locally the manager showed strong leadership and professionalism. All staff told us they were an excellent role model for the staff and worked above and beyond expectations. Staff reported the manager was approachable and responsive to any needs. This included assistance with clinical practice or personal support.
- Staff told us the centre was a good place to work, everyone was friendly, they had sufficient time to spend with their patients and they were proud of the work they did.
- Staff had monthly meetings. We saw a different member of staff was allocated as 'chair' for each meeting and this was planned for the year. The meetings had a set agenda and incidents, complaints and updates were discussed. Incidents were also discussed at handovers.
- However, we asked the provider to demonstrate how they were working to collect data according to the Workforce Race Equality Standards (WRES). Any independent unit which undertakes work for the NHS that generates an income of over £200,000 in any 12 month period is obliged to collect and publish data. This includes, but it is not limited to, the ethnicity of its staff and the positions held by those staff. The provider was unable to provide data relating to this standard when requested.

## Vision and strategy for this core service

- Diaverum's vision was to be the 'first choice in renal care' with a mission to improve the quality of life for renal patients. They had a care concept which was based on the approach to improving patients' lives, by providing the best treatment, and patient choice. Locally the team were aware of the vision and spoke openly about providing patients with the best care possible.
- There was an effective strategy for the delivering of quality care, with policies, guidance and procedures based on national guidelines. Staff understood this strategy.
- Performance was monitored through an organisational dashboard.

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

- Governance is a term used to describe the framework which supports the delivery of the strategy and safe, good quality care. We were assured there was an effective governance framework in place. Systems were in place to effectively manage risk and safety. There was understanding by senior centre staff and corporate processes had been put in place and maintained.
- The renal consultants from both referring acute NHS trusts were the leads for governance and quality monitoring for the service at the centre.
- Quality assurance was monitored by Diaverum centrally through regular audits. Staff guidance and procedures were based on national guidance and considered when completing staff training and workforce planning.
- Minutes from meetings showed the centre manager met with senior managers from other Diaverum centres every four months. This enabled a service review to discuss the key performance indicators (KPI) relevant to the two acute trusts the patients were referred from. We saw areas discussed included updating information technology, policies and staff training.

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- Data collected by the centre was inputted into the renal registry by the local NHS trust. This information was validated.
- Risk was managed at all levels of the organisation. Diaverum had an overarching risk register in place which covered clinical, operational, human resources and financial risks. The register contained risk ratings and subsequent mitigating actions.
- We saw the risk register specific to Crawley Kidney Treatment Centre. The register contained three risks. The first risk related to facility management and was described as a risk due to the increased number of outpatient clinic patients accommodating the reception area of the centre. The risk of overcrowding could obstruct the correct evacuation procedure in case of an emergency, for example a fire. The overall risk level was 'tolerable' (risks must be reduced as far as practicable). The mitigating actions recorded related to staff received regular fire training, fire alarms and detectors maintained and in place, and discussions with trusts to spread out the outpatients clinics in the five days to reduce the overcrowding of patients. The risk had a nominated individual and its status was active.
- The second risk on the register related to the recruitment of healthcare professionals due to vacancies. The overall risk level was tolerable. The mitigating actions were using temporary staff to facilitate the correct nurse to patient ratio. The responsible team to remedy the action was the corporate human resources team; its action status was in progress and risk status as active.
- The third risk related to the water treatment plant owing to multiple incidents of breakdowns. The overall risk level was tolerable. The mitigating actions were to follow the business contingency plan according to policy. The nominated individual was the centre manager; its action status was in progress and risk status as active.
- We reviewed the minutes of the monthly corporate board of directors meetings between August 2016 and January 2017. Standard items discussed included operational updates, human resources, clinical updates, incidents, audits and staff training. Actions required were nominated to a responsible person with a date to be achieved by. For example, the minutes of the January 2017 meeting showed incidents reported were discussed regarding shortened and missed treatments. We saw it was agreed the action required was for future meetings to include a report showing trends and history to gain learning. The action was allocated to the nursing director.
- Information from the Diaverum board was shared directly with staff working at the centre through emails and verbal feedback at team meetings. We saw the organisational leads were visible and included staff in all plans for development or change.

## Public and staff engagement

- The service engaged with key stakeholders as part of continuous quality improvement. The key stakeholders were the referring NHS trusts, patients and staff. We were told the organisation strived for an open culture where feedback, ideas for improvement and escalation of concerns were all encouraged. We saw processes were in place to foster high levels of engagement and included patient survey's, direct access for patients to senior managers, suggestion boxes and feedback cards prominently displayed, engagement with local, regional and national Kidney Patient Association advocates and an annual staff engagement survey.
- Patient satisfaction surveys were completed every six months and managed by an external agency. The survey was based on the Friends and Family Test (a single question survey introduced into the NHS which asks patients whether they would recommend the service received to friends and family) and allowed for anonymity for responders. The aim of the survey was to identify what was important to the service user, and identify areas for improvement. An action plan was developed with the patients' needs at the centre of the plan. The action plan was evaluated over a defined period to measure its effectiveness. The outcomes and action plan were made available to all service users and staff.
- We saw the action plan developed after the patient satisfaction survey for January to March 2017. The plan included two areas of improvement which were waiting times and patient involvement. The action plan for patient involvement comprised monthly



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discussions of results with patients in relation to their dietary needs, medication, monthly blood results and co morbidities. Further training was available for staff. Staff told us they were given the opportunity to work closely with a more senior nurse who supervised reporting and further discussions with patients.

- We were given examples of service improvements as a direct result of input from service users. These included following feedback from patients regarding waiting times for treatment. The service conducted a full time and motion study over a two week period, which led to changes being made to schedule times and transport provision, with a significant improvement in waiting times. The service temporarily opened a twilight shift on a Tuesday, Thursday and Saturday for a single patient, who for a specific personal reason could only dialyse at that time for a specific period.
- An annual staff survey was completed. The results of the 2016 survey showed a positive score of 3.6 out of five. The questions which scored highest were 'I know

what is expected of me in my job' (4.1) and 'In my daily work, I contribute to the achievement of the company goals' (4.4). The survey showed a score of 3.4 for 'I would recommend Diaverum as a place to work'.

- Staff told us they enjoyed working at the centre and felt the team and patients were an extension to their family.

## **Innovation, improvement and sustainability**

- Staff told us there were opportunities for development and the unit had a training budget. The unit manager told us staff came to them with suggestions for training, and if they could justify why it would be beneficial to the unit, they would approve funding.
- Patients were encouraged to participate in their own dialysis, and were trained to complete specific aspects of their dialysis if they wished. This included anything from weighing themselves, preparing their own dialysis machine or needling their own arteriovenous fistula.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure staff receive training to recognise sepsis in patients in line with national guidance.

### Action the provider **SHOULD** take to improve

- The provider should ensure two registered nurses check IV in line with policy and national guidelines.
- The provider should have plans in place to implement the Workforce Race Equality Standard (WRES) requirement.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <ul style="list-style-type: none"><li>• No staff had received specific training to recognise sepsis in patients despite the patients being a high risk group. Treating sepsis in patients receiving dialysis may differ from usual management intervention.</li></ul> <p>Regulation 12(2)(a)</p>