

# Hereford Kidney Treatment Centre

## Quality Report

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

## Ratings

### Overall rating for this location

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

## Overall summary

Hereford Kidney Treatment Centre is operated by Diaverum Facilities Management Limited. The service has 20 dialysis stations, including four isolation rooms. The service was commissioned by University Hospitals of Birmingham NHS Foundation Trust.

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

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 20 June 2017, along with an unannounced visit to the service on 4 July 2017.

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

# Summary of findings

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

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

## Services we 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:

- Staffing levels maintained patient safety during treatment.
- Patient records were well maintained, regularly updated and stored securely.
- Patient information was accessible to all staff at the point of care.
- Patient comorbidities and frailty were taken into account when planning patient treatments.
- In response to recruitment difficulties, the unit developed dialysis support worker roles, to offer staff development opportunities and to provide patients with timely care.
- Patients were regularly reviewed, involved with their care planning, and kept informed of treatment options.
- Staff were supportive of patients, treating them with respect and ensuring privacy during all interactions.
- Patients opinions were regularly sought and actions taken to improve the quality of the service in response to findings.
- There were effective systems in place to support and develop staff both locally and across the area. This included peer reviews and a deputy managers' mentorship programme.
- The service had a positive relationship with the NHS trust, supplying support networks to promote effective patient care and treatment.

- The local GP attended the unit daily and supported the consultant nephrologist to manage dialysis patients.

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

- Over half of the dialysis machines had not been serviced in line with recommendations. This was in breach of Regulation 15 of the Health and Social Care Act 2008. We raised this as a concern on the day of the inspection and the service took actions to address this.
- The unit was visibly clean, however we found some equipment was not clean and ready for use. Cleaning schedules did not reflect the needs of the service. This was in breach of Regulation 15 of the Health and Social Care Act 2008.
- Store room temperatures were higher than the manufacturers' recommended temperatures for the safe storage of sodium chloride solution and disinfectants. This was in breach of Regulation 12 of the Health and Social Care Act 2008. This was raised with the team locally and actions were taken to remove temperature sensitive items from the storeroom.
- There were inconsistencies in the checking of medicines, with two nursing staff not always checking medicine at the point of administration.
- Staff had not completed safeguarding children training.
- The service did not have a Workforce Race Equality Standard report.
- There was varied compliance with mandatory training and inconsistent annual reassessments of clinical skills.
- There was no formal risk register in place during our initial inspection. This was completed subsequent to our inspection and detailed areas of concern and actions to mitigate risks.

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

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though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices that affected the dialysis service provided. Details are at the end of the report.

**Heidi Smoult**

Deputy Chief Inspector of Hospitals (Central Region)

# Summary of findings

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# Hereford Kidney Treatment Centre

**Services we looked at**

Dialysis Services

# Summary of this inspection

## Background to Hereford Kidney Treatment Centre

Hereford Kidney Treatment Centre is operated by Diaverum Facilities Management Limited. The service opened in November 2014. This was following negotiations with the commissioning acute NHS hospital

trust to provide a dialysis centre for local patients. It is a dialysis clinic in Hereford, primarily serving the communities of Hereford and surrounding areas. It also accepts patient referrals from outside this area.

The current registered manager has been in post since November 2014.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector and a specialist advisor. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

## Information about Hereford Kidney Treatment Centre

Hereford Kidney treatment Centre opened in November 2014, providing haemodialysis to patients with chronic renal failure. The centre provides care for 69 patients on the caseload currently, with facilities open 6.30am to 22.30pm on Monday, Wednesday and Friday and 7.00am to 18.00pm on Tuesday, Thursday and Saturdays. This service was not located at an acute hospital site.

The clinic is registered to provide the following regulated activity:

- Treatment of disease, disorder or injury.

The centre provided 216 dialysis sessions per week. The majority of patients attending the centre were aged over 65 with 24 ranging from 18 to 65 years of age. The unit did not provide dialysis for patients less than 18 years of age. Peritoneal dialysis was not provided by the service.

During the inspection, we visited the service. We spoke with 12 staff including registered nurses, healthcare assistants, dialysis support workers, reception staff, and senior managers. We spoke with six patients. During our inspection, we reviewed 12 sets of patient records.

The provider is commissioned by University Hospitals of Birmingham NHS Foundation Trust. The service has support from the trust to provide medical cover, satellite

haemodialysis unit co-ordinator support, and regular contact with a dietitian. This team attend the centre regularly and assess patients in preparation for monthly quality assurance meetings.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service had not been inspected before.

Track record on safety;

- From January to June 2017, the centre reported no never events or serious incidents.
- The unit reported 199 incidents from January to June 2017. No incidents reported resulted in patient harm.
- From January to June 2017, the centre reported no incidences of healthcare acquired Methicillin-resistant *Staphylococcus aureus* (MRSA).
- From January to June 2017, the centre reported no incidences of hospital acquired E-Coli.
- From January to June 2017, the centre reported no complaints.

**Services accredited by a national body:**

# Summary of this inspection

- Clinical and or non-clinical waste removal
- Domestic cleaning
- Laundry

# 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 processes in place for the reporting of incidents.
- Staff demonstrated good aseptic techniques.
- Patient screening, using allocated dialysis machines and segregation of patients were completed regularly to reduce the risks of cross infection.
- Medicines were stored securely.
- Patients were assessed regularly, and their records updated to reflect any changes in clinical condition.
- Patients verbally confirmed identity prior to treatment and were required to wear identity bracelets for blood transfusions.
- GPs were available to review patients daily.

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

- 14 dialysis machines (out of 22) had not been serviced within the recommended timescale. This was escalated to the unit manager and immediate action taken to ensure equipment was serviced.
- Store room temperatures were in excess of the recommended temperatures for the safe storage of sodium chloride solutions and disinfectants. This was escalated to the unit manager and immediate actions taken to ensure temperature sensitive items were removed and stored safely.
- Nursing staff did not always ensure that two nurses checked medicines at the point of administration.
- The unit environment appeared clean, however some items of equipment were found to be soiled and not fit for immediate use. Cleaning schedules did not reflect all areas to be cleaned, and showed varied compliance.
- Corrosive fluids were not always stored securely. This was escalated to the unit manager and immediate action taken.
- There were variances in mandatory training with an average of 83% compliance. This was below the 100% target.
- Staff did not complete training for safeguarding children. This was raised with the manager during the inspection, who stated that this issue was to be addressed. Data provided after the unannounced inspection showed that the cleaning regimes had been reviewed and stickers introduced to alert staff to the need for cleaning and for signing once completed.



# Summary of this inspection

## Are services effective?

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

We found the following areas of good practice:

- Policies were in line with national guidance.
- Patient outcomes were in line with national average, with Hereford Kidney Treatment Centre performing in the top half of all Diaverum units nationally.
- Pain levels were monitored by nursing staff and relief was available for all patients.
- Dietitians were available for patients and maintained a patient information board.
- Competencies were used for staff on commencement of post to standardise practice.
- The IT system automatically updated patient dialysis records and information was available at the point of care.
- Patient's consent to treatment was recorded and updated annually.

## 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 respectfully and with compassion.
- The service provided a friendly atmosphere where patients engaged with staff and each other throughout their treatment.
- Patients told us they were kept informed of their treatment plan and were involved in decision making.
- The centre provided patients and their families with support networks, promoting access to charities and advice centres.

## Are services responsive?

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

We found the following areas of good practice:

- Staff flexed patient appointments in line with safe staffing numbers.
- When possible, the service facilitated dialysis for patients holidaying in the area.
- Treatment variances were recorded to monitor reasons for changes to treatment times.
- The centre was easily accessible for patients who used mobility aids.
- The centre had received no complaints regarding patient care or treatment.

# Summary of this inspection

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

- The provider was not responsible for transport services. However, patient transport did not always collect patients on time, which affected their treatments. Due to the rural location, some patients travelled for longer than the recommended 30 minutes to receive their treatment.

## Are services well-led?

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

We found the following areas of good practice:

- The centre manager was accessible and supportive.
- There was effective support networks across the area, which included manager support groups, a deputy manager development programme, peer review of centres and regular meetings to discuss learning.
- Staff were aware of the provider's vision to be the first choice in renal therapies.
- The governance structure included monthly quality assurance meetings and contract review meetings.
- The centre had an effective audit calendar, with audit results reviewed as part of the quality assurance meetings.
- Patients and their families were asked provide feedback regarding the treatment received and the centre using a biannual patient survey.

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

- There was no formal risk register on our announced inspection. This was escalated to the unit manager and a risk register was provided to us for the unannounced inspection.
- There appeared to be no oversight of dialysis machine servicing which meant that risks associated with non-compliance was not addressed.
- There appeared to be no oversight of cleaning schedules, with no evidence of actions to address any non-compliance. This was escalated during inspection and actions taken.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

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

# Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Are dialysis services safe?

### Incidents

- Staff had access to corporate policies to guide them including incident reporting, medicine incidents and managing serious medical incidents. The incident reporting policy provided a practical guide to ensure that staff reported incidents in the correct way.
- Staff had an understanding of their roles and responsibilities for recording and reporting of incidents, concerns, and near misses internally and externally.
- We saw that staff had access to the provider's electronic incident-reporting tool, which escalated incidents automatically to managers through emails. This process triggered the investigation and root cause analysis of the incidents. The service manager and deputy manager developed action plans to address any issues of risk. They would also liaise with the senior management team regarding the incident as required.
- Treatment variances were used to record when there had been a change from the expected dialysis treatment. We saw that any incidents or changes to the patient's normal dialysis session were recorded on treatment variance records (TVR). Paper treatment variances forms were completed and stored at the nurses station in monthly batches. The patients' record also recorded any variances automatically.
- The service reported no never events from March 2016 to March 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The unit reported 199 incidents from January to June 2017. This included 71 relating to dialysis machine errors, 21 referring to patients arriving late for treatment and 20 relating to swapped dialysis sessions. There were 10 incidents relating to patients low blood pressure, nine referrals to the emergency department and eight reported incidents of clotted vascular access. The remaining 101 referred to poor blood flow, multiple cannulation attempts, poor blood flow, medication errors (no harm) and staff verbal abuse. All incidents reported no harm to patients.
- We were told that staff debriefing was completed after all incidents to ensure learning across all staff groups. The patients and acute trust were kept informed of any actions to ensure all those involved were shared the learning. We saw that incidents were discussed at meetings to share learning and ideas on improving the service. For example, we saw that the area unit managers discussed the need for two nurses checking of medication in January 2017 following two incidents where one nurse checked medication. The meeting minutes recorded that an agreement was made for the identification of best practice for consistency across the area.
- The centre reported two patient falls from November 2016 to March 2017. Both were reported on Diaverum accident report forms which captured the details of the falls, treatment given and actions to be taken to prevent reoccurrence. For example, we saw that one patient fell whilst mobilising around the weighing

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scales, this resulted in the scales being moved to prevent reoccurrence. We saw that the patients were reassessed using the falls risk assessment tool following each reported incident.

- We saw that staff checked National Patient Safety Alert records and acted appropriately to ensure that any item reported was managed according to guidance.
- We saw that incidents and their learning were discussed at the managers' regional training days. This process enabled shared learning across the area.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. There was a corporate policy relating to duty of candour, which outlined actions to be taken when something went wrong.
- Staff were aware of the duty of candour regulations and the need to apologise for any errors, mistakes or incidents. Staff had completed training in what constitutes duty of candour and the steps to take following a trigger for implementation. Staff knew about being open and honest and even though they had not had any incidents that triggered duty of candour, staff were still writing to patients who were involved with incidents. They were provided with a written letter detailing the investigation, findings, and any actions taken by the centre to prevent repetition.

## Mandatory training

- All the staff at the unit had to complete mandatory training. This included annual updates regarding infection prevention and control, anaphylaxis, basic life support, fire training, and manual handling. This was in addition to two yearly training in safeguarding, slips, trips and falls training, practical manual handling and fire marshal training. There were e-learning modules that were also completed including legionella, control of substances hazardous to health (COSHH) and disability discrimination.

- We saw that there was varied staff compliance in mandatory training.
- The average mandatory training compliance was 83%. For example, data provided showed that as of March 2017; 54% of staff had completed medicines' management training and 76% of staff had completed COSHH training. Also, 94% of staff had completed their hand hygiene training and 88% staff had completed the basic life support training. The topic that had achieved the 100% target was adult safeguarding (level two).
- Training compliance was affected by long-term absence within the team.
- Mandatory training was managed by allocating topics to a set period. This meant that staff were aware of which topic to complete when.
- Staff completed training either online or in person depending on the topic. Classroom training was provided on site or at nearby facilities. Staff who unable to attend the sessions at the given time were able to attend other clinic sessions.

## Safeguarding

- There was an effective process in place to keep patients safe, with staff trained to recognise patients at risk of abuse and escalate their concerns.
- We were told that any concerns relating to patients at risk were discussed with the service manager or deputy manager who completed a local investigation to gather information. Patients would be referred to the local authority with a copy of the referral sent to the NHS trust for information. Staff told us they had not completed any referrals, but were able to describe a recent case where concerns were escalated to the local authority and immediate action taken to prevent any patient harm. This related to a patient becoming homeless, who was admitted to hospital until an appropriate placement could be sought.
- The service manager had completed safeguarding adult level three training and was available to staff as a resource and advisor. We saw that mandatory safeguarding adult (level 2) training had been completed by 100% of staff in March 2017.

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- The director of nursing was the corporate safeguarding lead for Diaverum.
- Safeguarding was the current topic on the staff information board in the service corridor. There was also safeguarding information for patients and visitors in the reception and waiting area.
- The Diaverum policy “Safeguarding Adults with care and support needs and dealing with concerns, suspicions or allegations of abuse, harm or neglect” (October 2016) detailed actions staff should take to escalate concerns. The policy provided staff with easy to read flowcharts and sign posted staff to additional reading.
- Staff at the unit had not completed safeguarding children training. Nursing staff told us that children did not attend the unit, with two members of staff stating they never saw children on the unit. The corporate safeguarding policy did not refer to children. This meant that staff were not trained to safeguard any children associated with the adults they cared for from abuse.
- medicines cupboards and fridges
- medicine infusion pumps
- and office items such as telephones.
- However, we found that the dirty utility room, and items that were located in there, such as the blood sample storage fridge, were not included. We brought this to the attention of the manager during the inspection and we were informed they were subsequently amending the cleaning schedules. On our unannounced inspection, we saw that the cleaning schedule had not been amended to include areas highlighted in our inspection on the 20 June 2017. This meant that we were not assured that effective cleaning schedules were in place to ensure that all areas and equipment were kept clean.
- Each dialysis machine was labelled with a name (from a musical theatrical show) and a number. A record attached to the machine would be updated daily to confirm that it had been cleaned and that internal controlled cleaning of the machine had taken place. However, we found that the two spare machine records had not been completed for June 2017.

## Cleanliness, infection control and hygiene

- The clinical area and equipment that we checked were generally visibly clean. However, there were two exceptions. In the dirty utility room, there was fridge dedicated for the storage of patient’s blood samples prior to collection for analysis. We found it was soiled with blood inside. Also in the same room, there was a commode, which was found to be very dusty. We brought this to the attention of the manager during our inspection, who stated they would address this.
- On our unannounced visit, we saw that the blood fridge and commode were visibly clean.
- There were schedules that detailed frequency and items for cleaning. The responsibility for the equipment cleaning was mainly for the health care assistants. There were monthly deep cleaning and weekly cleaning charts. The weekly cleaning schedule included:
  - resuscitation trolley
  - oxygen cylinders and holders
  - patients’ weighing scales
- We also saw that not all machines were deep cleaned weekly. For example, we found that in January 2017, 14 out of 22 machines had been cleaned. This was not in line with the provider’s policy number 628 “Cleaning and disinfection of internal fluid pathway of the dialysis machine” (reviewed December 2015). We raised our findings with the manager during the inspection, who stated that this cleaning regime would be discussed at the scheduled staff meeting (the following day). The unit manager introduced a deep cleaning sticker and a revised cleaning schedule following the inspection.
- The clinic had four spare dialysis machines for use in the event of malfunction or to allow routine servicing. This meant that interruptions to patient’s dialysis treatment due to machine availability would be minimal. However, we found that it was unclear from the documentation attached to two spare dialysis machines in the store room whether they were clean and ready for use. The exterior of the machine was to be cleaned once each month and machines put through a weekly deep clean cycle. According to the records (deep cleaning schedule and attached

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cleaning list), both machines were last cleaned in April 2017. This was raised with the manager during the inspection, who stated that this issue was to be addressed. Data provided after the unannounced inspection showed that the cleaning regimes had been reviewed and stickers introduced to alert staff to the need for cleaning and for signing once completed.

- On our unannounced inspection, we saw from records and staff confirmed that several dialysis machines had not been cleaned for three consecutive weeks. This meant that we were not assured that dialysis machines were clean and ready to be used at all times. Data provided after the unannounced inspection, showed that the cleaning regimes had been reviewed and stickers introduced to alert staff to the need for cleaning and for signing once completed.
- Staff ensured, as far as possible, that patients received their dialysis treatment via the same machine each time they attended the clinic. If this was not possible, this would be recorded for traceability issues in the case of an infection.
- We observed that staff wore appropriate personal protective equipment for interactions with the patients. This included facemasks for the connection and disconnection of dialysis catheters, to protect staff from possible blood contamination. We also saw that patients wore facemasks when being disconnected from lines.
- Staff had visors to use during high risk procedures. We saw that they were used appropriately and labelled for use for each member of staff. When not in use they were stored in the service corridor.
- Staff used appropriate aseptic non touch techniques to attach patients to their dialysis machines. This was completed through either the insertion of large bore needles into an arteriovenous fistula/ graft or central line. Arteriovenous fistulas (AVFs) are a connection or passageway between an artery and a vein created through vascular surgery specifically for dialysis. Grafts (AVGs) are artificial veins inserted for dialysis, and central lines are larger cannulas that are inserted for long periods for dialysis. Vascular access was reviewed at each dialysis session and audited monthly. Results were discussed with the NHS trust.
- We saw staff washing their hands appropriately to maintain patient safety and in line with the World Health Organisation's 'Five moments of handwashing' (2009). This included before and after any patient contact and use of hand cleaning gel. Hand hygiene training had been completed by 94% of staff according to March 2017 data.
- Hand hygiene audits were completed every three months. Results were reviewed by the manager and provided to the NHS trust as part of the contract review meetings. We saw that audits completed from January to June 2017, showed 100% compliance with hand washing, aseptic non-touch technique and use of personal protective equipment.
- The service had four side rooms. These all contained a hand wash sink. This provided adequate facilities for patients and staff. However, two were currently used for storage.
- The domestic cleaning was provided by an external provider. This was completed before the service opened and at lunchtime. Nursing staff were able to liaise with a supervisor if there were any issues. In addition, the domestic supervisor attended the clinic monthly to complete an audit in conjunction with the clinic manager and the infection control link nurse. These audits were used to identify any areas for improvement or changes required to the routine. We were given an example, whereby domestic staff were asked to clean the treatment area first to enable staff to prepare machines for dialysis. Audit results were also shared with the NHS trust and used to identify any trends or actions that were required.
- Patients were screened for virology blood tests, and MRSA every three months. The centre target was for no occurrences. The centre reported no MRSA cases from March 2016 to March 2017.
- The service had link infection control nurses who worked closely with representatives from other clinics and the NHS trust. They were responsible for the completion of audits and reporting results and any new processes back to staff.

## Environment and equipment

- The Department of Health provides best practice guidance for the design and planning of new



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healthcare buildings and the adaptation or extension of existing facilities, via health building notes. Hereford Kidney treatment Centre facilities were in line with Health Building Note 07 01: 'Satellite dialysis units' (2013).

- The centre was divided into three main areas, the reception area, treatment area, and service corridor.
- The reception area had access to disabled toilet facilities, four consulting rooms and a meeting room. The consulting rooms had a desk with computer access, examination couch and handwashing facilities.
- The treatment area had 20 dialysis stations. These were divided into four bays of four dialysis stations, and four side rooms. There was one work station per four dialysis stations, which meant that patients were observable at all times. Each station had a dialysis chair or bed, a call bell and dialysis machine.
- Two of the side rooms were being used for additional storage and were not currently used for patients. One side room contained a number of containers holding citric acid, which was labelled as a corrosive substance. This was escalated to the clinic manager and we saw that on our unannounced inspection that the citric acid had been removed from this area.
- A wheelchair accessible weighing scales and patient card store was located inside the treatment area. This was situated next to the main nurses' station so patients accessing the area were immediately visible to staff. The service did not have spare scales in the event of the wheelchair scales failing. We were told that there were specialist scales available in the dietitian's office. However, staff were not trained to use these.
- The ward manager's office was accessible allowing patients to see manager when needed.
- Additional facilities accessible from the treatment area included a disabled access toilet, patient kitchen, and treatment room (medicine storeroom).
- The service corridor enabled access to store rooms, water treatment room, technician's room, dirty utility room, linen store, staff changing and rest rooms.
- We saw that the service had security features, including CCTV at entrance to the clinic and alarms to

secure the property when it was vacant. Patients and visitors to the clinic had to buzz to gain access to the waiting room and were invited manually by staff through secure doors for their dialysis onto the main clinic.

- Staff could access certain areas using an electronic fob. The fob activity could be monitored and individual fobs could be deactivated if required, to keep the clinic secure.
- We saw that the unit manager kept a record of the dates that equipment such as blood pressure machines, defibrillator and glucose monitoring machines were serviced. All equipment we checked during the inspection had been electrical safety tested.
- We saw that each dialysis machine had a corresponding log or folder in the technician's room. The technician updated these when the machine was serviced or had undergone repair. However, on our unannounced inspection we found that 14 dialysis machines (out of 22) had not been serviced for 18 months, when they should have been serviced annually in line with manufacturers' recommendations. All should have been serviced in January 2017. We raised this with the nurse in charge and requested that urgent action was taken to address the concern. The unit manager provided us with information confirming that all dialysis machines were serviced within two weeks of our unannounced inspection.
- Staff reported faulty equipment to the clinic manager who escalated through a central reporting tool. Technicians attended the service regularly to complete routine maintenance and we were told would review any faulty equipment within 48 hours of reporting.
- The service had adequate equipment to meet the demands of the patient group and four additional dialysis machines, to ensure there was a machine available in the event of a sudden failure. However, these dialysis machines were not cleaned ready for use.
- The service had a water treatment facility, which we saw was monitored daily by nursing staff. The water treatment equipment was also continuously



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monitored remotely and technicians were available through a 24 hour on call service. This made sure that the water supply was appropriate for dialysis treatment. All water testing for the unit was carried out in line with the recommendations by the UK Renal Association and Association of Renal Technologists 'Guidelines in water treatment facilities, dialysis water and dialysis fluid quality for haemodialysis and related therapies'(2011).

- The service had equipment for use in a clinical emergency. The resuscitation trolley was located in the main clinic. The resuscitation trolley was sealed to reduce the risk that it could be tampered with. All resuscitation equipment was checked daily and consistently recorded.
- There was also an emergency bag available in the clinic, which could be taken to the patient if they collapsed outside of the clinic. This was not sealed and contained intravenous fluids, needles and syringes. It was located within sight of staff and in close proximity to a nurses' workstation, which reduced the risk that it could be tampered with. We saw there were weekly checks of the bag and contents.
- We saw that equipment used to check patients' blood glucose level were checked each day.
- We were told that equipment was standardised across the provider's services, and if necessary, equipment could be sourced from an alternative centre.
- Sharps bins were assembled correctly and were not overfilled. We saw that these were closed between use. On our unannounced inspection, we saw that four sharps bins were contaminated with dried blood, and two were not labelled. We were told that clinical waste (including sharps bins) were labelled before removal from the unit and checked to ensure that they were not contaminated.
- Waste was managed appropriately with the segregation of clinical and non-clinical waste. Bins were not overfilled and were emptied regularly. We were told that filled bin bags were stored in secure clinics awaiting collection. We saw that the unit had received new tape to label waste bags with their address prior to sending for disposal.

- Single use items were clearly labelled and disposed of after use. Dialysis sets were single use and CE marked. The CE mark demonstrates that items conform to the European standards for quality, safety and efficiency.
- There were posters in place above all the fridges in the clinic to remind staff regarding what actions to take, if the temperature was found to be out of range. These were dated 12 June 2017.
- There was a cupboard available for the storage of harmful substances. This was located in the machine room and was locked.
- Linen for use at the clinic was supplied through an external contract. We saw there was a process in place to check the linen once received.

## Medicines

- Medicines were prescribed on a chart specifically designed by the contracting NHS trust for use at satellite dialysis clinics. The consultant, GP, or satellite haemodialysis co-ordinator (a senior nurse) prescribed patients' medicines for their dialysis. We saw that this included antibiotics as required, iron supplements and any medicines for vascular line management.
- The GPs attended the clinic daily and would complete prescriptions as required. Nursing staff told us that GPs were available to prescribe any urgently required medicines.
- We saw 10 drug charts and saw that all detailed the patients' name, date of birth, NHS number, allergies, and weight.
- Medicine charts were reviewed monthly as part of the quality assurance meeting. Any changes to medicines were forwarded to the patient's GP by letter. Patients were also informed of any changes, either by the doctor or the nursing staff.
- The manager audited 20% drug charts monthly as part of the patient record audit. We saw results from the January 2017 audit, which showed that 35 records were reviewed: 33 of which were complete and up to date. Details of the findings were shared with staff and

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the acute trust at the contract review meeting. Any variances such as omissions or errors were investigated and an action plan devised to prevent reoccurrence.

- The service had systems in place for the administration of medicines but these did not always comply with the Nursing and Midwifery Council medicine administration guidance. We also found that medicines were not always stored safely, with storage areas that were too hot.
  - We saw that the medicine fridge temperature was recorded daily and maintained between 2 and 8 degrees centigrade, in line with the local “Cold Storage of Medicines – 3002.03” procedure (reviewed August 2016). Temperature sensitive medicine was stored in fridges. We saw that all medicines were in date and stored appropriately. Staff told us that any recordings outside the recommended levels were reported to the clinic manager who spoke with the pharmacy for advice. There were posters advising staff on actions to take if temperature readings were outside the recommended levels. There was a cold storage policy in place.
  - The main storeroom at the clinic was used to store intravenous fluids. The room was not in an area used by patients and was kept locked. The ambient temperature of the room was monitored daily by staff and documented. These records showed that the actual temperature when checked had been greater than 25 degrees centigrade from 22 May 2017 to 20 June 2017. The temperature had ranged from 25.2 to 28.7 degrees centigrade. The thermometer reading at the time of the inspection was 28.7 degrees centigrade. This meant that items such as intravenous fluids had not been stored consistently at less than 25 degrees centigrade, as per manufacturer’s instructions. This was not in line with provider’s policy 3002.01 “Standard HD Medications Ordering, Storage and Disposal” (reviewed June 2016). We raised this during inspection with the manager. They had already recognised the issue and had escalated to the area manager the requirement for an air-conditioning clinic. However, on our unannounced inspection, we saw that no action had been taken to address this.
- Temperatures continued to exceed 25 degrees centigrade. We raised this with the nurse in charge and requested that urgent action was taken to address the concern.
- Following our unannounced inspection, we received confirmation that the temperature sensitive fluids had been removed from the store room and placed in the medication treatment room. This room was air-conditioned. We were also provided with a copy of the order request for an air cooling system, for the store room. The unit manager had also spoken with the pharmacy department who confirmed that it was safe to continue to use the intravenous fluids.
  - Sodium chloride flushes (for dialysis catheters) were not prescribed. We requested a copy of the local policy relating to this: however, it was not clear whether sodium chloride was required to be prescribed. Staff followed the policy provided by the NHS trust. On our unannounced inspection, we saw that flushes had been prescribed on patient’s drug charts and were signed from the 29 June 2017.
  - We saw that there were inconsistencies with the checking of medicines by two nurses at the time of administration. During the announced inspection, all medicines and dialysis fluids were checked by two nurses at the time of administration. This was in line with the Nursing and Midwifery Council (2015) and Royal College of Nursing recommendations for safe medicine administration. On the unannounced inspection, we saw that this was not always the case. Some medicines were checked by one nurse and left with the patient until it was administered by the second nurse. This was due to the timings of medicines being administered at the commencement of dialysis, usually when all nursing staff were busy. Charts we checked showed that medicines were checked and signed for by two nurses.
  - Supplies of medicines came from two sources: the provider and the acute trust. When medicines arrived at the centre, the nurses would check the supplies against the delivery note, and register the delivery on the electronic stock system.
  - There was no nominated pharmacist. Staff had access to the acute trust’s pharmacy department or the provider’s pharmacist for any queries or concerns.

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- The manager was the lead for the safe and secure handling of medicines at the centre.
- Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled medicines or controlled drugs. The service did not use or have access to controlled medicines.
- The service maintained a small stock of medicines predominantly used for dialysis. This included anticoagulation, intravenous fluids and subcutaneous injections. Staff checked the stocks of medicines each month and ensured that any that were out of date were removed from use.
- All the medicines we checked during inspection were in date.
- Medicines were stored in the clean utility room, which required keypad access. Medicines were in locked cupboards or fridges.

## Records

- Records were kept securely. When they were not in use, records were stored in locked cupboards or locked in a dedicated archive storage room at the clinic.
- There were policies in place to guide staff regarding maintenance of medical records, information governance, and data protection. 82% staff had completed data protection training.
- Patients' records were held both electronically and in paper format. We saw that the electronic records detailed dialysis sessions by date and time. This meant that any changes in treatment, any problems occurring during the session or treatment changes could be easily identified. The clinic had an electronic patient treatment database that automatically uploaded information to the national database at the NHS trust hospital.
- Electronic patient records relating to treatment, blood results, clinic appointments and letters, were accessible to staff either on site at the clinic or at the NHS trust. This meant that when patients were seen at either service, their most up to date information was available. The consultant had access to their own

desktop from the NHS trust. Nursing staff had honorary IT contracts with the NHS trust, which enabled them to access patient information and policies and procedures.

- Communication between the service and the patients' GPs, was completed by letters written by the consultant. Any communication received at the centre, were shared electronically with the renal consultant's secretary, with a request that the information is added to the patients' NHS trust records.
- Details of any vaccinations given at the centre were shared electronically with the GP surgeries.
- Any changes made to patient's treatment following the monthly quality assurance meetings, were communicated to the patient via letter, and a copy sent to the patients GP and the clinic secretary.
- We looked at 12 patient records. Each file contained a dialysis prescription, consent for treatment, medicine chart, dialysis pathway, copy of blood results and an admission assessment document. We found that paper records were completed appropriately, legible, signed and dated as required.
- Patient records were audited each month at the clinic for compliance with policy. We saw the audit results for March to May 2017. There was on average 30 patient records reviewed and we saw that compliance with all audit questions were high. There were few exceptions, for example, there was one error noted regarding lack of post dialysis temperature recorded on one occasion in May 2017.

## Assessing and responding to patient risk

- Patient risk assessments were completed on referral to the clinic and then reviewed either in line with recommendations or as the patient's condition changed. For example, we saw that records were updated when a patient's mobility deteriorated prior to the review date.
- All patients were assessed for conditions such as hepatitis on referral to the service and every three months following the commencement of treatment.
- Patients were required to verbally confirm their identity prior to treatment and medicines. Patient's details were held on an electronic system and each

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patient had their own electronic card. Patients collected a named card on arrival to the clinic. These were stored in small labelled with the patients initial and surname and colour coded according to the treatment session. Patient cards held records of the last four-dialysis sessions. Immediately prior to their dialysis, patients would be weighed and the weight collected on the card. The data would automatically update the patient electronic record at the workstation and the parent trust database.

- Patients had clinical observations recorded prior to commencing treatment and at regular intervals throughout. This included blood pressure, pulse rate, and temperature. We saw that the frequency of monitoring was discussed with the patient and varied according to the patients' condition. Those patients who had previously become unwell during dialysis, were monitored more frequently. Data from observations were automatically recorded on the patient's electronic record.
- Patients who were receiving blood transfusions were required to wear identity bracelets for the duration of their dialysis. Due to the location of the clinic, blood was obtained through the nearest NHS acute hospital, and nursing staff were trained and followed the hospital's transfusion policy.
- During inspection, we saw that dialysis machine alarms were responded to by staff promptly. Alarms would sound for a variety of reasons, including sensitivity to patient's movement, blood flow changes and any leaks in the filters.
- The nursing staffing rotas were structured to ensure that there was a senior member of the team on duty to support the unit, in the event of a clinical emergency.
- Patient's venous access was reviewed on each dialysis session and graded to record any signs of infection/redness or swelling. Any complications with vascular access were discussed with the GP and when necessary medicine was prescribed to remove any blood clots. When access became difficult to manage, nursing staff and the GP were able to refer to the NHS trust for urgent advice and support. Any signs of infection were referred to the GPs for an urgent review and clarification sought as to whether the patient was fit to dialyse.

- The local GP was the first contact for staff when patients became unwell. If patients became unwell during their dialysis session, nursing staff referred patients to the NHS trust, either through the dialysis coordinator, consultant or the on call registrar. However, patients who were rapidly deteriorating were referred immediately to the emergency services for a 999 transfer to the acute trust.
- Patients requiring hospital admission due to renal related issues could bypass the emergency department and be admitted directly to the renal unit at the NHS hospital.
- The service was not completing national early warning scores (NEWS) as part of patient assessments in line with national guidelines. However, corporately they were in the process of introducing modified version for renal patients, with some staff having received training.
- We saw that some staff files contained certificates for attending sepsis and NEWS training. Staff followed the NHS trust's sepsis guidelines, with any patients thought to be unwell being referred directly to the renal team for an urgent medical review. There was a poster detailing a flowchart of actions to be taken by staff in the event of a suspected infection.
- We saw that the manager maintained a patient vascular access risk register. This detailed any issues with patients' vascular access, and what actions had been taken to address this.

## Staffing

- We saw that there were sufficient staff on duty to meet the needs of the patients during our inspection.
- The nurse staffing ratio was determined by patient dependency and the service level agreement (SLA) the unit had in place with their referring NHS trust. The clinic worked with a ratio of one registered nurse to four patients. The nurse in charge worked clinically but was supported by the manager, who was supplementary to numbers. The staff to patient ratio was predetermined by the acute trust to ensure that patients' needs were met. Any deviation from this ratio was reported directly to the acute trust during monthly contract review meetings.

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- At the time of our inspection, the staffing consisted of nine whole time equivalent (WTE) registered nurses, two dialysis support workers and four WTE healthcare assistants (HCA).
- The manager worked 80% in the management role and 20% clinically. The deputy manager worked 80% clinically and had 20% managerial time.
- Nurses were supported by the provider's area practice development nurse who provided training and supervision and competency assessments.
- The unit had two full time dialysis support workers who were able to complete nursing tasks such as attaching patients to dialysis, following training and a competency assessment. Four healthcare assistants were responsible for the preparation of equipment, ordering of stores, cleaning and preparing dialysis machines between patients. The service had one registered nurse and one HCA vacancy.
- Shortfalls in nursing staff were usually covered by substantive staff working additional hours. When this was not possible, staff were sourced through the provider's staffing bank, which provided trained staff to work where needed.
- The service had used bank staff on 34 occasions from January 2017 to March 2017. This was in response to a member of staff being on long-term sickness. We saw that the same temporary worker attended the clinic, which assisted with continuity of care.
- The service reported agency staff working on the unit for 159 hours in March, 134 hours in April and 95 hours in May 2017. Agency staff were arranged through the human resources department following a number of checks. This included a full disclosure and barring screen (DBS), a review of nursing qualification, renal experience and training records before agreeing to the individual. Where possible, the same agency staff were used to ensure continuity.
- Staff used an agency nurse induction checklist to orientate temporary staff to the clinic. The checklist included emergency procedures such as fire, evacuation and resuscitation equipment, equipment familiarisation, procedures, governance policy, electronic database training and compliance to uniform policy. All staff were required to wear personal identification at all times. We saw completed checklists that corresponded to shifts worked by bank staff.
- Due to working in an isolated unit not located at the NHS trust, staff were responsible for the management of any untoward incident or emergency. The duty roster was created to ensure that there was always a senior member of staff on duty, to ensure that staff had access to an experienced member of staff.
- Recruitment was managed centrally by the provider's human resources team. Pre-employment checks included the checking of professional registration and disclosure and barring service.
- The consultant nephrologist was the responsible clinician for all patients' dialysis and treatment and was contactable via mobile phone or secretary.
- In the event of an emergency, staff could access the renal team at the NHS trust for advice. We were told that staff would speak to the registrar on duty and discuss their concerns. Any changes to treatment were scanned across, to enable treatment to begin immediately and a hard copy posted to the centre. All scanned information was sent via secure NHS accounts.
- Due to the remote location of the clinic, the NHS trust had arranged for daily visits to the clinic by local GPs. The GPs reviewed patients and complete prescriptions as required. Nursing staff told us GPs would prescribe any urgent medicines and would offer support for unwell patients, arranging transfers to the NHS trust. GPs assisted with the monthly clinics and quality assurance meetings. This promoted shared learning about renal failure and treatment options.
- The dietitian support was provided by the NHS trust. The post was currently vacant and a temporary service was being provided three times per week.

## Major incident awareness and training

- The service had completed two fire evacuation practices since April 2017. The first had been unannounced and staff followed procedure ensuring patient safety: however, patients had generally chosen



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not to participate in the process. Therefore, the second practice was announced to staff and concentrated on educating patients to listen to staff instructions.

- Fire safety training had been completed by 88% staff, against a target of 100%.
- The service had a patient emergency evacuation plan, which was stored in the meeting room, and accessible to staff. This detailed actions to be taken, to ensure their own and patient safety in the event of an emergency.
- The provider had clear guidelines for the management of unforeseen or unplanned business disruptions. This included details of actions to be taken by staff at all levels. The service was registered as a priority location. This meant that in the event of loss in utilities, the service would be connected as a priority.
- Any issues relating to the failure of IT system, power, water, heating or telephone services were escalated to the senior managers through an automated email. This ensured that senior managers could coordinate any activities to reduce the risks with the failure. For example, patients could be transferred to alternative locations for treatment, and extra machines could be accessed.

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

### Evidence-based care and treatment

- The policies and procedures in place were developed in line with national guidance, standards and legislation. This included guidance from the UK Renal Association, National Service Framework for Renal Services and the National Institute for Health and Care Excellence (NICE).
- We saw that the IT systems enabled monitoring and data collection, as information was uploaded directly to the NHS trust database. Similarly, staff at the unit were able to access records at the trust; reducing time spent sourcing test results. The clinicians were able to access any patient information at the point of contact.

- Staff monitored and recorded patients' vascular access status each time the patient attended for treatment. This was in line with the NICE Quality Statement (QS72) statement 8 (2015).
- Patients were predominantly dialysed through arteriovenous fistulas. We saw that some patients had less established fistulas and were told that more experienced staff were responsible for cannulating these patients. This was in line with the NICE Quality Statement (QS72) statement 4 (2015): 'Dialysis access and preparation'.
- Patients' blood results were recorded monthly and discussed at the Quality Assurance (QA) meeting to identify the efficiency of the dialysis session. The team would review the blood results and amend treatment to ensure that the patients' blood results were optimised. Any changes to treatment were discussed with the patient before implementation. Therefore the centre met the national recommendations outlined in the Renal Association 'Haemodialysis Guidelines' (2011). For example, Guideline 5.7: 'The monthly measurement of dose or adequacy of haemodialysis' and Guideline 6.2: 'Monthly monitoring of biochemical and haematological parameter (blood tests)'.
- The service was not responsible for any patients who completed their dialysis at home. These patients were managed by the NHS trust.
- The service did not facilitate peritoneal dialysis (which is a type of dialysis that uses the peritoneum in a person's abdomen as the membrane through which fluid and dissolved substances are exchanged with the blood. It is used to remove excess fluid, correct electrolyte problems, and remove toxins in those with kidney failure).

### Pain relief

- All patients' prescription charts had paracetamol prescribed, which could be used for pain control. This was not used regularly.
- Patients were offered local anaesthetics for the insertion of their dialysis needles. We saw that this was accepted or rejected depending on the individual.

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- Nursing staff told us that if patients complained of pain, then they were initially assessed by the nurse. Patients were then reviewed by the visiting GP for additional support.

## Nutrition and hydration

- Patients in renal failure require a strict diet and fluid restriction to maintain healthy lifestyle. Patients attending the centre were supported by renal dietitians provided by the acute trust. The dietitians reviewed each patient monthly and offered advice on nutritional intake and managing conditions accordingly. They attended the service three times per week and included a twilight visit to capture patients attending later appointments.
- We saw that the dietitian produced an information board relating to what food patients could eat, should avoid and menu alternatives. Nursing staff told us that this was updated regularly and offered seasonal advice, such as what to eat at Christmas.
- Patients' nutrition was monitored through regular assessments of their weight and blood results. The dietitian attended the monthly quality assurance meeting to advise and support the patient's individual plan. At this meeting, patients' nutritional, fluids and blood results were assessed to identify the best treatment plan.
- We saw that staff completed a physical assessment to identify any additional fluid on each attendance to the service. We saw staff asking the patients if they had swollen ankles, were more breathless than normal and whether they had been eating well since their last appointment.
- The service provided patients with hot and cold drinks and a snack during their dialysis. We saw that most patients brought in their own refreshments.

## Patient outcomes

- The service had an audit programme to assess their effectiveness. This included healthcare documentation and infection prevention and control, and hand hygiene audits.
- Patients' treatment plan were defined by their renal consultant from the NHS trust. The renal consultant

provided clinical oversight at the unit and was also the responsible consultant for all the patients attending the unit. Individualised treatment prescriptions were developed to aim for positive patient care outcomes.

- The unit did not directly contribute data to the UK Renal Registry. Dialysis information was collected centrally at the NHS trust, and automatically uploaded from the dialysis machines.
- Data specific to the unit was available via the provider's own database and was used to benchmark patient outcomes both as an individual clinic and nationally against all Diaverum clinics. The service performed as expected, and within the top eight units nationally in January to March 2016.
- Treatment adequacy was reviewed monthly as part of the patient review (quality assurance meetings) in accordance with the Renal Association Standards. Staff reviewed patient's blood results to identify if the dialysis was adequately working, and treatment was changed accordingly. Treatments were adjusted to ensure the best results for patients and any changes to prescriptions were discussed with patients prior to completing them.
- Patient dialysis prescriptions were audited bi-monthly to ensure that patients were receiving the correct dialysis. Unit data showed that in January, May and June the unit achieved over 97% compliance against prescriptions. The common area that was not achieved was blood flow, which can be affected by patient clinical condition or vascular access difficulties.
- Data provided by the service showed that there was varied compliance with audits. We saw that the needle taping audit completed every two weeks showed 100% compliance on each occasion since January 2017. Needles used for dialysis are taped to the patient's skin to ensure they do not fall out during dialysis.
- The audit of dialysis prescriptions regularly showed non-compliance in over half of the records reviewed. With the "correct UF" (ultrafiltration- fluid removal), "correct Qb" (blood flow rate), and correct "Qd" (dialysate flow rate) not achieved. The reasons recorded were due to patients' requests or vascular access issues. We saw that patient compliance had

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improved over the six months up to July 2017. Nursing staff told us this was in response to patient education and patients seeing changes to other patients' treatment times and their compliance.

- We reviewed results of blood tests for three months from January to March 2017. The results showed how the unit performs in the achievement of quality standards based on UK Renal Association guidelines. These comprised of a number of outcomes, for example:
- Two standards we looked at show how much waste products are removed from the patient and how effective the dialysis is;
- the rate blood passes through the dialyzer over time, related to the volume of water in the patient's body (expressed as  $\text{eKt/V} \geq 1.2, \text{h}$ )
- and the Urea Reduction Ratio (URR)
- The unit performed well in respect of the first standard with just over 84% of patients receiving effective dialysis.
- For the URR, Renal Association guidelines indicate a target of 65%. The average URR for the patients at the unit exceeded this target with 99% from February 2017 to April 2017. 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 January to March 2017, the unit reported that 57% of patients met the NICE recommended target of Hb (100-120 g/l). This was in line with the UK average of 58-59% for April 2016 to March 2017. This meant the other 43% of patients had higher Hb levels and did not require treatment. 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 were monitored as part of the Renal Association standard. From February to April 2017, the unit performed well, with an average of 1.35% patients with high potassium levels (greater

than 6.0 mmol/l). If potassium levels are higher than 6mmols, it can cause acute cardiac problems. This meant around 98.6% of patients had potassium levels within acceptable ranges.

- Staff monitored patients' vascular access such as fistula, graft and dialysis catheter monthly. We noted that staff reviewed the targets for optimising vascular access by increasing the use of arterio-vascular fistulas (AVF) and reducing the use of catheters as set out by Diaverum. The clinic worked closely with the referring NHS trust to achieve the national standards. The service collected data for clinical performance measures. The patients' vascular access data for the period of January to March 2017 showed 60% had AVF access.
- Patient outcomes were monitored against the renal quality standards (Renal Association Guidelines). We were told that comparison against the national standards was discussed as part of the trust contract meeting.
- From March 2016 to March 2017, the unit reported eight patient deaths. This included three patients who withdrew from treatment and one who deteriorated whilst having dialysis and subsequently died in hospital. The remaining four patients died unexpectedly as a result of comorbidities either at home or in a NHS trust.

## Competent staff

- New staff received a minimum of eight weeks supernumerary time with an extensive induction programme that included, clinical and academic training. The practice development nurse and the clinic manager oversaw this process. All staff were allocated a mentor.
- Staff completed orientation programmes on commencement of post. These were developed in conjunction with the practice development nurse who assisted with the training and mentoring of staff.
- Staff were assessed against a competency package. The service used a 'train the trainer', and 'super user' approach to some clinical skills, with some members of the team receiving additional training to enable them to cascade training.



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- Each staff member had a training file, which detailed courses completed and dates of mandatory training. Training was supported by the practice development nurse and consisted of competencies, in-house training, external training (such as manual handling) and e-learning modules.
- Staff completed an annual appraisal, which reviewed training completed and any development plans. We saw that the service had 100% compliance with appraisals, for available staff.
- Staff were trained to use equipment within the centre through a service level agreement with the manufacturers. This meant that staff were fully trained by the manufacturer when any new equipment was purchased. We saw that staff also held competencies relating to specific equipment. We were told that any agency staff attending the clinic were offered a supernumerary day to ensure that they were familiar with the machines and equipment used at the service.
- We were told that staff had link role for specific topics such as infection control, diabetes, renal access and anaemia management. The link nurses attended additional training on the topics and ensured that the most recent best practice was used locally. Staff kept their colleagues informed of any changes at team meetings.
- The manager and the link health and safety nurse had completed training with the Institution of Occupational Safety and Health (IOSH).
- The manager and deputy manager held specialist renal qualifications. The service was planning to enrol two further members of staff to a renal speciality course later in 2017.
- Staff were encouraged to support peer learning and have added a peer learning session into staff meetings to support the Nursing and Midwifery Council revalidation scheme.
- The manager tracked nurse registration renewals (revalidation), to ensure that staff had a professional registration to work.
- The renal consultant supported the local GPs in relation to competence within the dialysis and renal speciality. Key areas for this were during the quality assurance meetings and clinics at the centre, which the GP attended with the consultant.
- Training and development was an agenda item at staff meetings and a clinic peer review system had been introduced to share practice across the organisation.
- Staff were required to undergo the NHS training for blood transfusions. Service records showed that 100% staff had completed blood transfusion training.
- All staff were expected to have an up to date disclosure and barring service certificate. These were held centrally by the provider's human resources department.

## Multidisciplinary working

- We saw that the nursing team worked effectively to ensure safe and timely patient treatment and care. There was evidence of collaborative working with the wider team, including the practice development nurse, area manager, lead consultant, GPs and dietitian.
- GPs attended the unit daily to assess any patients who were unwell and prescribed medicines as necessary. They worked closely with the consultant nephrologist who had overall responsibility for patient care and treatment. Joint consultant and GP clinics were held which enabled GPs to access specialist advice from the consultant nephrologist.
- We were told that GPs would be the first medical assessors when patients were unwell, offering support with prescribing medicines for any suspected infections and liaising with the NHS trust to refer or admit patients.
- Dietitians were provided by the NHS trust and liaised directly with the consultant and GPs as necessary.
- The consultant, GP, service manager, dietician and satellite haemodialysis coordinator attend monthly quality assurance meetings, during which, each patient was reviewed.

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- All audit results were discussed with the NHS trust as part of the monthly contract review meetings. This meant that the NHS trust had an overview of the performance of the clinic including any specific issues and actions being taken.
- The satellite clinic dialysis coordinator attended the service regularly to assist with the management of patients and offer support. We saw that there was a positive relationship between the clinic staff and the satellite dialysis coordinator, with open discussions regarding patient care, plans for treatment and development opportunities.

## Access to information

- The NHS acute trust and the provider had separate IT systems that communicated automatically. The provider's system (iRMS- International Renal Information Management System) collated patient information and allowed staff to raise incident forms, complete letters and access policies, training and procedures. The NHS trust system (electronic patient record) collected all dialysis information, allowed staff to access blood/ investigation results and substantive staff to access their own desktops. This process meant that wherever the patient was, staff could access the most up to date information held.
- Paper records were maintained to enable patients to continue to dialyse if the IT system was not working. Patient files contained a dialysis prescription, which was updated regularly according to any changes in treatment plans.
- Communication to patients GPs and services outside the NHS trust were completed by the consultant.
- Letters received from outside the NHS trust were scanned and forwarded to the consultant secretary for urgent review.
- Details of any changes made to patient's treatment following quality assurance meetings were typed by the team administrator and forwarded to the patient's GP. Nurses informed patients of any changes at their next dialysis session.
- Mandatory data protection training had been completed by 82% of staff against a target of 100%.

## Equality and human rights

- From 1st August 2016 onwards, all organisations that provide NHS care were legally required to follow the Accessible Information Standard. The standard aims ensure that people who have a disability, impairment, or sensory loss are provided with easy to read information and support to communicate effectively with health and social care providers.
- Staff reported that they did not have any patients who required additional support with communication. We were told that staff were able to facilitate patients who required additional support by allocating staff accordingly and working with the patient's usual carers. Staff were not aware of any easy to read versions of information leaflets.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their roles and responsibilities in relation to the requirements of consent. We saw that 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 found in the records that patients had signed consent forms for dialysis treatment. This was checked annually and a new consent was signed in line with corporate policy.
- Staff were able to explain the process of consent and actions that they would take for concerns relating to mental capacity. The local policy required staff to escalate concerns directly to the NHS trust.
- Mental Capacity Act training had been completed by 100% staff in February 2017.
- Deprivation of Liberty Safeguards training was included in safeguarding adults level two training. This had been completed by 100% staff.
- The staff reported that there were processes in place for when mental capacity was in question. This involved patients being assessed by the daily visiting GP who would complete a mental capacity assessment.
- Staff reported that there were currently no patients who were unable to understand their dialysis plan and treatment and were not concerned about any patient's ability to give informed consent.

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## Are dialysis services caring?

### Compassionate care

- Staff took into account patients' individual personal, cultural, social and religious needs when providing care.
- We saw that all interactions between patients and staff were respectful, considerate and polite.
- As patients attended the service regularly, sometimes for several years, staff reported that patients were considered as an extended family.
- Patient had clearly developed appropriate relationships with staff and other patients. The atmosphere was relaxed and patients chatted to staff and each other. Patients chose to listen to music during dialysis and often sang along with requested music.
- We saw that nursing staff spent time during the patients' dialysis session asking patients if they were well, had any concerns or wished to discuss anything.
- Patients we spoke with were unanimously positive about the service and the staff.
- Staff maintained patient confidentiality. We saw that patients were spoken to quietly so not to share information when speaking and were discreet when talking on the telephone and in meetings.
- We provided the centre with comment cards for patients to "tell us about their care"; however we found that none were completed during the inspection period

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

- Patients were kept informed of their care and treatment. We saw that patients were asked questions about their treatment and their condition since their last dialysis session.
- Patients knew who their named nurse was and confirmed that they were updated by them regarding any treatment changes.
- Patients were encouraged to take part in their care. For example, we saw a patient that preferred to dress

their own puncture sites following the removal of their dialysis lines. Nursing staff told us that all patients were encouraged to participate in their treatment to different levels. Training was provided for all patients wanting to participate in their own care.

- The service offered patients and their relatives with additional support networks. The service worked closely with the NHS trust, GPs and charities to provide patients with seamless care and support.
- Patients were able to bring carers to dialysis sessions if they wished.
- Patients who were referred to the service were offered a visit to meet staff, and have a look at the clinic prior to starting treatment at the centre. These visits were usually arranged by the haemodialysis satellite clinic coordinator with the clinic manager. Staff said that the visits gave patients the opportunity to meet other patients, and ask any questions about treatment. We spoke with several patients who confirmed that they had made a visit to the clinic prior to commencing treatment and stated this was a positive experience.
- Patients told us that they felt informed of their treatment and plans for ongoing care and were given the opportunity to speak to nursing staff or the GP. We saw discussions taking place about recent blood results, and treatment options during our inspection.

### Emotional support

- We saw that patients spent time talking to each other on arrival and when leaving the centre, often delaying their departure for long periods while "catching up" with fellow patients. Staff demonstrated that they understood the importance of the support that fellow patients gave each other.
- Staff were aware of the impact of renal failure, dialysis and ongoing treatment on patients and their families. They offered advice and access to different support networks.
- We saw that patients were given information in a timely manner. Patients seen in clinic appointments were given time to ask questions. The atmosphere in the service was very sociable and we saw patients offering each other support and discussing coping mechanisms.

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- The service had access to charities who offered support to patients and their carers. We saw that activities were arranged and well attended.
- Staff said that the service offered patients social activities such as meals and days out. These were well attended, and staff reported that patients and staff enjoyed the social aspects of an extended family.
- Patients were able to access a social worker for advice if necessary. We saw that the social worker advertised their attendance at the clinic and patients were asked to call to make an appointment. Staff brought this service to patients' attention when needed.

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

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

- The service completed monthly contract meetings with the NHS trust, which were attended by the senior nursing team and managers. The meetings reviewed audit data, patient dialysis performance and any contractual details. We saw that the meetings followed a set agenda and offered open discussions between the provider and the NHS trust staff.
  - The centre was purpose built in 2014, in line with specifications outlined in the health building notes, and had been converted from a garage building. The Department of Health provides best practice guidance for the design and planning of new healthcare buildings and the adaptation or extension of existing facilities, via health building notes. Hereford Kidney Treatment Centre facilities were in line with Health Building Note 07 01: 'Satellite dialysis units' (2013) guidance.
  - Some patients had received dialysis in the previous dialysis centre in Hereford. Staff told us that patients had been kept informed of the progress with the building of the new unit two years ago and in preparing the site for opening.
  - Patient transport services were provided by an external company and arranged by the haemodialysis satellite clinic co-ordinator on referral to the centre.
- Patients were responsible for arranging their own transport on a three monthly basis. Nursing staff told us that the opening of the satellite service had reduced patient travel times. However, due to the rural nature of this particular area, some patients faced long journey times. Some patients travelled for up to one hour.
- The service did not monitor patient travel times as per the National Institute for Health and Care Excellence (NICE) guidelines therefore could not provide confirmation that adults using transport services were collected pre and post treatment sessions within 30 minutes. However, this was outside of the clinic's responsibility.
  - Data provided from the service confirmed there was no transport user group for those patients who used patient transport services. Both staff and patients told us that the patient transport services caused problems such as patients being delayed following treatment. The manager told us of liaison between the service, the patient transport services and the NHS acute trust to identify solutions to better manage this. The commissioning group had taken over the management of the transport and was holding daily briefing calls to identify the issues and offer support.
  - Patients transport was arranged by the CCG; who had changed the transport contract in May 2017. Staff said that due to the remote location of the clinic, there were issues with obtaining local drivers. The impact of this resulted in drivers travelling from Birmingham, who were unfamiliar with the area and often were lost or delayed. The CCG were continuing to recruit local drivers and maintained daily performance meetings to discuss any issues.
  - Due to the remote location of the service, patients were reviewed daily by a local GP and seen by the consultant at their clinic appointment.
  - Two patients that we spoke with said that they saw the renal consultant every six months. They were happy with this, as they were well and stable on dialysis. They both stated that if they wanted to see them any more frequently this would be arranged easily.
  - All patients were aged over 18 years, with the larger portion being over 65 years. The unit did not provide dialysis for patients under 18 years.

# Dialysis Services

- The service had ramp access for patients who required a stretcher or wheelchair. There was adequate patient parking within a short distance from the main entrance. Patient and disabled parking was clearly signposted.
- Most of the rooms at the service were fitted with automatic movement sensing lighting, to reduce wasting electricity.

## Access and flow

- The service provided outpatient haemodialysis therapies for patients in end stage renal disease. They were either already established on renal replacement therapy or new patients who had been assessed by the referring doctor to be fit to commence treatment in a satellite setting. Referrals were made as part of the contract with the referring acute NHS trust.
- Patients were referred to the service if appropriate for their home address. Patients with renal failure living in Hereford were able to access the clinic when a space became available. This meant that patients did not have to travel further afield for treatment.
- The utilisation rate for the service from December to February 2017 was 90% and there were no patients currently on a waiting list for the unit.
- The service completed morning and afternoon dialysis sessions daily from Monday to Saturday. In addition, there was an evening dialysis session on Mondays, Wednesdays and Fridays. At the time of inspection, there were no plans to extend the evening sessions or add in an overnight service. Patients we spoke with were happy with the time of their dialysis session.
- The service was not running at full capacity at the time of the inspection, with 16 patients dialysed at most sessions with the exception of Tuesday, Thursday and Saturday afternoons and the twilight shifts when 12 patients were dialysed. This meant that the service was able to manage additional patients as they were referred providing there was adequate staffing numbers.
- Patients were able to change dialysis sessions if necessary or for the flexibility, additional sessions could be provided if staffing levels allowed.
- Patients were prioritised for their treatment depending on the duration of their dialysis. There were additional factors, which influenced the timing of the dialysis sessions, including, transport, appointments and clinical condition.
- We saw that dialysis sessions largely ran to schedule with patients waiting for short periods on arrival to the clinic for their machine to be ready and their treatment to begin. Where possible, patients were allocated to the same dialysis machine on each attendance. We saw that patients were called in as soon as their dialysis machine was ready for use.
- The healthcare assistants were responsible for the removal of dialysis machine lines and cleaning the dialysis station after each treatment. This meant that nursing staff were able to prioritise commencing or discontinuing treatments.
- Four patients transferred to other services from April 2016 to April 2017. This was in response to changes in clinical condition.
- The manager reported a high number of patients with complex needs due to their age and comorbidities. Staff reported that they were flexible with patients' treatments because of frailty and often reduced dialysis time because of other patient concerns. We saw that there were a number of treatment variation forms completed for each month detailing reasons for reduced dialysis. The total number of shortened dialysis sessions was 22 in March, 26 in April, 23 in May and 15 in June 2017 (up to 20 June).
- There were no patients dialysis treatments cancelled or delayed in the six month period ending July 2017.

## Meeting people's individual needs

- Access to the service was through a level automated door, which had a buzzer into the reception desk and nurse's station for access. Visitors were required to sign in and we saw staff check identity of individuals prior to allowing access to the clinic.
- The reception area was large enough to provide seating for 20 patients. We saw that some seating was appropriate for bariatric patients. The reception desk



# Dialysis Services

was staffed four days per week between 9am and 2pm. Outside of these hours; a shutter was closed to ensure that unauthorised persons did not have access to personal identifiable information.

- We were told that due to the distance between the commissioning NHS trust and some patients' home addresses, patients who had been admitted to the NHS trust for treatment were often accepted back to the service for ongoing dialysis sooner than at other clinics. This enabled patients to return home and to a familiar environment.
- There was one disabled toilet within the main clinic and two in the reception area. All areas were accessible to patients who required a walking aid or wheelchair for mobility. The service also had a serviced hoist, which could be used to assist with patients transfers from chairs to bed. We saw staff assist a patient to lie on a bed for the duration of their treatment.
- Each station had a dialysis chair or bed, side table, television with headset, call bell and dialysis machine. Privacy curtains or screens were also available for each dialysis station.
- Patients who required additional support for conditions such as dementia, were dialysed at the NHS trust where the nurse to patient ratio was altered to ensure patient safety. Nursing staff told us that they currently had no patients that required additional support for their dialysis. Patients with learning disabilities or those living with dementia were not excluded by the service, and were assessed by the NHS trust prior to being referred to the centre for treatment. This process was to ensure that the unit was able to provide the necessary support required for treatment.
- Our review of seven patient care records demonstrated to us where staff had considered individual patient needs for example, age, disability, race and religion or belief. This meant discrimination was avoided when making care and treatment decisions.
- The service provided treatment for patients holidaying locally, following a referral to the service. Prior to agreeing to treat patients, the centre ensured that there was sufficient capacity for the additional person.

There were strict guidelines for the accepting of patients on holiday, this included the completion of a referral letter from the current dialysis centre, completion of virology blood screening and if appropriate, isolation from other dialysis patients.

- We saw that information leaflets were largely available in English and not all staff were sure how to access translators if necessary. Staff told us that due to the limited ethnicity of the local population they did not see this as an issue, knowing to escalate any communication issues to the manager.
- Staff knew that interpreters could be accessed if necessary. However, some staff were not clear about the procedure for arranging this.
- Nursing staff taught patients who wished to complete their own treatment, using a patient competency package. We saw that patients were assessed for competence prior to completing their own treatment. Some patients completed all of their own treatment while others assisted with sections of it. For example, some patients inserted their own needles while others prepared their own dialysis machine.

## Learning from complaints and concerns

- The service had processes in place for the management of complaints and concerns. The manager investigated any complaints, with the support of the local team and the area manager. Patients would be kept informed of the complaint investigation and offered a copy of any records relating to their complaint.
- The service received four complaints from February 2016 to November 2016. These all related to transport. We saw that the manager had referred the complaints on to the relevant agency for a response and liaised directly with the patients to inform them of the actions taken. From December 2016 to June 2017, the service did not receive any complaints.
- Patients and their relatives were given information booklets on referral to the service. The booklet contained information relating to the complaints process and who to contact.

# Dialysis Services

- We were told that patients were encouraged to voice any concerns. There were poster displays and comment cards available for patients in the reception area.
- The provider completed a biannual patient feedback survey. Results of the last survey were displayed in reception, along with any actions taken to respond. We saw that comments included transport issues and the temperature of the clinic.

## Are dialysis services well-led?

### Leadership and culture of service

- Locally, the service was led by the clinic manager, who was also the registered manager responsible for the service. A deputy manager, nursing staff, healthcare assistants, dialysis support workers and a team administrator supported the clinic manager.
- Diaverum UK Limited (Diaverum) divided their services into three localities, the north, south and midlands. Each locality had an area manager and a practice development nurse. The national team included the director of nursing, operational manager, financial, commercial and operational clinical division leads and a managing director.
- The area manager and practice development nurse were present for the announced inspection. It was clear from their interactions with staff and patients that they regularly attended the clinic. Conversations were open and friendly.
- The manager attended a one to one meeting with their line manager monthly. This included a discussion on the clinics' performance, any issues with staffing, sickness levels, and any other service plans.
- Nursing staff reported that the senior nursing team and manager were approachable and always responded positively. The manager's office was located behind the nurses' station and staff and patients told us they could access the manager whenever they wanted.
- Local managers attended area manager meetings every six weeks. The aim of the meeting was to share learning, provide a support network and complete managers' training.
- The midlands team had introduced a peer review programme. This was the process where each clinic manager could visit the other clinics to see how they were managed and obtain ideas for their own development.
- Similarly, the deputy managers had been allocated a manager from another clinic who would act as a mentor. We were told that the deputy managers spent half a day with their allocated mentor manager to see how different clinics were managed, and develop ideas on their own management skills.
- We saw that all staff had completed an appraisal and contributed to their individual action plan for the year. Staff were encouraged to develop an action plan, which detailed their objectives and how they were planning to achieve them.
- Leadership created a culture where staff were aware of the importance of being open and honest with their patients. Staff gave us examples of when treatment was discussed and they supported patients with difficult decisions.
- We saw that the nursing team had an effective working relationship with staff from the NHS acute trust. We saw open discussions relating to patient's care and treatment; staff were given time to explain their thoughts and asked to confirm their agreement with plans.

### 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 that was based on the approach to improving patients' lives, by providing the best treatment, and patient choice. Locally, the staff team was 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.

### Governance, risk management and quality measurement

# Dialysis Services

- There was a governance structure in place, which included local monitoring and comparison against area and national data. Quality assurance was monitored through regular audits, guidance and procedures based on national guidance, staff training and workforce planning.
- The manager and consultant nephrologist were the clinical leads for the maintenance of governance and quality monitoring.
- The manager was aware of some of the risks in the service, but these were not formalised in a risk register at the time of our announced inspection. This was raised with the service and we saw that actions were taken to address this. Following our inspection, the unit manager completed a risk register, which detailed risks identified and actions to address them. For example, we saw that staff recruitment, interruptions to service and patient safety were highlighted as concerns, with development of healthcare assistants, priority callout and ensuring secure access noted as actions.
- There was a lack of oversight in some areas, including machine servicing, cleaning schedules and their compliance. We saw that dialysis machine servicing, weekly deep cleans were not routinely completed, and there appeared to be no checks in place to monitor compliance. However, when we escalated our concerns, staff took prompt action to resolve the issues identified, reviewing the systems in place and adding additional checks to ensure compliance.
- Dialysis performance was uploaded to the renal registry via the NHS trust following verification. Dialysis compliance information was also used by Daavrum to compare units nationally to identify any areas of improvement. Hereford unit consistently performed in the top half of units nationally.
- Quality assurance meetings occurred monthly and were attended by the consultant, GP specialist, clinic manager, satellite dialysis coordinator and dietitian. The clinic secretary recorded discussion topics and any outstanding actions. Minutes were circulated across all attendees and clinic staff. Nursing staff acknowledged any changes to treatment plans by signing the records.
- The service had an audit calendar that detailed which audits should be completed and at what frequency. We saw that audits were completed by a variety of staff, mostly link nurses for that area. For example, the infection control and prevention link nurse completed the environmental and handwashing audits.
- Area meetings occurred every six weeks. Staff said that these meetings were the opportunity to complete specialist training, discuss any changes to the service and gain peer support. We saw that staff in all roles were involved with these meetings.
- We saw minutes from the contract review meeting, which detailed key factors from each clinic and actions to be taken to address any concerns.
- We saw that the manager maintained a patient vascular access risk register. This detailed any issues with patients' vascular access, and what actions had been taken to address this. The vascular access risk register was used to provide an overview during quality assurance and contract meetings.
- The Workforce Race Equality Standard (WRES) is a requirement for organisations that 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 service was not located in a culturally diverse area and the majority of staff were white English by background. The unit did not currently have a WRES report, however were working towards completing one.

## Public and staff engagement

- Daavrum completed biannual patient surveys, which were managed by an external provider. Patients, their friends and families, were able to complete an anonymous questionnaire to identify any area for improvement. Results from the October 2016 survey, showed that 93% patients were satisfied with the service and would recommend to a friend. The response rate was 57 out of 69 patients. This score placed the service third best nationally of all Daavrum clinics.
- Main issues raised by the survey related to patient transport systems and we saw from the survey action plan that steps were taken by the service to address



# Dialysis Services

this, For example, direct correspondence with the transport provider when issues arose and informing transport of opening times. Transport services had changed in May 2017 in response to a high number of complaints. This was being managed by the clinical commissioning group.

- The NHS trust also completed a patient survey, where patients were asked to respond anonymously to a survey by post. These results were shared with the team locally at team meetings. We saw that between 10 and 15 staff members attended each team meeting between January and May 2017.
- The service had regular team meetings, which were well attended and held in the reception area. We saw that minutes showed detailed discussion of topics including, incidents, staffing, infection control, training and any company changes.
- Prior to the centre opening, patients were invited to attend an opening day when they could look around the centre. Patients and staff reported that patients had enjoyed the opportunity to look around the centre before attending for their dialysis.
- There was an active user group at the centre with patients attending meetings and organised events.

The centre had links with the Kidney Patient Association and the National Kidney Foundation who provided information leaflets and advertised support groups and events.

- Staff participated in seasonal activities to entertain patients during their dialysis. This included carol singing, fancy dress and patient parties.
- Diaverum completed annual staff surveys. Data from last year's survey (2016) showed that staff responded better than average for all questions, with one exception, which was support for practice development. Positive scores were reflected in staff feeling motivated, feeling valued, receiving constructive feedback, and support for the manager. 16 out of 17 members of staff completed the staff survey.

## **Innovation, improvement and sustainability**

- The service was developing their own staff in response to difficulties in recruitment. We were told that two healthcare assistants had completed training to become dialysis support workers.
- A deputy manager development programme provided opportunities to develop leadership skills and gain experience other clinics.

# Outstanding practice and areas for improvement

## Outstanding practice

- GPs attended the clinic daily to assist with the monitoring and planning of treatment for patients.

## Areas for improvement

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

- The provider must ensure that the workforce and race equality standards (WRES) are implemented in full.
- The provider must make sure that any medication management must be completed in line with requirements of the Nursing and Midwifery Council.
- The provider must ensure that all temperature sensitive medicines are stored in line with manufacturers' requirements to maintain patient safety.
- The provider must ensure equipment is serviced in line with manufacturer's recommendations.
- The provider must ensure that all equipment is cleaned and fit for use and cleaning schedules reflect the equipment used on the unit, and are monitored to ensure completion.

- The provider must ensure that all corrosive and harmful solutions and products are stored in line with manufacturer's recommendations and in line with COSHH regulations.
- The provider should ensure that risks are assessed, monitored and mitigated to reduce potential safety risks for patients.

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

- To ensure safeguarding children training is provided for all staff.
- To ensure that mandatory training is completed in line with requirements.
- To follow the Accessible Information Standard to ensure that people who have a disability, impairment, or sensory loss are provided with easy to read information and support to communicate effectively.
- To implement the National Early Warning Score tool to assist with identifying clinical deterioration.

## 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> <p>12.—(1) Care and treatment must be provided in a safe way for service users.</p> <p>(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—</p> <p>(b) doing all that is reasonably practicable to mitigate any such risks;</p> <p>(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;</p> <p>(g) the proper and safe management of medications.</p> <p>The provider was not meeting the regulation because:</p> <p>We saw that two nurse checks were not always completed when administering medication.</p> <p>We saw that temperature sensitive medicines were not always stored in line with manufacturer's recommendations.</p> <p>We saw that some equipment was not serviced in line with manufacturer's recommendations.</p> <p>We found that some equipment was not cleaned in line with recommendations.</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p>

This section is primarily information for the provider

## Requirement notices

17-(2) (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The provider was not meeting this regulation because:

There was no formal risk register at the time of inspection. There was a lack of oversight of risk in some areas, including machine servicing, cleaning schedules and their compliance.