Taunton Renal Unit

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Taunton Renal Unit is operated by B. Braun Avitum Limited. The service has 16 dialysis stations, which included two side rooms for patients and operates three sessions daily. The service is open six days a week, between Monday and Saturday and carries out 252 dialysis sessions a week for a caseload of 84 patients. The dialysis service is provided to NHS funded adults between the age of 18 years and above and has carried out 13,556 dialysis sessions in the last year prior to our inspection. The Royal Devon and Exeter Hospital commissioned B Braun to provide a haemodialysis service at Taunton Renal Unit.

The service is a nurse led unit which provides outpatient satellite dialysis provision to patients.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 20 June 2017 and carried out an unannounced visit on 28 June 2017.

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

- Staff did not receive feedback after reporting incidents.
- Staff were not fully compliant with mandatory training in line with corporate policy.
- Nurses did not check patients' identity prior to commencing haemodialysis treatment.
- The unit needed to ensure the safe management of all patient medicines which includes the administration of fluid boluses during haemodialysis, the safe administration of intravenous medicine in line with the Nursing and Midwifery Council Guidelines (2013), and ensuring dialysis prescriptions were up to date, signed and dated by the lead consultant for the unit.
- Nurses at the unit were transcribing the patient's dialysis prescription which was not in line with guidance from the Nursing and Midwifery Council (NMC, 2015).
- There was no policy or guidance available to staff about the early recognition or management of sepsis. Staff had received no specific training for the early identification of sepsis and management (infection) in line with national guidance (NHS England, 2015).
- There was no assurance actions following the continuous quality improvement meeting had been completed. Nurses were not signing and dating documents to identify when actions had been completed.
- Learning objectives set by staff over one year ago had not been signed off to demonstrate the staff member was competent and had achieved the objective.
- There was no awareness of and evidence of compliance with the Workforce Race Equality Standard (WRES) which became mandatory in April 2015.
- We were unable to find evidence in staff meeting minutes about discussions which should have taken place as a result of the patient satisfaction questionnaire, which had been signed off as completed in the action plan.
- We were not assured that risk, quality and performance was monitored for trends and learning.
- The processes to share learning, risk, quality and performance information with staff was not consistent or thorough.

Summary of findings

- There was not an effective process to monitor 'live' risks which included evidence of how local service risks were identified, mitigated and acted upon.
- However, we found the following areas of good practice:
- There was a good incident reporting culture and the staff were aware of the procedure to follow when reporting an incident or an adverse patient incident. Staff followed company policy with regards to infection, prevention and control.
- The unit had clear processes to ensure regular servicing and maintenance of equipment, and there were policies and procedures to follow in case of a failure in the water supply or power failure. Staff were aware of their roles and responsibilities to maintain the service in the event of a major incident.
- Evidence based practice and the Renal Association guidelines were used to develop how care and treatment was delivered. All policies and procedures were based on national guidance and updated when required to reflect change to national guidance and then distributed to staff. Patient outcomes were monitored in line with best practice guidelines.
- There was a comprehensive training and induction programme in place to ensure staff competency.
- There was good multidisciplinary working and strong communication links with the lead consultant and the local NHS trust.
- There were effective processes for gaining informed consent, which was sought and documented prior to treatment.
- Patients were treated with dignity, compassion and respect, and on the whole maintained their privacy and dignity in all aspects of care.
- Staff understood the impact of the treatment on patient's emotional wellbeing and actively supported patients.
- Services were planned and delivered to meet individual patient needs and improve their quality of life.
- There was a system to monitor and deal with complaints. There had been no formal complaints at the unit in the year prior to our inspection.
- Leaders had the skills and experience to lead and the senior management team were visible and accessible.
- Staff felt valued and supported in their roles and reported a positive working culture.
- There was a replacement programme for the dialysis machines, in line with the Renal Association guidelines.

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

Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis Services		We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Location name here

Services we looked at
Dialysis Services;

Summary of this inspection

Background to Taunton Renal Unit

Taunton Renal Unit is operated by B. Braun Avitum Limited. The service opened in 2008. The unit was designed and built in the Creech Castle area of Taunton and provides a clinical area, storage, offices and staff rest areas. The unit primarily serves the communities of Taunton. The unit also accepts patient referrals from outside this area.

The registered manager in post at Taunton Renal Unit since 2013 and is registered for the regulated activity of treatment, disorder and injury and diagnostic and screening procedures.

We inspected Taunton dialysis unit on 20 June 2017 and carried out an unannounced visit on 28 June 2017.

Our inspection team: The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector.The inspection team was overseen by an Inspection Manager and Mary Cridge, Head of Hospital Inspections.

Information about Taunton Renal Unit

The unit is registered to provide the following regulated activities:

- Treatment of disease, disorder and injury.
- Diagnostic and screening procedures.

During the inspection, we visited Taunton Renal Unit. We spoke with 10 staff including registered nurses, healthcare assistants and we spoke with seven patients. During our inspection we reviewed six sets of patient records. We also received 55 'tell us about your care' comment cards which patients had completed prior to our inspection.

There were no special reviews or investigations of the service on going by the CQC at any time during the 12 months before this inspection. The service had received an unannounced inspection in June 2013. The service had met all of the standards it was inspected against.

The unit has a service level agreement with the Specialist Commissioning Group for the provision of outpatient satellite haemodialysis to patients. The unit is nurse led, with clinical supervision being provided by two consultant nephrologists from the local parent acute trust.

Activity (January 2016 to January 2017)

- In the reporting period January 2016 to January 2017, the unit provided haemodialysis for both adult male and female patients from 18 to 65+ years of age. The unit opened six days weekly and carried out 13,556 haemodialysis sessions in the last year. The unit provided three sessions daily, morning, afternoon and evening sessions.

The unit employed 14 registered nurses and 4 health care assistants, working both full time and part time contracts. The unit also had its own bank staff and a consultant nephrologist, from a local parent acute NHS trust, providing medical support.

Track record on safety

- No never events
- No clinical incident
- No serious injuries
- One incidence of healthcare associated methicillin-resistant Staphylococcus aureus (MRSA),
- One incidence of healthcare associated methicillin-sensitive Staphylococcus aureus (MSSA)
- Zero incidences of healthcare associated Clostridium difficile
- No complaints.

Services accredited by a national body:

- Investors in People accredited award (2016)
- ISO 9001:2008 (accreditation given to organisations, which fulfil a set of quality management standards)
- IEC 62653

Summary of this inspection

Services provided at the hospital under service level agreement:

- Dietetics
- Building, plumbing and electrical maintenance
- Maintenance and repairs on dialysis chairs
- Electrical testing and medical device servicing and calibration
- Pharmacy support.

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 found the following areas where the service provider needs to improve:

- Not all staff were fully compliant with mandatory training in line with corporate policy.
- The unit needed to ensure the safe and proper storage, management and administration of medicines. The unit did not have a relevant policy, patient group direction or prescriptions for administering fluids to patients with low blood pressure. This was not in line with national guidance (National Institute for Health and Care Excellence, CG 174, 2013).
- Nurses at the unit were transcribing the patient's dialysis prescription which was not in line with guidance from the Nursing and Midwifery Council (NMC, 2015).
- Prescription medicines were left out on nurse's trolleys and not locked away.
- Staff did not follow the NMC 2015 guidelines with regards to checking a patient's identity prior to administering intravenous medicines.
- Dialysis prescription chart amendments were added by the nurse at the unit and not signed and dated by the prescriber, the lead consultant for the unit.
- There was no policy, standard operating procedure or specific staff training to promote the early identification of sepsis (infection) in line with national guidance (NHS England, 2015).
- Staff did not receive feedback form incidents they reported.
- Patient identity was not checked prior to commencing haemodialysis treatment.
- The majority of the dialysis chairs were damaged, which meant the chairs could not be disinfected effectively.
- There was no assurance that actions arising from the continuous quality improvement meeting had been completed. Nurses were not signing and dating the forms from the meeting to demonstrate actions had been completed.

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

- All areas appeared visibly clean and staff followed B. Braun policy and procedures to prevent the spread of infections.
- The unit had clear processes to ensure regular servicing and maintenance of equipment.

Summary of this inspection

- There were policies and procedures to follow in case of a power failure or disturbance with the water supply during a dialysis session.

Are services effective?

We found the following areas of good practice:

- Evidence based practice and the Renal Association guidelines were used to develop how services care and treatment was delivered. Patient outcomes were monitored against best practice guidelines.
- There was a comprehensive training programme to ensure new nurses were competent to carry out their role at the haemodialysis unit.
- There was good multidisciplinary working and strong communication links with the lead consultant and the local NHS trust.
- Staff at the unit had access to information about patients, which enabled effective care and treatment, including access to local NHS patient records, via computer systems.
- Informed consent was sought and documented prior to commencing treatment.
- Nutrition screening tools were used to identify patients at greatest risk of malnutrition.

However, we found the following areas where the service provider needs to improve:

- Some training records and learning objectives identified over one year ago had not been signed off as completed. We were unsure if these staff members had achieved some of their learning objectives and were competent in their role.

Are services caring?

We found the following areas of good practice:

- Patients were treated with dignity, compassion and respect.
- Staff took the time to interact with patients and patients found staff to be supportive.
- On the whole, privacy and dignity was respected in all aspects of care.
- The patients spoke highly of the unit, the staff and the care they received.
- Staff communicated with patients so they understood the treatment they received and were encouraged to ask questions.
- Staff understood the impact of the treatment on patient's emotional wellbeing and actively supported patients.

Summary of this inspection

Are services responsive?

We found the following areas of good practice:

- Services were planned and delivered to meet individual patient needs and aimed to improve patients' quality of life.
- Patients had access to entertainment during their haemodialysis session.
- Patients were supported to arrange haemodialysis at their holiday destination.
- There was a system to monitor and deal with complaints. There had been no formal complaints made at the unit in the year prior to our inspection.

Are services well-led?

We found the following areas where the service provider needs to improve:

- The governance framework did not consistently demonstrate how operational performance was discussed and actions documented to improve performance and quality of care for patients.
- The processes to share learning, risk, quality and performance information with staff was not consistent or thorough.
- Improvements were required to demonstrate how local risks had been identified and action plans put in place to mitigate against these risks.
- There was no awareness of and evidence of compliance with the Workforce Race Equality Standard (WRES) which became mandatory in April 2015.

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

- Senior staff had the knowledge, skills and experience to lead effectively.
- Staff felt valued and supported in their roles and reported a positive working culture.
- There was an effective systematic programme of audit which was monitored regularly and corporately.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Incidents

- There had been no never events or serious incidents at the Taunton dialysis unit between March 2016 and March 2017. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Serious incidents are can be identified as anincident where one or more patients, staff members, visitors or member of the public experienceseriousor permanent harm, alleged abuse or a service provision is threatened.
- Staff were aware of their responsibilities to raise concerns, record safety incidents and near misses and report them internally. There was a policy and system in place to report incidents which was available to staff and outlined the procedure for reporting incidents. Staff provided us with examples of incidents and near misses they would report.
- Incidents were investigated in accordance with the corporate policy. Incidents were reported on two different systems, which included reporting adverse patient occurrences in relation to treatment on a B. Braun electronic system and reporting incidents like injuries or falls on the environmental health and safety system. Information was captured electronically for both systems. Adverse patient occurrence incidents and the actions taken at the time of treatment were captured on the forms. The forms were then reviewed by the clinic manager and then the clinical quality team to ensure actions taken were suitable, and whether any further learning was needed following the incident. The operations manager maintained a log to monitor trends and themes from the incidents reported. Adverse patient occurrences were then closed by the senior management team. We were told; adverse patient occurrences were discussed at the monthly continuous quality improvement meeting with the lead consultant. There were no minutes documented to demonstrate this took place.
- The Taunton unit had reported 101 adverse patient occurrence incidents since January 2017. Categories for adverse patient occurrence incidents included arteriovenous fistula infection, arteriovenous fistula failure, missed dialysis sessions and severe symptomatic hypotension. The largest category of adverse patient incident reported as 'other' incidents. These included shortened patient sessions.
- Staff did not receive individual feedback on incidents they had reported. Staff were unable to provide us with any feedback following any adverse patient occurrence they reported. Once the adverse patient occurrence had been reviewed by the unit manager and the quality manager it was then closed. There was no evidence on the staff meetings minutes to demonstrate that adverse patient occurrence incidents had been discussed with the staff at the unit.
- There was evidence of service wide learning from incidents to drive improvements in practice. There had been a trend in venous needle dislodgement across B. Braun units. Following this, changes had been made to practice and further control measures were put in place to reduce the risk of reoccurrence. Staff were able to tell us about the changes to practice following this incident trend.
- The unit received and acted upon relevant safety alerts from the Medicines and Healthcare Products Regulatory

Agency. The unit manager received any safety alerts and if information was relevant to the Taunton unit, the manager would implement any action as recommended by the alert.

- Staff demonstrated an understanding of their duty of candour responsibilities. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 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. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Staff were aware of the thresholds for when the duty of candour process was triggered.

Mandatory training

- Staff completed mandatory training in the safety systems, processes and practices annually. Mandatory training included fire safety, falls, documentation/ confidentiality, manual handling, infection control, preventing sharps injuries, health and safety in the dialysis unit, aseptic non-touch technique and vulnerable adults training. Staff were issued with a training matrix which outlined what training was required and how often. Training records were submitted to the unit manager monthly and also to the operational manager. This ensured oversight of mandatory training to ensure all staff remained up to date and could safely carry out their role at the unit.
- Staff at the unit were not fully compliant with their mandatory training, which meant they were not compliant with their corporate policy. The service held a contemporaneous training record for mandatory training for each member of staff. Records demonstrated the majority of staff had completed fire safety training and infection control training; however, only 61% of staff had completed manual handling theory training, and 94% of staff had completed the practical training. Only 66% of staff had completed health and safety training and 83% of staff had completed infection, prevention and control training. This was against a target of 90%. B. Braun required staff to complete the annual updates in the first three months of the year between January and March.
- Basic life support training was undertaken twice yearly to give staff the confidence to deal with emergencies at the unit. An emergency drill was carried out to ensure staff competencies with basic life support and to ensure they understood their role and responsibilities, in the event of a real emergency situation like this occurring at the unit. The unit had a resuscitation doll and the training was scenario based. Sessions had been run in both February and March 2017 to capture all staff. All staff at the unit were fully complaint with this training.

Safeguarding

- There were systems and processes reflecting relevant safeguarding legislation to safeguard adults and children from avoidable harm and abuse. Staff we spoke with understood their responsibility to report safeguarding incidents. Staff told us what they would do if they needed to make a safeguarding referral. At the time of our inspection, staff at the unit had not had been required to make a safeguarding referral. The unit did not treat children or come into contact with children; however, staff had access to a policy for vulnerable children which provided information about what to do if they had concerns about a child's welfare.
  - The organisation required staff to attend both safeguarding adults and children training. Safeguarding adults and children, both at level two, was a mandatory requirement via an e-learning update, every three years. This was appropriate for their role and level of interaction with patients. Only 72% of staff had completed their vulnerable adult and child protection awareness training. The manager of the unit was trained to level two adults and child safeguarding as was the corporate named safeguarding lead. Any safeguarding concerns would also be reported to the parent local NHS acute trust.

Cleanliness, infection control and hygiene

- Staff adhered to infection, prevention and control policies and procedures. We observed effective use of personal protective equipment (equipment which protected the user from health and safety risks at work) and handwashing. This was in line with the corporate infection, prevention and control policy. There was good access to personal protective equipment around the unit and a handwashing sink in each of the three bays. Staff were bare below the elbow to ensure effective and thorough cleaning of their hands between patients.

- At each station, both staff and patients had access to antibacterial hand gel. The handwashing and aseptic non-touch technique audits between January and June 2017 had achieved 98% compliance. We saw evidence, in meeting minutes, the results of audits and infection prevention policy updates were documented and discussed with the staff team.
- The premises were visibly clean, tidy and free from clutter, and there was sufficient space for staff to access patients from both sides of their dialysis chair.
- The flooring in the unit was visibly clean. It was made of a hardwearing material and extended up a small proportion of the wall, which allowed for effective cleaning and decontamination.
- Decontamination of medical devices, including dialysis machines was carried out efficiently. Staff cleaned the dialysis machines after each session in accordance with their corporate guidance. There was an internal decontamination schedule after each patient, and once a week the machines were programmed to carry out an extended deep clean. This deep clean ran through the night. The unit maintained a deep clean checklist for the machines. We saw these records and saw that deep clean requirements had been carried out. If for some reason a machine had not been cleaned staff documented the reason why. This only reason a machine missed its deep clean was due to it being faulty and requiring repair.
- Not all of the chairs at the unit were in good condition. The reclining chairs in the clinic were of a wipe clean material, however, four out of the 16 chairs had eight ripped covers and chairs had damaged foot rests. This meant that staff were unable to clean the chairs effectively between sessions and during the deep clean. All but one chair was visibly clean. We told the unit manager about the unclean chair. The foot rest was covered with sand and mud. The manager said they would have the chair cleaned. We observed the nurses cleaning the chairs with disinfectant before and after the haemodialysis session, and we saw this was recorded on the daily cleaning rotas, which were all completed and up to date.
- Each patient was provided with their own blood pressure monitoring cuff which was stored in a plastic wallet in their care records. Staff told us this was done in recognition of the frequency of use and to reduce the chances of spreading infection between patients. The cuffs were replaced approximately every three months or sooner if required.
- There had been one episode of methicillin-resistant Staphylococcus aureus(MRSA) and one episode of methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia at the unit in the12 months prior to our inspection. These patients underwent decolonisation and treatment. There had been no reported cases of Clostridium difficile (C. diff). If swabs returned positive for MRSA or MSSA the unit called the GP to ensure the patient underwent decolonisation treatment. During this time, patients were dialysed using universal precautions according to company policy until they were found to be negative, which was after three clear results.
- There were procedures to assess patients as carriers of methicillin-resistant Staphylococcus aureus. The unit had protocols available in regard to infection control practice for monitoring MRSA. Swabs for methicillin-resistant Staphylococcus aureus were taken monthly from each patient using the unit. Patients were also screened for Hepatitis B and Hepatitis C every three months and for Human Immunodeficiency Virus annually.
- There were guidelines to ensure patients attending the unit for holiday haemodialysis were screened for blood borne viruses. Staff followed B. Braun policy and procedures to prevent the spread of infections when patients retuned from a holiday in a high risk area. Patients were screened every two weeks for two months according to company policy and national guidelines.
- Unit staff liaised directly with the infection prevention and control lead at the local acute NHS trust, who was contracted to provide infection prevention and control advice for the unit, if required
- Staff received training in aseptic non-touch technique for the management of haemodialysis vascular access. Staff at the unit had completed competencies in the use of aseptic non-touch technique and the management of vascular access and held their certificates in their staff files to demonstrate compliance. We observed staff following good practice with regards to using the aseptic non touch technique.
- Staff used recommended aseptic 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 are an abnormal connection or passageway between an artery and a vein created through vascular surgery specifically for haemodialysis. Grafts are artificial veins inserted for haemodialysis, and central lines are larger cannulas which are inserted for long periods for haemodialysis.

- Water used for dialysis was specially treated to reduce the risk of contamination in patients. There was evidence of bacteriological surveillance of haemodialysis fluids, and the service had effective water testing procedures in the water treatment plant area. Staff carried out checks prior to each dialysis session at the unit. Records from January and June 2017 demonstrated 100% compliance. If the test results showed variances, staff were aware of the procedure to follow and called in engineers who attended within four hours. This enabled them to identify any issues with supply, effectiveness of treatment or leaks.

Environment and equipment

- The Taunton Renal Unit was not purpose built for haemodialysis treatments and had been previously used as a local gym. For example, the unit did not have any windows and therefore no natural light to help with patient wellbeing. There was not at least one handwashing sink between two dialysis stations. This meant the environment did not fully comply with national guidance (Health Building Note: 07-02, 2013) for the delivery of a haemodialysis service. Patients told us they did not feel there was enough natural light in the building. The organisation was limited to providing a haemodialysis service within the constraints of the current building, however, no efforts had been made to compensate for the lack of daylight at the unit.
- The building was tired inside with paint chipping from the walls. This made the walls difficult to clean effectively. The organisation had not been unable to commit to any redecoration within the unit due to the uncertainty of the longer term contract. Since the inspection the contract had been awarded and redecoration of the unit was due to take place. There was no timeframe for the redecoration to be completed.
- The Department of Health 2013 Health Building Note: Satellite Dialysis Units had been used to ensure the facilities at the unit were optimised for the treatment being carried out, for example, there was sufficient space around dialysis chairs for two people and they could be accessed from either side.
- Each dialysis station had a reclining chair with a handheld electronic control, dialysis machine, nurse call bell, height adjustable table, and television with remote control. This provided patients with their own individual environment and direct access to the nurses on duty at the unit. There was weighing scales at the unit to weigh patients prior to their treatment and also a spare set of scales in case the preferred scales did not work.
- The unit had emergency equipment in case of medical emergencies and was in accordance with national guidance (Resuscitation Council, 2015). This included automated defibrillators, which staff were trained to use. All staff were trained in basic life support and the operational cardiac arrest procedure policy at the unit outlined what to do in the event of and an emergency. The resuscitation trolley record was signed daily by staff to confirm checks had taken place and was found to be safe to use and records we saw, to confirm this, were complete and up to date. The emergency trolley was stored in the main treatment area. The unit also has a portable emergency bag on wheels in case patients had to be evacuated from the unit in the event of an emergency. The bag contained equipment to ensure patients were safely clamped off from their dialysis machine and foil blankets to keep patients warm if they had been evacuated from the unit.
- There was inconsistent compliance with the storage of sharps bins not in line with the National Institute of Health and Care Excellence guidelines, Healthcare Associated Infections: Prevention and Control in Primary and Community Care (CG139). Sharps bins were located on wheeled trolleys between each dialysis station. Out of the 13 sharps bins we observed eight were closed when they were not in use but five remained open when they were not in use. The guidelines state when not in use, sharps bins should remain temporarily closed. Despite this, the sharps bins were in good condition, in date and not overfilled.
- The stock room appeared clean and tidy with shelving for all equipment. Entry was gained through a locked door with keypad entry. Fluids were stored on pallets

meaning they were raised off the floor. Stock was delivered weekly and staff told us there was an additional supply to ensure the service could continue if a weekly stock delivery was delayed.

- The unit had a contingency plan to ensure they held enough consumables at the unit to enable continuity of the service for patients, if they were unable to obtain the necessary equipment required for haemodialysis. The unit held enough stock to continue running treatment for patients for a further three days if they were unable to obtain their usual delivery.
- The ambient temperature of the stock room was recorded daily. There had been five incidents where the temperature had been outside the recommended maximum range of 25 degrees Celsius. However, only one action for one out of the five incidents had been recorded as being taken, a fan was brought into the stock room. The room contained stock for treatment which recommended that it should not be stored in conditions hotter than 30 degrees Celsius. Temperatures were recorded as 26.2 degrees Celsius and there had been two occasions where temperatures of 30.3 degrees Celsius and 30.9 degrees Celsius had been recorded. Staff had not removed certain stock from the room; however, all this specific stock with requirements for storage within specific temperature ranges was disposed of and had been re-ordered. The new order had then been stored in another area, which was also hot but there was no thermometer recording temperatures, so the provider was not ensuring storage arrangements were in place. A pharmacists advice had not been sought over this issue. We raised this with staff and the stock was removed to another area where the temperature was monitored and unlikely to exceed safe limits for storage. On the day of our unannounced inspection a fan was running in the stock room to keep the temperature down.
- All dialysis sets and machines used at the unit were single set use and were CE marked (CE marking defines how the equipment met the health, safety and environmental requirements of the European Union). All single use equipment was labelled accordingly, and disposed of after use.
- All staff were trained to use specific dialysis machines and medical equipment. Equipment-training records showed 100% compliance for all staff. The competency booklet also contained a section on training and management of the machines in use at the unit. This ensured all staff were competent and could safely use the machines and equipment provided at the unit to keep patients safe.
- During the inspection, we saw dialysis machine alarms were responded to within a few seconds. Alarms would sound for a variety of reasons, including sensitivity to patient's movement, blood flow changes and any leaks in the filters. Nurses attended all alarms promptly and dealt with any problems which arose.
- Technical staff to manage and maintain the equipment were employed by B Braun. The unit maintained records of annual servicing of equipment at the unit which demonstrated full compliance. The technical staff also carried out repairs on the dialysis machines and attended the unit for faults or breakdowns. The response time for the staff to attend to a faulty machine was dependent upon urgency and in order of priority. The unit had five spare machines on site which could be used during the breakdown period. This ensured there was no disruption to the service or patients in the event of equipment failure.
- Staff were aware of the escalation process for the reporting of faulty equipment to ensure patients did not experience delays or had sessions cancelled. One machine became faulty on the day of the inspection. Staff were able to show us the process for identifying and reporting faulty equipment.
- The layout of the unit helped staff to maintain the safety and privacy of the patients receiving dialysis. The unit did not have curtains around each station, but had privacy screens which were used when required. There was sufficient space around the dialysis chairs to enable staff to gain rapid access in case of an emergency.
- The layout of the unit ensured all stations were visible to nurses at all times, as recommended in the Health Building Note: 07-01. Staff were able to see all of the patients throughout their dialysis session. We also observed staff regularly visiting patients at their station to carry out physiological observations and check on patients.
- The unit had a service level agreement with an external contractor for any electrical testing required and also the servicing and calibration of other medical devices held at the unit. Electrical testing at the unit was carried out according to the maintenance schedule, along with machine calibration annually. The records demonstrated full compliance with all electrical testing.

Medicine Management

- Medicines were not always administrated and managed according to the corporate medication guidelines policy.
- Taunton Renal Unit did not have a relevant policy, patient group direction or use prescriptions when administering fluid boluses to patients following a drop in blood pressure. Although it is a common practice to give additional fluids in dialysis unit, there should be a policy for staff to refer to, or a patient group direction. Otherwise, the fluids used should be prescribed as they are being used as medicines to treat patients. This was not in line with national guidance (National Institute for Health and Care Excellence, CG 174, 2013).
- Staff did not ensure the safe administration of intravenous medicine to patients in line with guidance from the Nursing and Midwifery Council (NMC, 2015). Although we observed two nurses checking the anticoagulant provided was in date and correct for the patient, staff did not formally check patient's identification before administering intravenous medicines.
- There were systems to ensure the lead consultant from the local NHS acute trust ensured treatment optimisation for patients. The consultant attended a monthly continuous quality improvement meeting. At this meeting the patient's monthly blood results were reviewed and the consultant made amendments to the patient's dialysis prescription or medicine to ensure treatment was optimised for patients. Any changes were then explained to the patient at their next treatment session. However, we looked at 41 records of these meetings from January to June 2017. The records had actions, such as changes to treatment documented from discussions held at the meetings. However, many entries where nurses had to sign and date to state the actions had been completed were left blank. There was a total of 39 records unsigned out of 246 entries we saw. We followed through three unsigned actions which despite being left blank and unsigned had been completed. The system did not provide assurance that actions had been completed to ensure the safe care and treatment of patients.
- Nurses at the unit were transcribing the patient's dialysis prescription which was not in line with guidance from the Nursing and Midwifery Council (NMC, 2015). Therefore, processes did not ensure the unit held the most up to date, signed dialysis prescription by the lead consultant for each patient. Transcribing is defined as any act by which medicinal products are written from one form of direction to administer to another. The lead consultant reviewed and if required, optimised the patient dialysis prescription monthly. Each patient had their original dialysis prescription in their record which was signed and dated by the consultant for their first session. As treatment requirements changed and were reviewed at the monthly continuous quality improvement meeting, nurses would then add the revised treatments onto the dialysis prescription and date this rather than the consultant responsible for prescribing medicine adding this to the dialysis prescription record, and signing and dating the changes. Nurses told us there was a formalised prescription held on the lead parents trust electronic patient record and the paper dialysis prescription in the patient's record was just for reference for the nursing staff. The NMC (2015) guidance states this should not be undertaken routinely, and only in exceptional circumstances. The NMC (2015) guidance also states there should be a rigorous policy for transcribing that meets local clinical governance requirements. However, there was no process to audit or ensure the prescriptions were aligned. Information had to be inputted onto the unit's electronic system to upload the information to the patient's card which was inserted into the scales and dialysis machines to transfer prescriptions onto the dialysis machine.
- Staff received training on the safe administration of intravenous medicines if they had not already received training in their previous role, and had evidence of their competence in this area. The unit held an intravenous competency workbook which was scenario based. On completion of the workbook, the registered manager reviewed the workbook prior to signing off the nurse as competent. The workbook included a theory section and a practical assessment, covering a period of supervised practice and observation of the administration of intravenous medicine. New staff starting at the unit who had evidence they had completed training and were competent in the administration of intravenous medicine did not have to complete the workbook.

- Medicines which were temperature sensitive were monitored closely. We saw the minimum and maximum refrigerator temperatures were recorded daily, and had been maintained within the recommended parameters.
- The unit had a service level agreement with a local acute trust to ensure the provision of medicines to the unit. A weekly order of stock items were ordered from the pharmacy and delivered to the unit by a courier. The nurses checked and audited the medicines weekly, once the new order was received. Records confirmed the unit was 100% compliant with checking stock and expiry dates of medicines. The unit did not have a dedicated renal pharmacist. Pharmacy support was given through the supervising NHS Trust as part of the service level agreement.
- The unit did not liaise directly with the patients GP regarding patient medications. The lead consultant would contact the patients GP regarding medicine changes or any changes made to the regular dialysis prescription.

Records

- Patient care records were written and managed in a way which kept patients safe.
- Consultants managing patients who attended the unit were able to access the patient's record and blood results via the local NHS trust computer system. All nurses were also able to access the patient's full NHS record via this system.
- The service used a 90-day care pathway for new patients commencing dialysis at the unit. This pathway included information about infection screening; patient education programme and assessment of parameters at different points during the first 90 days of patient dialysis and the stage at patients new to haemodialysis treatment had an increased risk of mortality and required closer monitoring. Once the dialysis was well established, staff used a continuing care pathway which was re-assessed every three months and ensured on going care using evidence-based guidance.
- Day sheets detailed dialysis sessions by date, time and the number of the machine used during the session. This meant any changes in treatment, any problems occurring during the session and any treatment changes could be identified.
- The unit kept paper records for each patient, which included dialysis prescriptions, next of kin and GP contact details, risk assessments, clinic letters, medicine charts and patient consent forms. Paper records were stored in clear files and were kept in a locked cupboard overnight and when not in use. All six sets or records we looked at were completed legibly. Records were kept at the unit until a patient stopped dialysing, at which point the records were archived and locked away.
- Staff at the unit were able to access patient's NHS clinic letters. All clinic letters, following patient's appointments with their consultant, were electronically stored on the local trust's central renal database which could be accessed by staff from the Taunton dialysis unit. Information such as blood results, medicine lists, recent clinic letters, multi-disciplinary planning and all demographic and identity information was also held on this system. This ensured staff had access to the most up to date information about the patient, necessary to provide safe care and treatment.
- A documentation audit was carried out quarterly on patient records completed at the unit. Audit results ranged from 87% to 100%. The audit contained written information about what was lacking in the patient record which was fed back to staff. For the majority of staff at the unit, their documentation audit result improved over each quarter of 2016. This showed staff acted on feedback provided from the audit process to improve the standard of their documentation.

Assessing and responding to patient risk

- Systems were in place to assess and manage patient risks. Nursing staff used comprehensive risk assessments to review patients on a regular basis. Nurses completed a falls risk assessment for each patient attending the unit. We saw this risk assessment was reviewed every three months in line with company policy.
- Nursing staff completed a full patient assessment based on the activities of daily living to identify the patient baseline condition on referral to the centre. The assessment included past medical history, falls risk assessment, skin integrity assessment and a visual haemodialysis access assessment. This information was used to plan treatments and attendance at the centre.
- Patients had clinical observations recorded prior to, during and post their treatment session. This included blood pressure, pulse rate and temperature. The nurse reviewed any variances prior to commencing

haemodialysis, to ensure the patient was fit for the session. Where necessary, the nursing staff consulted with the consultant or on call renal registrar for clarification.

- Processes were in place to alert staff to potential treatment issues. The nurses pre-set alarms on the haemodialysis machines which were set to respond to pre-defined parameters related to each patient's treatment plan. We saw staff responded quickly when an alarm went off, and reviewed the cause of the alarm and checked how the patient was feeling.
- Patients were monitored throughout their haemodialysis session and staff recorded an assessment of patient's pre and post haemodialysis to ensure patients did not suffer any adverse effects both during and after haemodialysis which may impact upon their safety. However, the service did not use an early warning system to alert staff to a patient who was deteriorating. Nurses recorded a patient's weight, temperature, blood glucose levels and blood pressure prior to dialysis. Blood pressure was monitored half hourly and recorded hourly for each patient during the dialysis session and again at the end of the session along with the patient's weight. Nurses were able to tell us what they would look for if a patient was unwell and what they would to ensure the patients safety.
- Staff used the patient's half hourly observations to indicate if a patient was deteriorating. In the event of a medical emergency, staff described how they would administer oxygen, in line with company policy, and call 999 to transfer the patient to an acute NHS facility.
- There were no policies or standard operating procedures at the unit which made direct reference to the management of sepsis in line with national guidance (NHS England, 2015).There had been no training provided to staff around the early recognition management of sepsis. However, there was evidence that the senior management team were trying to rectify this. There had been of discussion of sepsis and the development of a pathway for B. Braun units at the April 2017 quarterly managers meeting.
- There was no formal assessment of a patient's identity prior to being connected to the haemodialysis machines. Staff told us this did not occur because the patients had been attending the unit for a long time and they knew them well. There was a risk to patients, if bank or agency staff worked at the unit and were not familiar with the patients, that a treatment may be administered incorrectly. The unit had no policy to follow with regards to checking the identity of patients prior to commencing treatment.

Staffing

- The unit based it staffing levels on guidance set out by the Renal Workforce Planning Group 2002, on the service level agreement set out with the local trust and patient dependency. The unit used one nurse to four patients, meaning there were at least four nurses covering each shift and an additional health care assistants to support the nurses. The unit employed 12 full time nurses and two part time nurses. Three healthcare assistants held full time contracts at the unit with one healthcare assistant working part time.
- There had been four members of staff leave the unit in the 12 months prior to the inspection, however, a further four nurses had been recruited to fill the vacancies. These nurses had left the unit for a variety of reasons including travel times to and from the unit, renal nursing was not for them and one member of staff did not pass their probationary period. At the time of our inspection, there was one vacancy for a qualified nurse.
- The unit had a plan to cover for annual leave or sickness. Between January and March 2017, four shifts had been covered by an agency nurse. Agency nurses were required to have signed off renal competencies by the agency. The first shift would consist of a demonstration of emergency procedures, for example, fire evacuation, aseptic non-touch technique, use of personal protective equipment, infection, prevention and control protocols discussed and declaration of confidentiality were completed and signed.
- Medical support and advice was provided by the consultant nephrologist managing patients who attended the unit, who was based at the local acute trust. Nurses were able to contact the consultant directly by telephone, or email with any concerns about patients attending the unit. The consultant also attended the unit once a month. One patient attending was also under the care of another acute NHS trust. In this instance, the unit were able to write a message directly to the consultant via the electronic system or call the consultant directly to resolve any concerns or queries.
- There was a contingency plan in place in the event of absence of the patient's named consultant. The unit

were able to contact the on call renal consultant at the local NHS trust or the renal registrars. The nurses called the switchboard and asked to be connected to the consultant.

- Nurses carried out a daily handover to ensure all staff were aware of the continuing needs of the patients from the previous and the current day. Nurses used a communication book and diary during their shift to ensure important information was handed over to the staff the following day. The handover allowed nurses on shift to follow up any outstanding actions for the current day and previous day patients.

Major incident awareness and training

- Emergency equipment was available at the unit and staff had received training to safely use the equipment. The unit had an in date policy for medical emergencies and cardiac arrests which provided information for staff about how to manage these incidents. Staff were also able to tell us what they would do in the event of an emergency situation at the unit.
- There was an emergency contingency plan folder available for staff at the unit. Staff knew where to access this. It contained policies and procedures in the event of a power failure or a disruption to the water supply. There was a copy of the emergency contact list in both the main treatment area and the main office for staff to use in the event of an emergency.
- Each patient had an emergency evacuation plan which was completed when they started treatment at the unit. The plan outlined the procedure for patients in the event of a fire which the nurses went through with patients at their first session at the unit.

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

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Evidence-based care and treatment

- Current evidence based guidance; best practice and legislation were used to develop how services, care and treatment was delivered. Key Performance Indicators (KPI) were based on Renal Association and B. Braun Group guidelines. For example, each month, all patients had bloods taken to monitor the adequacy and efficiency of dialysis treatment as set out by the Renal Association standards. This enabled any changes to treatment to be made in line with best practice guidelines.
- Treatment plans took account of national best practice guidance. Clinical care was consultant led and delivered on the nurse led unit. On referral, patients commenced on a 90-day treatment plan followed by a continuing treatment care pathway. These were based on the Renal Association Haemodialysis guidelines (2009) and the National Institute for Health and Care Excellence (NICE, Quality standard QS72, 2015). Patients were at their most vulnerable and had an increased risk of mortality within the first 90 days of starting haemodialysis treatment; therefore the 90 day care plan enabled nurses to closely monitor patients new to the treatment.
- NICE Quality Statement (QS72, 2015) was followed with regard to how staff monitored and maintained each patient's vascular access (for treatment). At the unit, 81% an arteriovenous fistula which was a surgical created vein used to remove and return blood during haemodialysis, and 11% of patients had an arteriovenous graft for vascular access. The renal association's target for patient's haemodialysing through a arteriovenous fistula was 85%, which the unit was slightly below this target. We saw individual care plans for those patients with arteriovenous fistulas which were difficult to cannulate (insert a tube into). These care plans included detailed drawings and written guidance from the vascular consultant who had completed the procedure. Only 8% of patients at the unit had a central venous catheter which was used for vascular access.
- The unit did not facilitate peritoneal dialysis (which is a type of dialysis which 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).
- Staff monitored patients receiving dialysis in line with Renal Association Haemodialysis Guidelines (2009). For example, guideline 6.2: monthly monitoring of biochemical and haematological parameters (blood tests).

- Water testing, disinfection of the water plant and dialysis machines were all carried out in line with best practice guidelines. The unit followed recommendations from the Renal Association, manufactures instructions and the European Pharmacopoeia Standards for the maintenance of water quality for haemodialysis.
- Staff followed evidence-based guidance regarding clinical observations and checks before the start of treatment (Renal Association, 2005) This included checking weight and vital signs such as blood pressure, pulse and temperature. We observed how staff discussed results with patients and adjusted treatments accordingly and within the parameters set by the patient's consultant. This promoted optimum haemodialysis treatments.
- Policies used by the unit were all based on evidence based and best practice guidelines. Each policy available at the unit showed where the information had been taken from to develop the policy. The unit used the B. Braun Quality Management System to ensure all policies and procedures were reviewed and amended when new guidance was released. New information was added to the existing policies and was highlighted in blue. All policies were available for staff to access through the organisations intranet. If these were required to be printed, all policies stated they were valid for a 24 hour period only. This promoted the use of the most current best practice standards by prompting staff to recheck the intranet for updates.

Patient Outcomes

- The unit routinely collected data and submitted it, via the parent trust, to the Renal Registry for monitoring. The Renal Registry is part of the Renal Association who collected, analysed and reported on data from renal centres in the UK, as mandated by the NHS National Service Specification. The registry also provided access to a clinical database which could be used in renal research. The unit collected the relevant data which contributed to the registry by the local NHS acute trust. The registry provided an annual report for the unit detailing the quality of care and treatment provided for patients by the unit. Comparisons could then be made with other haemodialysis units to compare performance against other centres.
- Patient outcomes were monitored in accordance with best practice guidelines. Bloods were taken from all patients attending the unit each month and were recorded on a specific document set out by the Renal Association and monitored by the organisations quality manager. The completed document audited the percentage of patients achieving standards in line with best practice guidelines, as set by the Renal Association. The parameters audited included, haemoglobin, phosphate, calcium, dialysis adequacy, treatment time, albumin and the type of access used. The data was also reviewed at monthly meetings with the local lead consultant for the unit. The data highlighted where prescription changes were required to ensure patients were within the parameters set out by best practice guidelines. Data was also monitored for the unit at the central manager's operational meetings and the manager of the unit was asked for explanations as to why results were not in line with standards set by the Renal Association.
- B. Braun set and collected key performance indicators on a monthly basis for the unit, based on Renal Association and B. Braun Group guidelines. Patients care needs were assessed and their care planned, delivered, and monitored to ensure compliance. Data was collected on a monthly basis and reviewed by the unit manager. A report was completed about the results which enabled staff to monitor the effectiveness, quality of the treatment and any variances. The report was discussed at the continuous quality improvement meeting, held each month with the consultant, unit manager and dietician. Changes made to dialysis prescriptions and medicines at this meeting ensured quality and standards were maintained in line with evidence based guidelines.
- The registered manager completed a monthly operational management plan report about the unit's performance. The management plan held information about key performance indicators, which was reviewed against set targets. Data between January and May 2017 demonstrated the unit had not met all of the key performance indicators. When a key performance indicator had not been met, the registered manager documented what measures had been taken to ensure improvement in each category. For example, in May 2017, the unit had not met targets for haemoglobin ranges. Patients should have a haemoglobin level of 10-12g/dl. The unit's target for achieving this range was

65%, however in May 2017; only 53% of patients were within this target range. The unit manager's action was to take this to the monthly continuous quality improvement meeting to review patient's treatment plans and optimise treatment for patients to ensure they remained within target ranges. The management plan also presented information in relation to other performance indicators such as infection control, water testing, mandatory staff training and information about staffing levels.

- One patient outcome captured looked at the effectiveness of haemodialysis treatment and how much waste product was removed from the patient's body. The rate the blood passes through the haemodialyser over time, related to the volume of water in the patient's body is expressed at Kt/V should be <1.2. The units target was 90% however, the unit had achieved 100% between January and May 2017, demonstrating all patients had received an effective haemodialysis treatment. Urea reduction ratio is another measure of how effectively a dialysis treatment removed waste products from the body, and is commonly expressed as a percentage. The renal association standards recommend patients achieve a urea reduction ratio of >65%. B Braun did not require this measure to be collected and reported on as a monthly performance indicator of patient outcomes at the unit. Although, each individual patients urea reduction ratio was available on the patients individual blood results on a monthly basis and available for the consultant to review.

Pain relief

- Patients' pain was assessed and managed effectively. Patients did not routinely receive oral analgesia (painkillers) during their dialysis sessions. However, local analgesia was available for cannulating (needling) the patients' arteriovenous fistula or graft and would be administered as part of the patients individual prescription set out by their lead consultant. Needling is the process of inserting wide bore dialysis needles into the arteriovenous fistula or graft, which some patients' found painful when undergoing haemodialysis.

Nutrition and hydration

- Patients' hydration and nutritional needs were assessed and managed effectively.
- Patients in renal failure require a strict diet and fluid restriction to maintain a healthy lifestyle. Patients and staff at the unit had access to specialist dietary support from a dietician from a local NHS trust. The dietician attended the unit two days per week, at different times, to ensure they reviewed and monitored all patients effectively. The dietitians spoke with staff about any changes on the same day and documented their assessments and actions in the patient's record. The dietitian also reviewed patients' monthly blood test results and attended the monthly continuous quality improvement meeting with the unit manager and the lead consultant from the local acute NHS trust to ensure effective optimisation of the patient's treatment for their condition.
- Patients' dietary requirements were assessed using a subjective global assessment pathway to help identify patients at risk of malnutrition. A series of questions around protein intake, skin condition, body mass index and weight loss gave each patient a score, which in turn was categorised as red, amber or green. The subjective global assessment pathway provided clear advice for patients depending on their colour category, which included the addition of high calorie diet supplements for patients at greatest risk. We observed completed subjective global assessment pathways in patient's records with completed action plans following the assessment. Patients were provided with written information and guidance relating to their diet and fluid management.
- Patients were weighed on arrival to the unit at each visit. This was to identify the additional fluid weight which needed to be removed during the dialysis session. This varied from patient to patient.
- Some patients were observed weighing themselves prior to dialysis, and gave this information to the nurse who recorded it on the day sheet. Nursing staff told us all patients were encouraged to participate in their treatment to different levels.
- Patients had access to food and drinks whilst undergoing their treatment. The nurses provided patients with tea and biscuits during their haemodialysis session. Some patients also chose to bring their own food into the unit to eat during their session.

Competent staff

- Staff were only employed on the basis they could demonstrate appropriate qualifications, skills and experience relevant to the post applied for. The organisations human resources department completed checks upon appointment. These included: confirmation of nursing registration, Disclosure and Barring Service (DBS) checks, review of references and an occupational health assessment.
- Staff had the right skills, qualifications and knowledge to carry out their role. On joining the unit, nurses attended a nurse development programme, providing them with specialised training in renal failure and dialysis. New nurses were allocated two mentors, who were experienced renal nurses, for support to achieve their competencies over the supernumerary period. The duration of the supernumerary period was dependent upon the individual nurse and reviews were carried out at one, three and six months after joining the unit. This enabled managers to monitor progress with development and training. Before being allowed to work independently, new staff were required to demonstrate a range of competencies which had to be signed off by their mentor. These included: medical devices training for the dialysis machines and infusion pumps used and understanding of the principles of drugs used, such as anticoagulants.
- It was unclear whether staff had met certain learning objectives included in their training record. We reviewed four staff training records which contained certificates demonstrating other external training or conferences which nurses had attended. However, we reviewed two sets of training records where learning objectives such as machine trouble shooting, single needle crossover, needling difficult grafts and putting patients on a machine had been identified. These objectives had all been identified in February, March and April 2016 but had not been signed off as completed. There was no action plan to demonstrate how the member of staff would go about becoming competent in these areas. It was unclear whether the member of staff was competent within these areas which they had raised a requiring more development.
- A practice development nurse had recently been recruited to the organisation to support the development of existing staff and new recruits in their role. The nurse visited the unit and worked with new staff to assess their competencies. A large part of the role was to review and update policies and protocols. These were returned weekly to the manager of the Taunton unit to circulate to staff to ensure their awareness of any policy updates.
- Bank and agency staff completed an induction checklist specific to the unit. This included emergency procedures, use of fire safety equipment, layout of the building, access to basic renal information, policies and procedures, haemodialysis prescription and operation of essential equipment such as the haemodialysis chair.
- All staff had received a performance appraisal within the year prior to our inspection, where discussions had taken place about performance and career development. Staff set goals to enable career progression and were encouraged to develop in line with the patient and service needs. Appraisals contained learning requirements and actions were clearly documented. Staff felt listened to during their appraisals and supported to achieve their learning objectives.
- All staff completed additional training and competency assessments in bacterial water sampling. Staff carried out water plant checks between each treatment session to ensure ultra-pure water for patient safety. The healthcare assistants mainly carried out this role. Staff were able to tell us competently and confidently what they would do if water tests were out of range. Records demonstrated 100% compliance with water testing and tests being within range between January and June 2017.
- Staff at the unit had additional qualifications in renal nursing. Four nurses at the unit had received advanced training in renal care and two nurses were also due to attend the course later in the year. Whilst the specialist course was not compulsory, requests to attend the course were identified as part of the yearly appraisal process.

Multidisciplinary working

- The unit had systems and procedures to ensure the lead consultant was closely involved and kept up to date with the patient's conditions including their blood results. Continuous quality improvement meetings were held monthly at the unit. The nurse manager, consultant and dietician all attended to discuss the patient's care and outcomes for example monthly blood results. Following the meeting, letters were sent to patients' GPs detailing any changes to treatment or requests, for

example, for non-renal investigations. Outcomes from this meeting were recorded into the continuous quality improvement file and the named nurse for each individual patient would discuss and action the outcomes of the meeting. For example, any changes to treatment following recent blood results.

- Dieticians from a local NHS trust were involved with the care and treatment of patients attending the unit for dialysis as necessary. If the nurses at the unit had any concerns about a patient's nutritional status or weight they would discuss these with the dieticians who visited twice weekly. The staff at the unit felt well supported by the dietician and told us they were a valuable asset to the team.
- The consultant nephrologist at the local acute NHS trust had overall responsibility for the patients care. Both nurses, the senior management team at the unit and the consultant felt there was effective communication and multidisciplinary working, which enabled efficient patient centred care.
- Patients had access to a renal social worker via their GP who assisted with any financial advice, benefits claims and helped inform patients of their entitlements. Nursing staff did not have regular feedback from the social work advisor unless information directly affected patients' care.

Access to information

- All of the information needed to deliver effective care and treatment to patients was available to all staff involved in their care in a timely manner. The unit had access to the most recent clinic letters following a patient's appointment with the consultant. This enabled staff at the unit to keep up to date with the patient, their condition and any other concerns or issues arising from their review with the consultant.
- Staff at the unit and the patient's lead consultant had access to the most recent blood results for the patients. Any changes to treatments which were identified through the monthly blood results were discussed at the continuous quality improvement meeting.
- The unit has specific documentation and information requests which had to been returned to the unit prior to a holiday patient attending the unit for treatment. Information was shared appropriately with the host unit from the admitting unit to ensure the patient was suitable to attend the unit and the nurses had all the information required to provide effective ongoing care for the patient.
- Patients were also enabled, if they wished, to access electronic systems to view their blood test results. This enabled patients the options of accessing their records at times which suited them and from their home.

Equality and human rights

- The Equality Act 2010 places a legal duty on all services to 'make reasonable adjustments' in order to avoid putting a person with disabilities at a substantial disadvantage when compared to a non-disabled person. Staff obtained information about patients' communication needs in line with the Accessible Standards (2016). This was done as part of each patient's initial assessment. Staff ensured patients' needs were met wherever possible for example by purchasing specific equipment or facilitating the dialysis treatment in a single room if required.
- There was a corporate patient equality and diversity policy which ensured patients with protected characteristics were not discriminated against and identified ways of empowering patients with different needs. The policy provided guidance about accessing, for example, translation services or written information in large-scale print or Braille and detailed the responsibilities of staff with regards to equality and diversity at the unit.
- Staff ensured patients' needs were met wherever possible. The unit had level access to accommodate patients with varying levels of mobility and could also accommodate wheelchairs. Patient toilets were spacious to allow for wheelchair access and also had different coloured toilet seats and rails to support people with a disability. The toilet also had an emergency call bell to summon assistance if required.

Consent, Mental Capacity Act and Deprivation of Liberty

- Staff understood the requirements and guidance and received training about the Mental Capacity Act 2005. The unit had systems and processes in place for patients who did not have the capacity to make a particular decision where consent was required. If nurses had concerns about a patient's capacity to make a decision about their care and treatment, they would

raise concerns with the patients lead consultant at the monthly continuous quality improvement meeting who would take action to address the concern. The unit, at the time of the inspection was not treating any patients a patient with memory problems or any patients who lacked the capacity to consent to treatment; however, we were assured from staff that where patients lacked capacity, they would not proceed with dialysis until this had been resolved.

- Consent was sought from patients at the initial appointment prior to treatment. We saw written consent forms for treatment which were completed with patients at their initial appointment. The consent form was kept in each patient record and was signed by the patients and the nurse obtaining consent. This was in line with the units consent policy. The consent form explained the benefits and risks of treatment to enable patients to make an informed choice about their treatment. All six records we looked at contained completed consent information. Staff did not ask for verbal consent each time prior to receiving care and treatment at the unit. They explained that patients gave implied consent by sitting at their stations and allowing cannulation of their fistulas. Staff also explained that a patient could withdraw consent and gave an example where a patient wished to shorten their treatment session. This as in line with the units consent policy. In this instance, staff held a conversation with the patient about the risks associated with this and recorded it in the patient's notes.

Are dialysis services caring?

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Compassionate care

- We spoke with seven patients, one family member and two carers of a patient during the inspection and received 55 completed comment cards from patients who wrote about the care they had received.
- Staff interacted with patients in a respectful and considerate manner. We observed interactions between staff and the patients. Staff remained courteous and polite during all interactions with patients.
- Staff treated patients with kindness, dignity, compassion and respect. Patients we spoke with during the inspection were complimentary of the care and treatment they received at the unit. Quotes from patients included, "the care shown by staff does credit to their professionalism," "excellent," "I don't think the care and treatment can get any better than this" and "a first class service."
- Patient's privacy and dignity on the whole was maintained at the unit. Although there were no curtains between the stations, there was access to privacy screens which were used. We observed a consultant reviewing a patient where staff had put screens around the patient to ensure privacy. However, we did observe staff assisting a patient with poor mobility to transfer onto the dialysis chair, where the use of a screen would have been appropriate to protect the patient's dignity. A patient also commented with regards to the lack of dignity for the patient due to the difficulty of the transfer. In the 2016 patient satisfaction questionnaire, 34 out of 40 patients stated they were very satisfied with the level of privacy and dignity during their visit to the unit, whilst, 18 out of 20 patients were quite satisfied with the level of privacy and dignity during their visit.
- Staff demonstrated a supportive attitude to patients at the unit. We observed staff checking regularly to ensure the patient was alright.
- Staff at the unit quickly built up a rapport with patients who attended the unit for treatment and interacted with patients in a respectful manner. Staff put patients at ease, communicated with them like friends and engaged in day to day general conversation. Patients described the atmosphere at the unit "welcoming" and "very friendly."
- We saw staff were responsive to all patients' needs, including calls for help, alarms on dialysis machines and any non-verbal signs of distress. All staff were compassionate and attentive.
- Nursing staff tried to maintained patients comfort through the use of additional pillows and pressure relieving aids. We saw many patients brought their own blankets and comforters. However, comments we received from patients included, "the chairs are uncomfortable," and patients told us they were cold during their sessions due to the air-conditioning. Patients felt the temperature extremes could make sessions uncomfortable. In the 2016 patient satisfaction

questionnaire, 35 out of the 53 responses identified they felt the room temperature could be improved. Following this, the manager had booked an inspection of both the air conditioning unit and the heating vents as at times both were appearing to be active at the same time.

Understanding and involvement of patients and those close to them

- Staff communicated with patients to ensure they understood their care and treatment. Some patients told us the nurses would explain what was happening with their care and treatment and would identify any changes set out by the patients lead consultant. Patients told us they felt comfortable to ask questions about their care and treatment to the nurses. The patient feedback questionnaire and some comment cards we received indicated patients felt listened to, however, they did not feel the nurses spent enough time with them explaining and planning their care.
- Patients felt informed about their blood results and were given the opportunity to discuss any treatment changes made by the consultant. Nurses discussed the meaning of the results with each individual patient and any changes to their treatment which the consultant had made following the blood results. Patients told us they understood what was happening and felt clear about the status of their condition, following an explanation of their blood results. We received one comment from a patient stating they felt at times the nurses could take more time to listen to them.
- Staff understood the importance of involving family members and close relatives as partners in patients' care. We spoke with a family member and carers who had accompanied patients to the unit and stayed with them during the session. They told us they felt they could ask questions if they wanted to and were as involved as they were involved as much as they wanted to be with the care and treatment of their loved one. They told us the staff were accommodating and always offered them refreshments.
- Staff spoke openly about the treatments provided, the blood results and dialysis treatment plans. Many of the patients were observed speaking to staff and discussing their treatment as the nurses were setting them up for treatment.
- Nursing staff told us due to seeing the patients frequently, they were familiar with their moods and were able to identify when patients were having a bad day or were feeling unwell. This enabled them to spend additional time with the patients as necessary to support them with their treatment or assist with any concerns they may have.
- Nurses ensured patients understood their kidney condition and how this related to other medical problems they may have which impacted upon the life choices made by patients. However, nurses told us there were some patients who did not want to know about their condition or treatment and they respected the patient and their choice to do this but always provided them with the opportunity to ask questions or offer information in case they changed their mind.
- Patients and those close to them were involved in care and treatment. Nurses at the unit took the time to talk to patient's families and relatives during the changeover time if required. This enabled the patient and their family to ask questions and be kept informed about care and treatment.

Emotional support

- Staff recognised the broader emotional wellbeing of the patients under their care. One nurse told us about a patient who experienced emotional ups and downs with regards to treatment. Concerns had been raised with the lead consultant however the patient did not want any formal support. The named nurse at the unit told us how they took time to talk to the patient and provide reassurance when the patient was having a bad day. The nurse told us they were able to recognise when the patient was not themselves due to knowing the patient well and having built up a good rapport with them over time.
- Staff understood the impact on a patient's condition, care and treatment and how this affected their family and relatives. Staff had raised concerns about a patient at the unit, which had led to the receiving psychological support.
- One patient told us about a relatively new diagnosis they had been given. The patient told us how the nurses had continually closely monitored their wellbeing and provided them with support. They also told us how the nurses had worked closely with nurses from the local

acute NHS trust to ensure the patient's treatments were compatible which had provided support to the patient and ensured there was no negative impact upon their emotional and psychological wellbeing.
- Nurses discussed and sign-posted patients to where they could gain support about their condition. We saw that the centre provided details of support networks for patients and their loved ones. This included organisations such as the Kidney Patients' Association who held social events, and had support networks for patients and their loved ones and newsletters provided by kidney charities.

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

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Service planning and delivery to meet the needs of individual people

- The Royal Devon and Exeter NHS Foundation Trust commissioned B. Braun to provide haemodialysis treatment to service users in and around the Taunton area at the Taunton Dialysis Unit.
- The dialysis service reflected the needs of the population served and provided flexibility and choice for patient care. Patients were able to access the unit six days a week and had the choice of either the morning or afternoon session to receive their treatment. The unit also provided six twilight (evening) sessions per week, to further increase choice and flexibility for patients. This enabled patients to maintain a good quality of life and incorporate dialysis at a time to best suit them.
- Services were planned to account for the needs of different people. The unit had a side room which was allocated to patients who may need isolating, for example due to infection, post chemotherapy, or post radiation therapy. This side room was also in use for regular patients who benefitted from dialysing in a private room rather than out on the main floor.
- A named nurse was allocated to each patient on starting treatment at the unit which provided patients with better continuity and gave them a point of contact if they needed support or advice.
- At the time of our inspection, a new meeting had been set up to include stakeholders and other providers in the planning of service delivery at the Taunton unit. The local acute NHS trust, the commissioners, and the transport service had agreed from July 2017 to meet on a quarterly basis to discuss service provision at the unit. This meeting had been set up to ensure the unit met the needs of the local population accessing it. The local trust was keen for the Taunton unit to develop and expand to offer more choice and flexibility to the local population. Prior to this meeting starting in July 2017, the unit had not been involved in any contract meetings with the lead NHS acute trust.
- The monthly continuous quality improvement meeting provided a forum for professionals to ensure services were planned and tailored to meet the needs of the individual patients at the unit. Concerns or issues around a patient's treatment were brought to the meeting and professionals determined the best ways to ensure the quality of the care and treatment provided for individual patients met the standards set out by the Renal Association.
- Services were planned and organised so patients could participate in their own care if they chose to do so. There were some patients who participated actively in their own care. Some patients at the unit had obtained access to 'Patient View.' This system enabled patients to review their own blood test results online. Patients were encouraged to participate in their treatment for example; patients were encouraged to weigh themselves. The unit also had a competency framework available for patients who wanted to self-needle and manage their own treatment session. At the time of our inspection, no patients self-needled or managed their own treatment.
- The unit had access, via the local NHS trust, to psychological support or counselling for patients who attended the unit for treatment, to ensure their psychological wellbeing. If the nurses at the unit had concerns about the psychological wellbeing of a patient, they would raise concerns at the monthly

continuous quality improvement meeting and discuss their concerns with the multidisciplinary team. It was the responsibility of the lead consultant to make a referral.

- The unit had designated parking and disabled parking adjacent to the dialysis unit for patients who travelled independently to the unit for treatment. There was convenient and safe access to the dialysis unit for ambulant and disabled patients.

Access and flow

- Taunton Renal Unit had the capacity to provide up to 1008 haemodialysis sessions per month. However, the number actually varied every week dependent upon the needs and demands of patients. There were 84 patients who attended the service, with B Braun's budgeted forecast for 88 patients in 2017. Between March 2016 and March 2017 the service operated at 100% of its total capacity.
- Dialysis care and treatment could be accessed by patients once a session had been vacated. Sessions were then offered to patients on the parent trust waiting list for the unit. However, existing patients at Taunton Renal unit had the option to request their preferred session and would be allocated that session when a place became vacant. The unit had, up to the time of our inspection, been able to accommodate patients' needs in this respect. The unit was open six days weekly and provided a choice of daytime or evening sessions. There was a waiting list of three patients at the unit at the time of the inspection of patients who wanted to change their session time. This list was addressed before new patients were allocated to the unit and the slots. At the time of the inspection, the unit was being used to 100% capacity.
- Patients were assessed for their appropriateness to attend the centre by the local NHS trust. Patients with acute kidney disease were treated at the local NHS trust and only chronic, long-term dialysis patients, who could be safely treated in a nurse led unit, were referred to the unit.
- When a patient was identified as being suitable to attend the centre, a referral was completed by the local acute NHS trust. Patients could attend the unit to have a look around and meet staff. Staff told us of occasions where this had occurred in the past. Once the patient had agreed to attend the centre, Taunton Renal Unit liaised with the transport service for all patient activity including new patient transfers from the parent local NHS acute trust to Taunton Renal Unit.
- Patients experienced varying waiting times on arrival at the unit prior to their treatment starting. The patient satisfaction survey from 2016 demonstrated 19 patients waited 15 minutes or less for their treatment to start, 31 patients experienced waits between 15 and 29 minutes, whilst two patients waited more than 30 minutes for their treatment to commence once they had arrived at the unit. Messages for patients regarding waiting times and potential delays were written on a whiteboard in the reception area for patients to read on their arrival to the unit.
- Patient appointments with the dietitian were scheduled for the same day as the patient's haemodialysis sessions to prevent multiple attendances at the centre where possible.
- The service had a process to prioritise care and treatment for people with the most urgent needs. The unit had a Taunton specific contingency plan, covering a partial or total loss of water, electricity or machine failure at the unit. In the event of an emergency where patients were unable to dialyse at the unit, patients' monthly blood results, potassium levels and fluid gains were reviewed to determine the urgency of a patient requiring haemodialysis. The unit would liaise with the local NHS trust, other B. Braun units or any other local dialysis units to ensure patients received their dialysis treatment. This event had not occurred at the Taunton unit.
- There had only been one dialysis session between January 2016 and 2017 where treatment had been delayed for 45 minutes. This was due to a small flood in the water treatment plant. Despite this, the unit acted efficiently and patients were able to continue with their treatment.

Meeting the needs of local people

- Processes were in place to introduce new patients to the service and enable individual concerns and needs to be addressed. The renal consultants instigated new referrals. New patients were welcome to visit the unit before starting their treatment. Staff told us this did not

happen regularly, but they would approach patients who had already been attending long term to see if they would be willing to discuss processes and procedures with newly referred patients.

- The dialysis service reflected the needs of the population served and provided flexibility and choice for patient care. Patients were able to access the unit six days a week and had the choice of either the morning, afternoon or twilight session to receive their treatment.
- Services were planned to take into account for the needs of different people, to enable them to access care and treatment. Admission criteria was set out, so all patients irrespective of age, gender, race, religion, belief or sexual orientation could access the services. However, there were patients who would not be able to dialyse at the unit, due to the unit not being able to cater for their individual needs as the unit was nurse led. For example, if they had a high dependency or were unable to dialyse in a chair.
- There were processes in place to ensure a patient new to haemodialysis was provided with information to ensure their understanding of the nature and purpose of the treatment, the effects, the risks and benefits and any post procedure instructions. Patients were provided with information booklets about haemodialysis treatment and the risks by the lead consultant at the local NHS acute trust, prior to starting their treatment at the unit. Nurses at the unit would also provide written information to patients at their first session. The information included how haemodialysis worked, coping with fluid restriction, diet, understanding blood results, and vascular access. Information was set out clearly and simply for patients to follow.
- There were arrangements in place to account for patients with complex needs or learning disability. The unit had experience of managing complex patients and told us they would work closely with families and carers to ensure the needs of the individual were accommodated. One patient at the unit was accompanied by carers during each haemodialysis session and another complex patient was always allocated a side room for their comfort and the comfort of other patients on the unit.
- The unit had access to translation services via the local acute NHS trust. Although at the time of the inspection no patients had attended the unit who had required translation services.
- There was a provision for patients to be able to use the toilet prior to commencing treatment at the unit. The toilet facilities also enabled disabled access and were spacious enough to accommodate a wheelchair. The toilet also had disability facilities, such as a blue toilet seat and blue hand rails to help a patent with cognitive difficulties or sight problems to identify the object in the bathroom more effectively.
- Patients had access to entertainment or activities during their haemodialysis session. Each station had its own individual television, integrated handsets and a call bell to get the nurses attention. Patients also had access to the Wi-Fi at the unit to access the internet via laptops and other personal electronic devices. One haemodialysis chair had a set of bike pedals for patients who wanted to carry out some light exercise during their treatment session. One patient we spoke with using this equipment told us how he they had seen improvements to their mobility and medical conditions since having access to this facility.
- There were provisions to ensure patient comfort during their treatment. Patients were provided with pillows and a drink and biscuits during their session. Patients told us the unit was as comfortable as it could be for the treatment it was providing, although patients told us the chairs were not always the most comfortable and some were old and needed replacing. This reflected the results of the patient satisfaction survey.
- Patients were provided with support once they had booked their treatment at a dialysis centre at their holiday destination. Nurses completed all the paperwork required by the chosen treatment centre in order to ensure a seamless transition into the haemodialysis unit for the patient going on holiday. Nurses at the unit liaised directly with the holiday dialysis unit, to arrange dialysis for patients who were coming on holiday to the area and who wanted to attend the Taunton unit. The unit had set criteria for holiday patients and paperwork requirements to be completed and reviewed prior to a patient attending the unit for treatment. The information requested ensured the patient was treated safely and effectively. Information required included details of the dialysis prescription, including maximum fluid removal and all treatment parameters. Recent blood biochemistry, haematology and virology results were also required at least four weeks prior to attendance.

- There was no transport user group at the dialysis unit; however, patients raised any issues regarding their transport with the nurses or the unit manager. The nature of the issues raised were minor however, the unit manager would always feed these back directly to the transport company for the patient. The unit manager attended a meeting with the commissioners in February 2017 regarding an update about the transport provision and how this would affect the Taunton unit. At the time of our inspection, decisions regarding the contract for the transport services had not been finalised. The unit manager was planning to feed this back to patients via the patient forum at the end of June 2017.

Learning from complaints and concerns

- People using the service told us they felt could raise any concerns with the clinical staff if they wanted to make a complaint. The complaints procedure was made available to all patients at their first session at the unit and was displayed on the wall in the reception area.
- The unit had received no formal complaints between March 2016 and March 2017. However, one patient had written a letter to the unit manager regarding the lack of investment at the unit and the need for new chairs and redecoration. The patient did to want the letter formally documented as a complaint so the unit manager responded verbally to the patient to reassure the patient. At the time the letter was written, the tender to extend the contract at the unit had not been confirmed. Until this was confirmed, the unit could not commit themselves to purchasing new equipment or redecoration.
- There was a comprehensive complaints policy and procedure to ensure all complaints were handled effectively and confidently. The procedure ensured complainants received a timely response, acknowledgement within five working days and a full response in 20 working days. The complaints policy also outlined the complaints process flow chart documenting the stages a complaint would go through with regards to a complaint.

Are dialysis services well-led?

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Leadership and culture of service

- Leaders had the skill, knowledge, experience to lead effectively. The manager at the unit had been working in renal care for 17 years and had extensive experience in management within renal care. The manager was supported by an operations manager, clinical quality manager and a practice development nurse, who visited the unit on a monthly basis and were available anytime via telephone or email. The unit manager was also supported by two senior dialysis nurses who had qualifications in renal nursing. Since February 2017, the manager had been supporting another B. Braun unit in the absence of a unit manager. This had reduced the capacity to enable the managerial role at the Taunton unit to be carried out effectively, for example, limiting the ability to hold staff meetings more regularly and having oversight of compliance and completion of mandatory training due to the increased workload. At the time of our inspection, a manager had been appointed to the other B. Braun unit and the manager was in the process of handing things back over and resuming a full time role managing the Taunton unit.
- Leaders understood the challenges to good quality care and were able to identify actions to address them. The unit manager talked about the importance of ensuring a stable workforce and retaining both new and existing members of staff by providing support and good quality training. The manager also discussed the clinical challenges of providing good quality care, for example, ensuring effective infection prevention and control processes.
- The senior management team also understood the challenges to ensure effective oversight of the unit. B. Braun is a vast organisation, with units covering a large geographical area across the country. Therefore, they were not able to be present at the unit every day. In order to ensure they maintained oversight of the unit, a member of the senior management team had weekly telephone calls with the unit and visited monthly. This was to check on staff wellbeing and make sure there

were no problems or concerns they could support with. The unit manager also told us if there was a problem, the senior management team could be contacted by either telephone or email at any time.

- Leaders were visible, approachable and supportive. Staff spoke highly of the unit manager, about the support they provided and their leadership skills. Staff told us they felt comfortable to discuss any concerns both work related and personal with the manager. One member of staff told us "she is like a mother to me." Staff also praised the manager's work ethic and their dedication whilst also taking on an extra workload providing managerial cover at the neighbouring B. Braun renal unit since February 2017, to cover for a vacancy.
- Staff told us they felt valued and respected, were proud of the patient care they provided and spoke of the positive working culture. Staff told us they enjoyed working at the unit and they worked well as a team to support each other. Staff also told us they valued the unit manager working clinically on the unit. The manager's time was split 50% managerial and 50% clinical. Staff felt their presence working clinically on the unit gave them a better understanding of the challenges they faced and contributed to their ability to lead effectively due to having an awareness of what was happening on the ground.
- The unit maintained a strong working relationship with the local NHS trust. Feedback we received from the consultant nephrologist based at the local NHS acute trust responsible for patients attending the unit was: "I have built up a good relationship with the staff and am able to raise any issues that occur very easily and amicably."

Vision and strategy for this core service

- There was a realistic strategy for the organisation for achieving the priorities of the unit and good quality care. It was a clear B. Braun had a corporate strategy which was identified a commitment to provide safe patient care and to engage with local communities. The company had a strategic vision of how to achieve this, which focussed on four elements: clinical care, multidisciplinary working, recognising the importance of additional support for patients and their families outside of the dialysis centre and to have effective governance processes. The company also had a strategy to support positive staff experiences. The strategy was focussed around the four 'P's: prioritising people, practicing effectively, preserving safety and to promoting professionalism. All staff were aware of their role and responsibilities in providing effective and safe care to all patients.
- The organisation also had a vision and strategy looking towards developing services at the Taunton Renal Unit. The contract for B. Braun providing renal services at the Taunton unit had been extended until March 2019. The unit was achieving 100% capacity usage of the unit during the daytime sessions and was looking to increase the numbers of patients attending the twilight sessions which were held six evenings per week. At the time of our inspection, the numbers of patients during the twilight shifts were capped at eight patients, three days a week and 12 patients, at the other three twilight sessions weekly. This was due to there being one vacancy for a qualified nurse and there not being enough staff to safely cover any more patients on the twilight shift. Since the contract had been secured, recruitment was the priority in order to be able to increase the capacity and usage of the unit during the twilight shift. The organisation was also looking to redecorate and update the unit.

Governance, risk management and quality measurement

- There was an organisational governance framework in place to support how risks and quality issues were monitored and managed. However, the governance framework required some improvement to provide assurance operational performance was discussed and actions documented to improve performance and quality of care for patients.
- The registered manager completed an operational report management plan every month which was sent to B. Braun head office. This recorded information about, key performance indicators, reported incidents and staffing. Quarterly operational management meetings were held during which the operational reports were discussed. We reviewed four sets of meeting minutes from June and July 2016, January 2017 and April 2017. There was a section for unit managers to discuss their unit, however, there was no documentation with regards to what had been discussed. There was a lack of an audit trail to show how quality, risk and performance information had been scrutinised for trends and learning. The minutes

also had a section looking at actions from previous meetings. We saw from the minutes of the April 2017 meeting, there was no documentation of the discussions with regards to progress against previous actions and we found there were still on going actions from 2014, 2015 and 2016 which had not yet been completed and closed.

- Improvements were required as to how risks were evidenced and managed. The unit had a health and safety corporate risk register which covered all risks associated with service managers, clinical staff and senior management team and also held copies of risk assessments, including fire, arson, environmental risks and disability and discrimination specific for the Taunton unit. The risk register was not a 'live' document, and although risks were 'RAG' rated (rated red, amber or green according to the level of risk) according to company policy, there were no mitigating actions and dates for reviewing the risk and mitigating actions.
- For example, the fire exit at the unit was accessible by six steps. The only other route out of the building was via the entrance. This meant, if patients had to evacuate the building via the fire escape, patients with poor mobility would be at risk in the event of a fire. The unit manager had taken actions and the local fire brigade had visited the unit in May 2017 to identify the risks and discussed with the manager a plan of action to ensure the unit and the fire service were prepared if this event was to occur. There was no documented evidence on the risk assessment or risk register to identify this mitigating action had taken place at the unit, or any further plans to monitor and review the risk in the future. However, the risk register did not identify the units inability to comply with the national guidance (Health Building Note: 07-02, 2013) for the delivery of a haemodialysis service and any mitigating actions. For example, there was no natural light at the unit and not enough hand washing sinks available.
- There was a systematic programme of clinical and internal audit used to monitor quality and identify where actions needed to be taken. This included the rates of patient falls, safety incidents, infection rates, staff hand hygiene and water system management which results were sent to the senior management team monthly. A report was produced and there was a system in place to manage and monitor the unit's performance. The unit manager also submitted monthly performance reports, against set targets to the corporate operations manager. These reports included the monthly management plan, information about treatment time and adequacy analysis, treatment start times, staff rotas and management of consumables. However, we were not clear how this information was used or how feedback was given to the registered manager and staff at the unit.
- We were not assured there were consistently effective processes to ensure in the provision of quality and risk information to the staff. Staff meetings were held; however, these were not a regular occurrence. Meetings were meant to be held six weekly, but this did not always happen due to work pressures. We saw the last three sets of meeting minutes from the Taunton staff meeting, from October 2016, and January and May 2017. The minutes demonstrated that there was a set agenda, which included 'quality management'. However, the amount of information and quality of the information provided was not consistent at each meeting.
- In the meeting in October 2016, staff were given some detail about recent audit results, whilst at the January 2017 meeting, a detailed discussion was held around performance indicators. In the May 2017 meeting no information was discussed about quality and performance at all. The minutes also documented key performance indicators were displayed in the staff room on a monthly basis. The manager had no assurance staff had read the key performance indicator reports if these had not been discussed at the staff meeting. The minutes did not demonstrate any discussion about patient safety, patient outcomes or adverse patient occurrence incidents which were reported by the unit. This meant that we were not assured if staff had a full understanding of lessons learnt from incidents or when key performance indicators were not met, which could contribute to a missed opportunity to improve service delivery and ensure safe care and treatment.
- The consultant involved was due to be involved in attending joint service review meetings and was part of the strategic management of the commissioning arrangements. The first meeting to discuss the working contract and service provision was due to take place in July 2017. The meeting also aimed to provide effective systems and processes to ensure efficient working arrangements with other parties such as the local transport service and the commissioners, along with the consultant and representatives from the local NHS

acute trust. This meeting was to provide a platform for all parties to discuss any concerns regarding service provision and to ensure the most effective safe high quality care was being provided for patients attending the unit.

- The registered manager did not have any knowledge of the Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2). This became mandatory in April 2015 for services which deliver £200,000 or more of NHS-funded care. WRES looks at the extent to which black and minority ethnic (BME) background employees have equal access to career opportunities and receive fair treatment in the workplace. Services are required to collect, report, monitor and publish their WRES data and take any required action to improve workforce race equality. Whilst corporate reports could be written, information should have been collected and reported at local level. There was no understanding of the Workforce Race Equality Standard at the Taunton unit. We acknowledged the local area had low numbers a of black and minority ethnic population.

Public and staff engagement

- The service gathered the views of patients via the annual patient survey. In 2016, the unit received a 63% response rate for the patient satisfaction survey, meaning 53 out of 84 patients completed the survey. The action plan identified to ensure improvements were made following the patient satisfaction survey in 2016 demonstrated patients were unhappy with, treatment start times, clinical staff interaction and the dialysis chairs. The issues about start times and staff interaction had been signed off as closed on 24 January 2017, the date of the staff meeting. The action was for the unit manager to take these topics to the staff meeting and discuss these further with the staff. However, there was no documented evidence in the staff meeting minutes from 24 January 2017 which demonstrated these issues were not discussed. The issues with the chairs are due to be discussed at the next patient forum meeting in June 2017. There was also a box in the waiting area where patients or their relatives could submit their views about the service or suggest improvements to the unit which was reviewed by the unit manager.
- The unit held usually held a patient forum meeting every six months which was minuted, and shared with all staff to keep them informed of issues raised by patients. The forum comprised of seven patients who volunteered to be a representative for other patients attending the unit. Topics for discussion included the quality and standard of the service at the unit. The last two meeting has not taken place due to illness amongst the patient representatives. The next meeting for the patient forum was scheduled for June 2017.
- Patients at the unit were involved in providing feedback to support the planning for the current extended contract to provide the haemodialysis service at Taunton Renal Unit. In the lead up to reopening of the tender process the Specialised Commissioner for NHS England (South West), was invited by the manager at the unit to attend a patient forum meeting in November 2016. This enabled patients to have their say about any changes and to better understand the upcoming process. Patients were encouraged to provide their thoughts and feedback about the unit, for example, any areas they felt could be improved or changed and aspects they would like to keep. The patients who attended found this to be a beneficial process. Patients were able to have input following a period of consultation about the change of the service.
- An Employee Forum met quarterly which provided a link between senior management and frontline staff. Operational updates were shared in the forum meetings and representatives acted as advocates for the staff group, putting forward their own agenda of items they wished to discuss. Minutes from these meetings were then distributed to the staff group.
- Staff felt engaged with the service and felt their views were reflected in the planning and delivery of services and shaping the culture. The organisation held road shows where the managing director visited the units to engage with the staff. This gave staff the opportunity to receive information about the business and raise concerns with a member of the senior management team. One issue resolved through these road shows was the variance in shift patterns across the different B. Braun run sites.

Innovation, improvement and sustainability

- There was a system to ensure the phased replacement of older haemodialysis machines. The organisation had a replacement programme for their haemodialysis machines in line with the Renal Association guidelines. The recommendation for machine replacement was either every seven years, or after 40,000 hours of use. An

asset register was maintained by the senior management team and unit managers and proceedings to replace machines would start up to 12 months in advance of machines needing replacing.

- The unit had an initiative for succession planning, to ensure the future of trained renal nurses at the unit. The unit provided a comprehensive training and development programme for staff. The unit held one full time senior dialysis nurse in post and had just recently taken on another senior dialysis nurse part time role. Staff were also actively encouraged to develop their knowledge and skills within renal services and had been encouraged and supported to do so. This year (2017) some staff members had attended end of life conferences and had had the opportunity to observe fistula formation surgery.

Outstanding practice and areas for improvement

Outstanding practice

- Patients at the unit were involved in providing feedback to support the planning for the current extended contract to provide the haemodialysis service at Taunton Renal Unit. In the lead up to reopening of the tender process the Specialised Commissioner for NHS England (South West), was invited by the manager at the unit to attend a patient forum meeting in November 2016. This enabled patients to have their say about any changes and to better understand the upcoming process. Patients were encouraged to provide their thoughts and feedback about the unit, for example, any areas they felt could be improved or changed and aspects they would like to keep. The patients who attended found this to be a beneficial process. Patients were able to have input following a period of consultation about the change of the service.
- One patient told us about a relatively new diagnosis they had been given. The patient told us how the nurses had continually closely monitored their wellbeing and provided them with support. They also told us how the nurses had worked closely with nurses from the local acute NHS trust to ensure the patient's treatments were compatible which had provided support to the patient and ensure there was no negative impact upon their emotional and psychological wellbeing.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the proper and safe administration of medicines which includes using a relevant policy, patient group direction or use prescription when administering fluid boluses to patients following a drop in blood pressure.
- The provider must ensure safe administration of intravenous medicine in line with the Nursing and Midwifery Council Guidelines (2013).
- The provider must ensure dialysis prescriptions are up to date and signed and dated by the lead consultant for the unit in line with the General Medical Council guidelines: Good Practice in Prescribing and Managing Medicines and Devices (2013)
- The provider must ensure the nurses at the unit are not transcribing the patient's dialysis prescription which was not in line with guidance from the Nursing and Midwifery Council (NMC, 2015).
- The provider must ensure there is an appropriate policy and specific staff training for the early identification of sepsis (infection) in line with national guidance (NHS England, 2015).
- The provider must ensure there is evidence and an audit trail that risk, quality and performance was monitored for trends and learning.
- The provider must ensure that there are consistent and effective processes to provide staff with quality and risk information, such as, patient safety, performance and adverse patient occurrences.
- The provider must review their risk management processes to include evidence of how local service risks are identified and acted upon.

Action the provider SHOULD take to improve

- The provider should ensure all staff are fully compliant with mandatory training.
- The provider should review processes to ensure patients identity is checked prior to starting dialysis treatment.
- The provider should ensure the dialysis chairs are in good condition to enable effective disinfection and cleaning.
- The provider should ensure that sharps bins are maintained, when not in use, in accordance with the National Institute of Health and Care Excellence guidelines, Healthcare Associated Infections: Prevention and Control in Primary and Community Care (CG139).

Outstanding practice and areas for improvement

- The provided should ensure processes are completed to provide assurance that actions regarding patient care and treatment are completed following the continuous quality improvement meeting.
- The provider should review processes for monitoring and signing of staff learning objectives to demonstrate competence in a particular area.
- The provider should ensure staff have enough time to interact with patients with regards to their care and treatment.
- The provider should ensure there is documented evidence of all discussions which take place at staff meetings to identify completed actions, for example actions from the patient satisfaction questionnaire.
- The provider should ensure they have knowledge of and evidence compliance with the Workforce Race Equality Standard (WRES) which became mandatory in April 2015.
- The provider should ensure the temperature at the unit is maintained at a suitable level to ensure the comfort of the patients receiving treatment at the unit.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)(g) Care and treatment must be provided in a safe way for service users. The registered person must ensure the proper and safe management of medicines. Staff did not ensure the safe administration of intravenous medicine to patients in line with guidance from the Nursing and Midwifery Council (NMC, 2015). Although we observed two nurses checking the anticoagulant provided was in date and correct for the patient, staff did not formally check patient's identification before administering intravenous medicines. Taunton Renal Unit did not have a relevant policy, patient group direction or use prescriptions when administering fluid boluses to patients following a drop in blood pressure. This was not in line with national guidance (National Institute for Health and Care Excellence, CG 174, 2013) Processes did not ensure the unit held the most up to date dialysis prescription for each patient. As treatment requirements changed and were reviewed at the monthly continuous quality improvement meeting, nurses would then add the revised treatments onto the dialysis prescription and date this rather than the consultant responsible for prescribing medicine adding this to the prescription record, and signing and dating the changes. The General Medical Council guidelines: Good Practice in Prescribing and Managing Medicines and Devices (2013) states documents, including clinical records should be made at the same as the events being recorded or as soon as possible afterwards.

This section is primarily information for the provider

Requirement notices

We found prescription only intravenous medicine was left out on three nurses' trolleys in the main treatment area and not locked away. The anticoagulant used was a prescription only medicine which is required to be locked away when not in use.

Fluids for intravenous administration were stored on trolleys in the main dialysis area. This does not comply with safe practice for storage of intravenous fluids as outlined in the Safe and Secure Handling of Medicines guidance from the Royal Pharmaceutical Society (2005)

Nurses at the unit were transcribing the patient's dialysis prescription which was not in line with guidance from the Nursing and Midwifery Council (NMC, 2015). Therefore, processes did not ensure the unit held the most up to date, signed dialysis prescription by the lead consultant for each patient.

There was no policy, standard operating procedure or specific staff training to promote the early identification of sepsis (infection) in line with national guidance (NHS England, 2015).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(2)(b) Quarterly operational management meetings were held during which the operational reports were discussed. We reviewed four sets of meeting minutes from June/July 2016, January 2017 and April 2017. There was a section for unit managers to discuss their unit, however, there was no documentation with regards to what had been discussed. There was a lack an audit trail to show how quality, risk and performance information had been scrutinised for trends and learning. The minutes also had a section looking at actions from previous meetings. We saw from the minutes of the April 2017 meeting, there

This section is primarily information for the provider

Requirement notices

was no documentation of the discussions with regards to progress against previous actions and we found there were still ongoing actions from 2014, 2015 and 2016 which had not yet been completed and closed.

We not assured there were consistently effective processes to ensure in the provision of quality and risk information to the staff. Staff meetings were held however, these were not a regular occurrence. Staff were given updates and reminders about operational changes and October and January's meeting minutes detailed a some discussion around performance. The minutes also documented key performance indicators were displayed in the staff room on a monthly basis. The manager had no assurance staff had read the key performance indicator reports. The minutes did not demonstrate any discussion about patient safety, patient outcomes or adverse patient occurrence incidents which were reported by the unit.

The risk register was not a 'live' document, and although risks were 'RAG' rated (rated red, amber or green according to the level of risk) according to company policy, there were no mitigating actions and dates for reviewing the risk and mitigating actions.