Fresenius Medical Care Renal Services Limited

Sparkhill Dialysis Unit

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Sparkhill Dialysis Unit is operated by Fresenius Medical Care Renal Services Limited. The service has 24 dialysis stations including four isolation rooms. There are three rooms for consultations and one meeting room. Dialysis units offer services which replicate the functions of the kidneys for patients with advanced chronic kidney disease. Dialysis provides artificial replacement for lost kidney function.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the unit on 3 August 2021.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We rated it as requires improvement because:

- Staff did not complete risk assessments when using bed rails with patients. Not all staff were fully compliant with infection prevention and control processes. Staff did not respond to one dialysis machine alarm, although they could see the patient from their location. We observed once instance where medicine administration was not done safely.
- Staff did not support patients who did not speak English to give informed consent to treatment.
- Staff did not always follow provider policies when delivering care and treatment.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service mostly controlled infection risk well. Staff kept good care records. They mostly managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and advised them on how to lead healthier lives. Key services were available to suit patients' needs.
- Staff treated patients with compassion and kindness, mostly respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis services	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Sparkhill Dialysis Unit

Sparkhill Dialysis Unit is operated by Fresenius Medical Care Renal Services Limited. The service opened in 2011. It is a private unit delivering NHS care in Sparkhill, Birmingham, within a residential and business area.

The unit primarily serves the communities of the surrounding local areas. It also accepts patient referrals from outside this area, if required. The unit offers holiday dialysis sessions. The main referral point is from University Hospitals Birmingham NHS Foundation Trust.

The clinic was set up for patients who are clinically stable and safe to dialyse in a nurse led, outpatients setting.

The unit operates two dialysis sessions, morning and afternoon, Monday to Saturday. The unit opens on Sundays to cover Christmas and New Year closures only.

The unit has 24 dialysis stations in total, including four isolation rooms. At the time of the inspection, 94 patients were registered to receive treatment at the unit.

The service has two current registered managers. One has been in post since 2011, the second since 2018.

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

How we carried out this inspection

We inspected this service on 3 August 2021. The inspection team comprised of one CQC inspector and one specialist advisor. An inspection manager oversaw the inspection off site.

During our inspection we spoke with eight staff members and a staff member from the referring NHS trust. We spoke with three patients. We reviewed seven patient records and seven staff records. We observed one huddle and observed episodes of care and treatment.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure all patients are given the opportunity for informed consent. For example, the use of interpreters as necessary. (Regulation 11(1))

Summary of this inspection

- The service must undertake risk assessments before using bedrails with patients and ensure patients or their families consent to this in line with the referring trust's policy. (Regulation 12(2a))
- Staff must follow provider policies when delivering care and treatment. (Regulation 17(1))

Action the service SHOULD take to improve:

- The service should ensure staff maintain their competencies when following infection prevention and control processes. (Regulation 12(2h))
- The service should ensure they attend to all dialysis machine alarms during treatment sessions. (Regulation 12(2b))
- The service should consider securing the IT room off the patient waiting area.
- The service should consider the use of patient photographs in patient records as an extra means to identify patients receiving treatment.
- The service should consider using one of the available privacy screens every time a patient requires this.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dialysis services	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Dialysis services

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

Are Dialysis services safe?

Requires Improvement

We rated it as requires improvement.

Mandatory training

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

Staff received and kept up to date with their mandatory training. We saw all staff, except one person who was absent from work, were up to date with mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. The clinic manager kept an up to date log of training compliance and sent reminders to staff who were due to complete training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service provided treatment for patients who were over the age of 18. People under 18 did not access the clinic.

Staff received training specific for their role on how to recognise and report abuse. The clinic manager was trained to level three in safeguarding adults and level two in safeguarding children. They were the local safeguarding lead for the unit. All other clinic staff were trained to level two in both safeguarding adults and children. This level of training was role appropriate and in line with the Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate Document (2018) and Safeguarding Children and Young People: Roles and Competencies (2019) for Healthcare Staff Intercollegiate Document.

Staff could access provider wide named safeguarding leads who were trained to level four should they require specialist advice. Staff knew how to make a referral according to local policy.

The safeguarding policy covered both adults and children and was in date. This policy included information on Prevent, the government strategy to protect people at risk of radicalisation.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff described the signs which may indicate a patient was at risk of abuse or harm.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Information for staff and patients was visibly displayed which showed the details of local authorities, and the unit local safeguarding lead.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. All the areas we visited in the unit, with one exception, were visibly clean. The one exception was one of the toilet doors in the patient waiting area was visibly dirty with what appeared to be red/brown stains. We raised this with the clinic manager who arranged for this to be cleaned.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. A third-party company undertook routine domestic cleaning. Healthcare assistants and, at times, nurses undertook clinical cleaning duties such as cleaning dialysis stations in between patients.

Staff completed a deep clean of every dialysis machine on a fortnightly cycle. The machines were heat disinfected after each treatment, and staff did a weekly disinfection.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). We saw all but one staff member following infection control principles. Staff wore PPE as necessary. Staff wore shoes which could be easily disinfected in between shifts.

We observed one staff member to enter an isolation room in which a patient with a BBV was dialysing. They did not put on the full suite of PPE (mask only, no gloves or apron) when attending to the patient and did not wash their hands after this contact. They gelled their hands on exiting the room.

Hand hygiene audits demonstrated general compliance to all opportunities to use hand hygiene measures. Audit results were discussed in team meetings, including required improvements and learning.

When nurses connected and disconnected patients from the dialysis machines, they were required to use a technique similar to the 'aseptic non touch technique' (ANTT) to prevent the transmission of infection to patients' access site. We observed five episodes of care where this technique was used. We found some staff did not consistently follow the principles of ANTT which increased the risk of infection transmission. For example, one staff member did not wash their hands before putting on their gloves and they touched 'dirty' areas (such as the dialysis machine) then touched items in the 'clean' field without changing gloves therefore contaminating sterile equipment. Although audit results from May to July 2021 showed 100% compliance.

Staff worked as per the Department of Health guidance regarding COVID-19. Patients did a Polymerase chain reaction (PCR) screening test for COVID-19 weekly. Results were returned within two days.

Every person who attended the clinic, including staff, patients and visitors had their temperature taken on arrival. This was logged, and all individuals were asked to declare if they had any symptoms of COVID-19 or had been in recent contact with someone who had tested positive. If a patient was identified as having symptoms, they were sent to dialyse at the referring trust until clear. When this occurred, the staff member taking the temperature would not look after any other patients and would take additional lateral flow tests to check their COVID-19 status. Staff told us some patients took paracetamol before arrival to lower their temperature, therefore enabling them to dialyse at the unit. Staff had taken action to address this including re-taking temperatures during dialysis and advising patients not to do this.

We saw a plentiful supply of antibacterial hand gel in all areas of the unit except the bottle which was in the entrance. This was almost empty; however, there was a further full bottle within two metres.

Most of the patients we saw wore face masks when in the clinic. This was clearly embedded as staff did not have to prompt any patients.

Staff worked effectively to prevent, identify and treat dialysis access site infections. Staff completed assessments for each patient at each dialysis session to asses patients' access points. We saw evidence of staff escalating patients to the referring trust's renal assessment unit, or directly to the renal ward, if concerns were identified. From February to August 2021, two patients were identified to have an access site infection. Both were treated at the referring trust.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well. However, one lockable room was left unsecured.

The design of the environment followed national guidance such as Health Building Note 07-01: Satellite dialysis unit. For example, the water plant area had flooring designed to prevent or slow down the progress of potential flooding in the event of overflow.

All patients were visible to staff, even when staff were not in the same room.

Only staff and official visitors could access the waiting room and the clinical area. A CCTV system was in place to identify patients and visitors, so staff were aware of who was in the building. This meant staff could ensure different cohorts of patients were not mixing (for the purposes of COVID-19) and also to ensure patients were not left unattended with dialysis machines or medicines.

The waiting area had been re-modelled to encourage social distancing. Some chairs had been removed to avoid patients sitting too closely together. Staff had placed 'X' marks on the floor to indicate the amount of personal space each patient should have when waiting.

Staff carried out daily safety checks of specialist equipment. Staff checked the water used for dialysing regularly.

The service had suitable facilities to meet the needs of patients' families. However, at the time of inspection, due to the COVID-19 pandemic, families were not permitted to attend treatment sessions unless there was a specific need.

The service had enough suitable equipment to help them to safely care for patients. The unit had 31 dialysis machines in total.

Data from the service showed nine of the 31 machines were out of date for their service; they had been due in July 2021, and as of 10 August 2021 had not been completed. However, each service date could be extended by two weeks which meant the machines were still in the acceptable range. Data from the service showed all outstanding machines were services by 24 August 2021; the delay was linked to illness within the staff group at the third-party servicing company which had limited routine maintenance work.

Technical support was always available for the dialysis machines and the water treatment plant.

The water treatment plant room was monitored to ensure the temperature was within range. We checked from January to July 2021 and found all checks had been recorded appropriately.

Staff had immediate access to emergency resuscitation equipment located in the clinical area. All pieces of equipment checked were in date and staff completed daily and weekly checks. The suction machine and defibrillator were recently serviced and in date with routine maintenance.

Staff used wipe clean privacy screens around patients' stations as necessary. The service had four available. These had temporarily replaced the use of curtains around the stations during the COVID-19 pandemic as an extra precaution to prevent the transmission of infection.

Routine disposable stock was managed by the health care assistants. The storerooms were tidy and well organised. We sample checked a variety of stock products and found all were intact and in date.

The fridge used to store patient blood samples were temperature monitored daily. Staff were aware of how to escalate concerns such if the temperature fell out of range.

We observed staff using hoist equipment to support a patient onto a bed. Staff used the equipment appropriately and carefully as directed.

Staff disposed of clinical waste safely. Clinical waste bins were collected twice weekly and were secured away from patients and the public.

Substances subject to control of Substances Hazardous to Health (COSHH) regulations were safely stored in line with requirements. For example, flammable substances were stored in metal cupboards to reduce the risk of spreading fires. Risk assessments were in place for all relevant products such as dialysing fluids and cleaning products.

We observed the IT server room, located just off the patient waiting room, was unlocked despite a sign saying, 'no unauthorised personnel'. Due to the location of this area, away from the reception desk, there was a risk a patient could enter this area unobserved.

Fire extinguishers checked were serviced and in date.

We checked a range of electrical equipment and found they had all been safety tested within required timescales.

Assessing and responding to patient risk

Requires Improvement

Dialysis services

Staff did not complete bed rail risk assessments as per national guidance before using these. However, staff completed and updated all other risk assessments for each patient and removed or minimised risks. Staff mostly identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health. Staff used standardised clinical observations, such as temperature and blood pressure, to monitor patients and identify deterioration. Observations were taken before, during (up to three times) and after dialysis. Staff recorded the observations on the patients' electronic record. We saw when the electronic record was not working, staff were able to use paper-based records to enable regular monitoring of patients.

When connecting patients to dialysis machines, staff engaged with them and asked relevant questions regarding health, weight and fluid levels. Staff checked the identification of patients before connecting them to a machine for prescribed treatment.

Dialysis machines had alarms to indicate any clinical changes such as low blood pressure. We observed one patient's machine to alarm. The patient silenced the alarm, and no staff member attended to check the patient. At this point, staff could see this patient to identify any obvious deterioration; however, could have missed more subtle signs of deterioration. Staff attended to all other patients when their machine alarmed during our inspection.

If staff identified a patient was deteriorating, they took appropriate action such as calling for an emergency ambulance to go straight to an emergency department or calling patient transport to take the patient to the local renal assessment unit for less urgent concerns. Staff gave an example of a patient who had a cardiac arrest at the unit. Staff undertook cardiac compressions at the unit whilst awaiting an emergency ambulance. The patient was quickly transferred and survived the episode.

Staff were trained in basic life support and anaphylaxis to support patients with urgent needs. At the time of our inspection, all staff except one who was on maternity leave were up to date with this training.

Staff had access to the provider policy relating to managing deteriorating patients.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. Staff completed falls risk assessments, moving and handling risk assessments and pressure ulcer risk assessments for each patient. These were updated regularly. We saw personalised emergency evacuation assessments (PEEPs) were completed where appropriate to support patients to evacuate in the event of a fire.

Where patients had scored as a higher risk of harm on any risk assessments, we saw actions were mostly in place to mitigate the risk. For example, patients assessed as having a high risk of developing tissue damage or pressure sores were provided with special pressure relieving cushions and encouraged or supported to adjust their position regular. We saw some falls risk assessments where no specific actions were set to minimise the risk. However, staff were aware of who had a higher falls risks and took some actions to prevent these. For example, patients at risk of falls were placed, where possible, on dialysis stations nearest to the nurses' station. This meant staff could easily observe these patients more regularly and provide assistance quickly. Healthcare assistants knew which patients needed support when moving within the unit. Staff were aware of incidents such as recent falls outside of the clinic.

The service had four beds to use for patients who needed these. We observed staff to put bed rails up to prevent a patient from falling. The risk assessments should be undertaken by staff trained to do so. During the inspection we

found staff did not complete bed rail assessments which meant patients could be at risk of harm from inappropriate use. We requested the provider policy around bed rails and were sent a copy of the referring trusts' policy. This clearly stated assessments should be completed before using bedrails and consent for their use should be sought. Therefore, staff did not work within this policy. After our inspection, managers from the service told us they were had started to train staff to undertake bed rails assessments in line with this policy.

We saw one staff member did not use the 'chevron' technique when taping the needle connecting the patient to the dialysis machine. This method means it is less likely that the needle will become dislodged from a patients' arm causing bleeding. We raised this at the time, and the staff member demonstrated an understanding both of the technique, and the need to use this consistently.

Staff shared key information to keep patients safe. Staff attended a huddle twice a day which was led by a senior nurse. This included healthcare assistants. The staff discussed patients receiving treatments, any incidents and actions which needed to be completed such as specific blood tests. We observed a huddle and noted staff had a good knowledge of the patients dialysing at the unit.

Staffing

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

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service was staffed to maintain a ratio of one nurse to four patients. This was in line with best practice guidance as per Renal Workforce Planning Group 2002.

The number of nurses and healthcare assistants matched the planned numbers. Where necessary the manager requested bank staff to support the unit. Bank staff, in the main, had substantive posts at other local dialysis clinics under the same provider therefore were familiar with the policies and procedures. Where staff were absent at short notice, such as on the day sickness, the unit manager worked clinically to make up nurse numbers and support the team.

Managers made sure all bank and agency staff had a full induction and understood the service. We checked three files for temporary staff and saw all had received an induction and were familiarised with the service.

The service had low vacancy rates. The service had recently recruited nurses to meet the staffing requirements of the unit.

The service had low turnover rates. The staff turnover rate was 2.7% for the previous 12 months as of August 2021.

The service had low sickness rates. The staff sickness rate for the clinic was under 5% for the previous 12 months as of August 2021.

Records

Requires Improvement

Dialysis services

Staff mostly kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

During the inspection we reviewed seven patient records.

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely. The records were both paper based and electronic. The paper-based records contained risk assessments, consent forms, the patient's initial admission form, personal emergency evacuation plans (PEEPs), sepsis risk assessment paperwork and signed disclaimers where patients had signed to end treatment sessions early.

The electronic records contained dialysis prescriptions, incidents relating to each patient and clinical observations. Staff from the referring trust were able to view this information remotely. Staff at the unit could access relevant patient information from the referring trust.

Staff did not consistently update falls risk assessments with required actions to support patients. However, staff were aware of who had a higher falls risks and took some actions to prevent these.

The paper records were stored in lockable filing cabinets behind the nurses' station. This was not locked during our inspection as the cabinet was in regular use. In addition, the area was not left unattended or unobserved.

We saw patient records did not contain photographs of patients. Whilst this is not a legal requirement, it can be seen as good practice as it provides another form of identification and recognition of patients; particularly when using non-regular staff.

Senior nurses undertook audits of patient records. The audits included checks for assessments being updated and clinical observations being recorded. We reviewed a range of these from May to August 2021. All audits reviewed showed 100% compliance.

When patients transferred to a new team, there were no delays in staff accessing their records. This unit was used as a temporary unit for some patients who were awaiting a long-term dialysis slot at their chosen clinic. Patient records were transferred across quickly including when the receiving unit was run by a different provider.

Medicines

The service used systems and processes to safely prescribe, record and store medicines. However, systems and processes when administering medicines were not always followed.

Staff mostly followed systems and processes when administering medicines. We observed one instance where a staff member administered an iron infusion medicine intravenously. The nurse did not check the medicine dosage or expiry date, nor did they check the patient's identify before administration. This meant there was a risk the medicine may have been incorrect for that patient. This was not in line with the provider policy.

Staff followed systems and processes when safely prescribing, recording and storing medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed updated prescriptions and administered medicines to support patients with diabetes and anaemia in addition to dialysis specific medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff stored medicines appropriately and monitored the fridge and ambient room temperature.

Medicines were stored in locked cupboards, which were within a locked storeroom. A nurse on shift always kept the keys on them.

All medicines checked were within their expiry date.

Portable oxygen cylinders were stored safely and contained enough oxygen to be used when required.

Staff at the unit received training each year to be able to administer the general flu vaccine under patient group directions (PGD).

Staff followed current national practice to check patients had the correct medicines. Consultants at the referring trust updated prescriptions every three months for each patient as a minimum. If changes were required sooner than this following monthly blood tests, the consultants actioned these and shared the information with the staff at the clinic. All prescriptions we reviewed were within the three-month timescale.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. When medicine pathways were changed nationally, staff were updated. Where patients were still on older pathways, this was reflected in monthly quality assurance meetings.

Incidents

The duty of candour regulation was not always carried out as per provider policy. However, the service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. We reviewed a range of incidents that had been reported within 2021. These were appropriately reviewed and investigated as necessary.

Staff understood the duty of candour regulation however it was not always carried out in accordance with the provider policy. Staff told us about the duty of candour and understood the principles of this. We saw one example where the duty of candour was appropriately applied following a patient fall with harm in 2020. However, we found another incident which occurred in June 2021 graded as moderate severity and duty of candour had not been applied.

Managers debriefed and supported staff after any incident. Most staff received feedback from investigation of incidents. Incident investigations and action documents showed managers spoke with staff to share learning and updates. However, staff told us they were not always informed of actions taken after every incident, particularly incidents where patients had been aggressive towards staff. Staff met to discuss the feedback and look at improvements to patient care. Managers discussed incidents in regular team meetings. We saw evidence of provider wide learning bulletins where serious incidents had occurred. These were circulated to local managers who implemented actions including sharing the information with staff.

Requires Improvement

Dialysis services

The service had no never events since opening. Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Are Dialysis services effective?

Requires Improvement

We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff delivered high quality care according to best practice and national guidance. Staff assessed patients access points using nationally recognised assessment tools such as the British Renal Society vascular access tool.

Patients were encouraged to undertake 'shared care' training. This meant patients learnt how to do aspects of their care independently such as taking their own blood pressure or weighing themselves. Staff worked through a structured training programme with patients who wished to do this to ensure patients were competent.

During the inspection, we mostly observed staff to display competency when undertaking clinical activities, and to adhere to best practice guidelines. This included 'needling' (inserting a needle into an arteriovenous fistula or graft to connect the patient to a dialysis machine) and disconnecting patients from dialysis machines. However, we observed one occasion where a staff member did not secure a connecting needle to a patient using the 'chevron' technique which is recognised as the most effective way of preventing needle dislodgement. We discussed this with the staff member who immediately realised the concern and identified what should be done differently.

At quality assurance meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. This meant information was escalated to the referring trust who provided a renal psychological service.

Staff used technology effectively to support care and treatment. For example, all patients had an individual card which sorted their treatment details on it. This uploaded information to the dialysis machine to support accurate treatment.

Nutrition and hydration

All patients had access to dietitians.

Specialist support from dietitians was available for all patients as per national guidance. Dietitians from the referring trust attended the service to see patients, assess dietary needs and provide advice and guidance on renal diets.

Written information about renal diets was available in a variety of languages for patients to read and take home.

Staff provided patients with water, hot drinks and biscuits whilst dialysing. Patients could bring their own food to treatment sessions if they wished to eat something different.

Pain relief

Staff gave pain relief to ease pain.

Where prescribed, patients received pain relief. If patients chose to, they could request their GP prescribe pain relief such as numbing cream for their access point. This meant the patient would experience less pain when nurses inserted needles during connection to dialysis machines.

Patient outcomes

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

Outcomes for patients were positive, consistent and met expectations, such as national standards. The British Renal Society sets out a standard that at least 80% of dialysing patients should have definitive access because they last longer than any other dialysis access types, are less prone to infection and clotting. At the time of our inspection, the clinic had 36 patients with a central venous catheter (CVC) 54 patients with an arteriovenous fistula (AVF) and five patients with arteriovenous graft (AVG) access (an arteriovenous graft is another form of dialysis access, which can be used when people do not have satisfactory veins for an AV fistula. This meant 62% of patients had definitive access (AVF or AVG). We explored the reasons behind 38% patients having CVCs and found this was based on clinical decision making from the referring trust. For example, where a patient was unable to have an AVF or AVG.

The service exceeded the minimum treatment effectiveness (haemodialysis adequacy) as specified within national guidelines as per The National Kidney Foundation. Data demonstrated the unit performed well against the reduction of urea as a key performance indicator.

Data demonstrated the unit performed well against renal guidelines in relation to monitoring the volume of blood cleared of urea within the time spent on dialysis.

The National Kidney Foundation guidelines specify patients should receive at least 12 hours of treatment per week to maximise effectiveness. Data from the service showed five patients routinely chose to reduce their time spent dialysing. Where this happened, staff asked the patients to read and sign a disclaimer which explained the impact of reducing treatment time. Staff updated the trust when patients regularly chose to reduce their treatment time, and staff developed individual patient plans to manage this.

The provider benchmarked clinics against each other to determine internal performance. The clinics were measured against different perspectives including patient, community, staff and stakeholder perspectives. For April, June and July 2021 we saw this unit came in the top five clinics overall. In particular the unit consistency scored very highly against ‘patient perspective’ and was rated the top clinic in April 2021. The UK figures were also compared to the provider’s clinics in northern Europe for July 2021. We saw the Sparkhill Unit achieved higher than average scores for four out of the five measures demonstrating good compliance to the provider’s expectations.

Data from the service showed all available staff attended a meeting ran by the unit manager to develop an action plan to improve patient experience after the most recent patient survey. Staff clearly identified the areas which were to be improved and created a robust action plan to improve performance.

The referring trust collated patient outcomes following blood results and submitted these to the renal registry. As these results were collated with those from other satellite units, it was not possible to identify individual performance against other individual units.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. These included hand hygiene audits, patient record and documentation audits and ANTT audits. Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits. Minutes from team meetings showed staff were kept up to date with most recent audit results. The manager shared actions and learning. Improvement was checked and monitored.

Competent staff

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

We reviewed seven staff files during our inspection. Four were permanent staff and three were for bank/temporary staff.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff completed competency training relevant to their role. We saw this was updated within provider timescales to ensure staff maintained their skills. Staff were up to date with their competency training despite the COVID-19 pandemic.

Managers made sure staff received any specialist training for their role. Seven nurses had completed the recognised renal qualification. This equated to over 50% of staff. We saw a newly recruited nurse had been booked onto the course for 2022.

Managers gave all new staff a full induction tailored to their role before they started work. This included bank and agency staff.

New nursing staff undertook a programme which enabled them to undertake dialysis specific competency training and to work supernumerary for a set period. This could be tailored, for example if a nurse had already completed competency training elsewhere, they may not need to complete all modules.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisals were planned in advance and staff agreed a date and time. At the time of our inspection, 84.2% of staff had received an appraisal. Overdue appraisals were scheduled to be completed by the end of August 2021.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The manager attended a monthly safeguarding supervision meeting where relevant cases were discussed in order to develop learning.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. During the COVID-19 pandemic, team meetings and 'face to face' training were conducted by tele or videoconferencing. The manager told us this had led to a better attendance at team meetings as it allowed more flexibility. Staff who attended meetings or training from home, due to not being on shift, were paid for their time.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Senior staff at the unit attended a monthly quality assurance meeting which included trust consultants, dietitians and other relevant professionals.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff could refer patients to a third-party service which provided social support, such as financial or housing support. If staff identified patients were experiencing mental ill health, they could raise this with the referring trust who had access to renal psychological support.

Staff at the clinic had direct links with dialysis access specialists at the referring trust, and the renal assessment unit. This meant any concerns or problems could be quickly escalated and resolved.

Staff could access either a renal consultant or an on-call registrar at any time for advice and guidance.

The referring trust had various professionals who worked well with staff at the unit to deliver coordinated care.

Patients had their care pathways reviewed by the relevant consultants. Staff took monthly blood samples and discussed the results with consultants at the monthly quality assurance meeting.

Staff at the clinic could share information with staff from the referring trust and vice versa through the electronic patient record systems. This enabled timely review of updates and information for each patient to be completed.

Staff kept copies of letters from consultants to patients in patient records. These were also shared with patients' GPs to ensure shared knowledge of the patients' care and treatment plans.

Seven-day services

Key services were available seven days a week to support timely patient care.

The service opened between 7.30am to 6.30pm Monday to Saturday. Patients could attend either a morning or afternoon slot for their scheduled treatment sessions. Most patients attended three times per week as per their treatment plan.

The service did not routinely open on Sundays; however, opened on Sundays to cover Christmas and New Year closures.

Staff could call for support from doctors, dietitians and the satellite co-ordinators at the referring trust at all times the clinic was open. Staff could access the safeguarding leads and clinical support from the provider at any time.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on the unit. We saw literature was available for patients to support a healthier lifestyle. For example, we saw a poster about renal diets displayed in a range of languages.

Staff recorded aspects of patients' health within admission assessments such as smoking status so they could be offered support if wanted.

Staff encouraged patients to become vaccinated against COVID-19 and flu. The referring trust provided COVID-19 vaccinations within the clinic to all patients who wanted them. Clinic staff encouraged patients to have the vaccine to protect their health.

The satellite coordinator at the trust trained clinic staff to be competent to administer general flu vaccines every year. This helped keep patients safe and minimised the number of medical appointments needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not support all patients to make informed decisions about their care and treatment.

Where patients spoke English and had capacity, staff gained consent from patients for their care and treatment in line with legislation and guidance. However, staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005, although staff had access to a provider wide policy which clearly outlined this. Most patients had the opportunity to give informed consent. We saw signed copies of consent to receive dialysis treatment within patient records. We observed three occasions where we were not assured patients had been given the opportunity to give informed consent, or this had not been recorded appropriately.

One patient had a lasting power of attorney (LPA) for health in place since September 2020 enabling a designated relative to make decisions about medical treatment. At the time of inspection, this patient displayed signs of a lack of mental capacity to give their own informed consent. Staff told us this was normal presentation for this patient. When we reviewed the consent forms from 2021, we saw these had been signed by the patient, despite concerns over capacity. The person with the LPA had not signed these to demonstrate they had made an informed decision about care. Similarly, an 'early termination of treatment against medical advice' form (a form patients are asked to sign if they choose to not complete their full treatment time) was signed by the patient and not by the person with LPA. This demonstrated staff were not aware of how to gain legal consent for treatment when a patient had an LPA for health in place. Despite this, staff were actively working to support the patient to return to hospital-based dialysis where the patient's needs could be better met.

Requires Improvement

Dialysis services

Staff did not always make sure patients consented to treatment based on all the information available. The other two occasions where we were not assured informed consent was given was in the case of two patients who both spoke very little English. The consent form for both starting treatment at the unit, and to share information were written documents in English. Both patients had signed the document to say they had read and understood the information. Although an area was available for interpreters to counter sign if used, these boxes were not completed, and in one case had 'n/a' (not applicable) written in. We spoke with staff who told us they did not use interpreters when gaining consent to treatment. Instead family members or staff who spoke the same language were used. There was no evidence to suggest family members or staff had provided any language interpretation of the risks and benefits of treatment for the patients. We checked the provider policy relating to use of interpreters. This clearly outlined a qualified interpreter should be used when gaining initial consent to treatment and during consultant appointments. The provider consent policy did not specify interpreters must be used but highlighted the importance of providing information to patients who did not speak English in a format they understood.

Staff clearly recorded consent in the patients' records. In all records we checked, consent documents were filed including where patients had signed disclaimers to end their treatment sessions early.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff were up to date in mandatory training which covered the Mental Capacity Act, Deprivation of Liberty Safeguards and Equality and Diversity.

Are Dialysis services caring?

Good

We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. Most staff took actions to respect patients' privacy and dignity.

Most staff were discreet and responsive when caring for patients. However, we observed two occasions where screens could have been used to protect the patients' dignity. On one occasion, a staff member was connecting a patient to a dialysis machine by a central venous catheter (in the chest). Most of the patient's chest was exposed during this time. Another occasion, a patient was hoisted into bed. Whilst staff did this very kindly and in a caring way, a screen would have helped to maintain the patient's privacy. We did see screens in use on other occasions.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff told us they enjoyed working with patients and providing care.

Staff including the manager knew all the patients dialysing at the clinic and were able to talk about each patient knowledgably. Staff took time to get to know patients.

Staff we spoke with told us they loved working with their patients and enjoyed providing care.

Requires Improvement

Dialysis services

Patients said staff treated them well and with kindness. Patients told us they were happy coming to the unit for their dialysis and felt the staff provided a caring service. We saw evidence of two patients who chose to stay with this unit rather than attend their original choice due to the caring nature of the staff.

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, staff ensured two enclosed communal areas containing dialysis stations were separated by gender to support women who preferred to be in an area with other women.

Some patients preferred to have a male/female nurse work with them due to cultural preferences. Where possible staff accommodated this.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff spoke with patients about how they were feeling and escalated this to the referring trust as necessary.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Data from the service showed staff escalated patients to the referring trust who were identified as requiring extra emotional or psychological support.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients told us they felt included in their treatment and decisions about care. Each patient had a named nurse who was their main link with the clinic.

As discussed in 'effective', following a recent patient survey, staff tried to improve patients' understanding of their medical condition and treatment. Named nurses were tasked to give patients weekly updates and information. The named nurse was responsible for updating patients on their blood test results, prescription changes and any other aspects of the patients' care or treatment.

When discussing day to day issues, staff talked with patients, families and carers in a way they could understand. When patients did not speak English, or had additional needs, staff spoke with family members.

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

Requires Improvement

Dialysis services

Patients gave positive feedback about the service. We saw a range of 'thank you' cards and letters sent in by patients and relatives, highlighting the caring work of the staff.

The clinic scored within the top five for patient communication against all other provider clinics in the UK. In April 2021, the unit was the number one clinic for this measure.

Are Dialysis services responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

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

The service worked closely with the referring NHS acute trust to deliver a service which was suitable for the local population. The service also worked with the local ambulance trust which provided the patient transport services for many patients in order to plan care.

The local area was very culturally diverse, and staff were responsive to specific requests around this. The service had three communal areas; one was in front of the nurses' station, the other two were separated by clear glass. Staff ensured patients in the enclosed communal areas were segregated by gender in response to requests by patients. Where this was not possible for any reason, staff spoke with the individual patient and sought to support them to meet their cultural needs while still receiving treatment.

The facilities and equipment were suitable for bariatric patients and patients with limited mobility.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff referred patients onwards if required; for example, to a third-party organisation who supported patients with social and welfare concerns.

Staff supported patients who wanted to dialyse elsewhere on holiday, or people attending the local area and wanted to temporarily dialyse at Sparkhill Dialysis Unit.

The service took patients who were on a waiting list to dialyse permanently at other clinics. Therefore, they catered for several patients who only intended to attend Sparkhill Dialysis unit for a short period of time until a slot became available elsewhere.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted. Staff contacted patients who did not attend appointments. If the reason for the missed session was due to patient illness, staff referred the patient to either their GP or the referring trust. Staff then re-booked the patient to make up their missed session as soon as possible. If a patient chose not to attend the additional session, staff alerted the referring trust.

If staff were unable to contact a patient who had not attended, they followed the process of alerting the referring trust and asking police to conduct a welfare check. The manager told us the local police had said it was not in their remit to carry out welfare checks; however, the unit still requested these as part of the provider process on protecting vulnerable patients.

Meeting people's individual needs

The service was inclusive and mostly took account of patients' individual needs and preferences. However, they did not always arrange appropriate interpretation services or consider the risk of using family members for this task. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Where staff identified patients' cognitive impairment was declining, they referred the patient for assessments at the referring trust. Due to the setup of the satellite clinic, such as a nurse led outpatient setting, it was not suitable for patients who needed significant extra support.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to an 'accessible information policy'.

All doors within the clinic had signs indicating the room or areas' use. The signs were written in English and Braille to support patients who used this form of communication.

When patients started treatment at the unit, staff completed an admission assessment form. This included a psychosocial assessment including any mental health conditions, patients' social and living status and their general lifestyle. This assessment also included information about how well patients could understand and speak English. Where patients spoke little or no English this was documented, although in one record we saw the language most used by the patient was not documented. We found staff did not always arrange interpreters when required as directed by the provider policy. Interpreters were not routinely provided when taking consent to treatment and consent to store and share personal information. Staff told us family members or staff who spoke the same language would be used instead; however, we did not see evidence any interpretation (formal, staff or family members) was used. It is not appropriate to use family members as they may not understand the information being given and therefore misinterpret it to the patient. In addition, patients may be at risk of abuse or harm from family members; not providing an independent trained interpreter removes the opportunity to speak openly to the patient. Not all staff being used to translate were fully fluent in the language they were using. This meant, again, information could be misinterpreted.

The service had information leaflets available in languages spoken by the patients and local community. This was an improvement since our last inspection where none were available. We saw a range of information booklets and posters in different languages which represented common languages spoken by the local community. Posters which asked patients to alert staff if they needed an interpreter were displayed in a range of languages.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. Sparkhill Dialysis Unit took patients who were on a waiting list to dialysis at other satellite units. This meant patients could dialyse in a community setting whilst awaiting a permanent placement without having to attend hospital.

Patients could attend the unit as soon as they were referred and accepted as suitable. There was no waiting list to dialyse at this location.

Managers and staff worked to make sure patients did not stay longer after treatment than they needed to. The manager had regular meetings with the local NHS ambulance trust to discuss issues and concerns regarding patient transport delays.

Due to the COVID-19 pandemic, changes had been made to the way patients were transported to and from the clinic. For example, previously several patients could travel in the same vehicle. However due to social distancing, this was no longer possible. This had impacted upon patient arrival and collection times.

When patient transport was delayed when collecting afternoon patients after treatments, staff had to stay late to ensure the patients were safe. As this was a regular occurrence, the staff rota was adapted so staff knew what hours to expect and they would be paid for their time.

Some patients chose to end their treatment sessions early due to patient transport delays. Where this occurred, staff asked patients to complete a disclaimer form and alerted the referring trust.

We requested data about patient transport times to identify how many patients were transported out of timeframes as set by national guidance. The NHS ambulance trust providing the patient transport service held this data therefore we were not able to review this.

When patients had their treatments cancelled or delayed at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Data from the service showed four incidents from January to July 2021 where treatments were delayed or stopped. These were all due to equipment faults which were rectified as soon as possible.

Staff supported patients when they were referred or transferred between services. Six patients were transferred directly from the service to an acute hospital from January to July 2021. There were no themes identified, all were individual cases. Staff made appropriate transfers and reported each as an incident.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Details of how to make a complaint about this service, the referring trust and the ambulance trust delivering the patient transport was available in the patient waiting room. Posters were displayed explaining how to make a complaint or raise a concern.

Requires Improvement

Dialysis services

Managers investigated complaints and identified themes. Themes included the temperature of the unit, waiting times for patient transport and communication/staff attitude. We reviewed a sample of six complaints from 2021 and found appropriate actions were taken in each case. Where necessary, staff apologised to patients or referred the complaint for more investigation.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The manager sought to resolve complaints quickly and informally where possible. Where this was not possible, the complaint was escalated to the regional manager for investigation and resolution.

Managers shared feedback from complaints with staff and learning was used to improve the service. We reviewed 11 compliments about the service from patients, family and professional visitors given in 2021. All complimented the cleanliness of the unit and positive work by staff.

Are Dialysis services well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Local leaders had the skills and abilities to run the service. The unit manager was supported by an appointed deputy clinic manager. The manager also had support from the provider level human resources department for any workforce related queries. The unit manager was taking a training course on leadership skills as part of their development plan. Nursing staff were encouraged to develop leadership skills through an initiative which allowed them to work alongside the senior nurse on set shifts.

The unit received support from the referring trust. Satellite co-ordinators attended and liaised with the unit regularly and were a first port of call for queries or concerns. The manager described a good level of communication with all team members at the referring trust.

Managers supported staff to undertake their role. During to COVID-19 pandemic, team meetings and 'face to face' training were conducted by tele or videoconferencing. The manager told us this had led to a better attendance at team meetings as it allowed more flexibility.

The unit manager understood the priorities and the issues faced by the service. They knew every patient and member of staff and could talk through any concerns or risks linked to the clinic knowledgably.

The unit manager was visible for patients and staff. They worked at least one shift clinically per week; more if staffing numbers required this. Staff told us they could speak with the manager about clinical concerns.

Nurses at the service were supported to develop. Most staff we asked told us the provider was a supportive company, who supported them to improve. As below, staff told us some development opportunities had been withdrawn over the pandemic.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The service had a realistic strategy for achieving priorities and delivering good quality, sustainable care. Staff knew and understood what the provider vision and values were. Staff told us about the vision of the service, describing key elements as being collaborative, effective, reliable and proactive.

Patients had access to information about the vision and values of the service. The manager displayed posters which laid out the values and aims of the service. These were visible for both patients, staff and visitors.

The unit manager told us of plans for the clinic to improve the service, such as plans to create more dialysis stations, and re-decorating programme.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff felt supported, respected and valued. Staff told us they felt comfortable to raise concerns or issues with the local unit manager. Bank staff working at the unit reported feeling supported as part of the team and able to raise any concerns about patient safety.

Staff told us they could support team members, and mostly were able to receive support if they required this. Occasionally some staff were less willing to undertake additional tasks to support the team.

Staff had access to a wellbeing programme which was provided by a third-party organisation. This was also used as an occupational health service to support staff who were unwell or absent from work through sickness.

Most staff were able to access opportunities for professional development. Most staff we asked told us the provider was a supportive company, who supported them to improve. Staff told us some development opportunities had been withdrawn over the pandemic. Eighty four percent of staff had received a yearly appraisal at the time of inspection.

We saw an action plan following the most recent staff survey (2021) which identified actions to improve staff satisfaction.

We saw several staff had won recognition awards throughout 2021, with all staff being awarded a team award in August 2021.

The service had a culture which centred on the needs and experience of people that used the service. Staff told us they felt passionate about providing a good service to patients. Staff understood the duty of candour and the importance of being open and transparent with patients.

Governance

The service had governance processes in place, but these were not always effective as staff did not always follow provider policies, and this was not recognised. Staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a governance structure which enabled information to be escalated up to provider level and cascaded down to clinic level.

The manager attended several meetings to share information and receive updates. These included a monthly regional business meeting, a weekly unit manager meeting and a monthly safeguarding supervision meeting. In addition, the manager attended a monthly quality assurance meeting with the referring acute trust and a monthly meeting with the ambulance trust which provided patient transport services.

We reviewed minutes and agendas of the above meetings and saw topics included clinic performance, incidents, complaints and staffing. The regional meeting minutes showed a focus on patient and staff satisfaction, and a review of any serious incidents.

Local team meeting minutes showed items such as local audit results and incidents were discussed, and learning was shared.

We saw examples of shared learning bulletins highlighting serious incidents and the learning outcomes of these. The bulletins were escalated to local managers with attached actions to ensure all staff received the information.

Arrangements with third party providers were managed effectively to encourage appropriate interaction and promote coordinated person-centred care. Staff at the service worked well with the referring trust to monitor performance and share information.

Staff did not always follow provider policies and procedures. This had not been recognised by the organisation suggesting governance processes were not fully effective. Staff did not follow the referring trust's policy in relation to the use of bedrails and there was no provider policy in place. After our inspection, managers from the service told us they were had started to train staff to undertake bed rails assessments in line with the referring trust policy.

The duty of candour was not always carried out in accordance with the provider policy. We found one incident which occurred in June 2021 graded as moderate severity. We reviewed the incident and noted there were no aspects of care or treatment that went wrong to trigger the cardiac arrest, which does not trigger the legally required duty of candour under Regulation 20 of the Health and Social Care Act. However, the provider policy stated incidents graded as 'moderate' severity or above would be subject to duty of candour. We asked the service about this and were told duty of candour was not carried out as the patient was discharged from the satellite unit, back to the referring trust, after this incident. However, this reasoning is not reflected within the policy as a reason to discontinue duty of candour.

Staff did not follow the provider policy fully relating to provision of interpreters when working with patients who did not speak English. Interpreters were not booked, as per the policy, when staff consented patients to starting treatment at the unit. Staff told us the referring trust provided patient details when referring patients to them, therefore staff at the service were aware of patients who did not speak English and therefore would need an interpreter for their initial admission appointment.

Staff did not fully follow the consent policy when working with a patient who had a lasting power of attorney for health in place.

We saw one member of staff who did not follow the provider medicines management policy around checking the patient identification and the medicine prescription and dose before administering intravenous medicine.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The clinic manager, although not in post at the time of the last inspection, was able to talk through the changes that had been made as a result. For example, formal sepsis training had been introduced for staff to ensure early identification and response.

Arrangements were in place to identify, record and manage risks, issues and mitigating actions. The manager was knowledgeable about local risks and general risks that could affect all dialysis clinics. For example, a local risk was the potential for access site infections due to the high number of patients with central venous catheter access points. A more general risk was that of needle stick injuries due to the high use of sharps within dialysis clinics.

Potential risks were considered when planning services. The risk register reflected this and contained risks around disruption to staffing, power failures and water supply problems. Business continuity plans were displayed in clinical areas. Staff knew how to use the emergency equipment.

The unit management team, in line with the provider, had set up actions for staff and patients to take to reduce the risk of COVID-19 transmission. This included a triage of every person who entered the building, including temperature checks as per Department of Health guidance. This was recorded and monitored. As in 'safe', staff were aware some patients actively tried to continue to dialyse at the clinic even with symptoms and would take paracetamol before attending. The manager had set actions to address this as much as possible.

Local managers were aware of the personal safety risk to staff and patients due to the location of the clinic, which had previously had a high rate of sexual and violent crime compared to other offences (as of 2019). As a result, the clinic did not offer twilight sessions to ensure staff and patients were not leaving the clinic late at night.

Processes were in place to monitor and manage current and future performance. These were regularly reviewed by the referring trust to ensure compliance to national standards. The service performance in terms of treatment efficacy exceeded national key performance indicator targets.

Information Management

Requires Improvement

Dialysis services

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service had clear and robust performance measures which were monitored and reported on. Monthly blood tests were conducted on every patient; the purpose of these was to identify treatment effectiveness. Consultants at the referring trust reviewed and reported on blood test results. Staff from the service and staff from the referring trust met monthly to discuss the results and identify treatment plans and changes.

Staff undertook internal audits as part of their contract with the referring trust and provider wide standards. These included hand hygiene audits and audits of the aseptic non-touch technique. The results of these audits were shared with staff and used to drive improvement where necessary.

On one occasion we observed a staff computer was left unlocked at the nurses' station. We were able to access patients' electronic medical records through this. However, all patients were connected to dialysis machines at this point and due to the site security, no unauthorised access would be possible.

Engagement

Leaders and staff engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There was evidence of regular engagement of patients in their treatment plans. Staff engaged with patients through the provider wide named nurse scheme. Each patient had an allocated nurse who was responsible for updating them on treatment changes, general information or changes to the service. Patients we spoke with felt welcome and respected by staff.

We saw a strong focus on patient satisfaction through governance meeting minutes. Patient satisfaction surveys were scrutinised, with specific actions set to improve measures.

The provider engaged with staff through the staff survey. We saw a localised action plan was in place to address specific areas of dissatisfaction.

The service had not completed any engagement with the general public or local community. Over the past 18 months this was attributed to the COVID-19 pandemic.

Learning, continuous improvement and innovation

All staff were committed to continually learning.

Nursing staff were able to access support and training to support continued professional development. All staff we spoke with were committed to continued professional development.

Nursing staff at the service took part in a 'co-in charge' role every dialysis session. The purpose of this was to support nurses to develop leadership skills with the support of more senior nurses.

Requires Improvement

Dialysis services

The provider was using the unit, in conjunction with the local referring trust, to train patients who chose to undertake home dialysis. The staff undertaking this work were separate to the unit staff, therefore this did not impact upon the unit's staffing levels. However, it enabled patients to gain access to this programme if they were interested and suitable for this method of treatment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff did not support all patients to make informed decisions about their care and treatment. Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005, although staff had access to a provider wide policy which clearly outlined this.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Staff did not always follow provider policies and procedures.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not complete risk assessments when using bed rails with patients. The service had four beds to use for patients who needed these. We observed staff to put bed rails up to prevent a patient from falling. The risk assessments should be undertaken by staff trained to do so. During the inspection we found staff did not complete bed rail assessments which meant patients could be at risk of harm from inappropriate use. We requested the provider

This section is primarily information for the provider

Requirement notices

policy around bed rails and were sent a copy of the referring trusts' policy. This clearly stated assessments should be completed before using bedrails and consent for their use should be sought. Therefore, staff did not work within this policy. After our inspection, managers from the service told us they were had started to train staff to undertake bed rails assessments in line with this policy.