Chandlers Ford Dialysis 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

Chandlers Ford Dialysis Unit is operated by Fresenius Medical Care; it is commissioned by the local NHS Trust, as part of their renal service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 26 April 2017 along with an unannounced visit to the unit on 9 May 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 services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There were effective processes in place to keep patients safe, including a well-embedded process for reporting incidents and learning from them**.** The unit's patient data was inputted to the renal registry through the commissioning NHS trust.
- Staff showed effective, robust infection control, with high compliance in cleaning, hand hygiene, and strict segregation of high risk patients. There was an effective monthly audit programme to ensure standards were maintained.
- There was an effective process for obtaining and recording patient consent for renal dialysis. There was good access to renal dietician support and staff referred patients appropriately. Patients felt they were involved in decision making about their renal care.
- There was a good standard of compliance in mandatory training. All staff had an annual review of their practice competencies, assessing both knowledge and skills. Temporary staff within the unit had a work place induction. There were many routes for training and education that staff could access.
- The unit used a 'named nurse' system; we witnessed a good rapport between staff and patients who knew each other well. Staff treated patients with kindness and with consideration for their individual and cultural needs. All patients who spoke with us were happy with their care and this was reflected in the positive patient satisfaction survey results.
- Staff and patients felt that the local leadership was visible and approachable and felt well supported. Staff recognised and understood the Fresenius Medical Care core values.
- Policies and procedures in use within the unit, were based on national guidance and all clinical policies had been regularly updated. There was well prepared business continuity and disaster planning.
- We saw 100% of staff had participated in the staff satisfaction survey undertaken in 2016. The FMC human resources department had been actively involved in improving the retention of staff.
- There was a monthly review of the unit's clinical dashboard by the area team to assess progress. They monitored the unit's key performance indicators were monthly with actions identified for any shortfalls. The unit was involved in a pilot of a new local risk register.

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

Summary of findings

- There were no dialysis beds or pressure-relieving cushions to promote the comfort of dialysis patients. There were no privacy curtains fitted enabling patients to maintain their privacy and dignity.
- There was a risk to the accuracy and completeness of patient records due to the duplication of records, the frequent transposing from written to electronic systems and the inability of staff to fully access the patients NHS records.
- There were no re-assessment of patient safety risks and a lack of person centred care plans found within the written records.
- There were no formal patient identification checks prior to administration of medicine and dialysis.
- Staff did not recognise or understand the Duty of Candour requirements.
- The unit flooring was damaged, so cleaning was ineffective.
- The waste compound was accessible by the public through the metal railings; and the bins were unlocked.

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 three requirement notice(s). Details are at the end of the report.

Professor Edward Baker

Chief Inspector of Hospitals

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Background to Chandlers Ford Dialysis Unit

Chandlers Ford Dialysis Unit is operated and managed by Fresenius Medical Care. It is a private dialysis unit in Chandlers Ford, Southampton in Hampshire. The unit opened in March 2006. The unit's NHS contractual referral partner was the renal centre from a local NHS Trust. The Chandlers Ford unit primarily serves the communities of the Southampton and Winchester areas.

The unit has had a registered manager in post since 2006. At the time of the inspection, the unit manager had been registered with the CQC since 2012. The nominated individual had been registered since June 2016.

NHS consultant nephrologists from the NHS Trust renal centre and the service commissioners, held the responsibility for the patient's clinical care. They visited the unit at least three times per month for renal clinics and referred appropriate patients for dialysis.

An announced inspection was carried out on 26 April 2017 and followed up by an unannounced inspection on the 9 May 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Julie Sprack, an additional CQC inspector, and a specialist advisor with expertise in dialysis.

Lisa Cook, Inspection Manager, oversaw the inspection team.

The team were on site between 7.15am and 6pm on the announced inspection on 26 April 2017 and 11.30am and 3.30pm on the 9 May 2017.

Information about Chandlers Ford Dialysis Unit

The unit had 18 dialysis stations, which included two segregated stations in side rooms for infectious patients or precautionary segregation for post-holiday patients. The unit provided 'standalone' dialysis for patients over 18 years, for six days per week, with two sessions running between 7.30am -12.30pm and 12.30pm-6.30pm on Tuesday, Thursday and Saturday. An additional twilight session from 6 –11pm took place on Monday, Wednesday and Fridays.

At the time of inspection, there were 73 patients who attended the unit for dialysis, 34 were between 18-65 years and 39 over 65 years.

The unit did not provide for patients requiring peritoneal dialysis. The unit occasionally provided accommodation for patients undertaking holiday dialysis dependent upon available capacity and the correct referral information being received.

The unit had one large open clinical area, divided into 16 dialysis stations and two segregated side rooms for dialysis. The staff only access to the clinical stores, waste disposal and water treatment plant was located at the rear of the unit through double doors.

The dialysis unit was accessed by a bell through a locked entrance door, with a receptionist, waiting area, patient toilet and other clinical rooms and offices located at the front of the unit. Access into the clinical area was through a keypad locked access door.

The unit was registered with the Care Quality Commission to provide the following regulated activities:

- Treatment of disease, disorder or injury

During the two inspections, we visited the main unit and inspected the various clinical stores, water treatment and utility rooms. We spoke with 17 staff including; registered nurses, renal assistants and senior managers. We spoke

Summary of this inspection

with 22 patients. We also received four 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed 13 sets of patient paper records.

There were no special reviews or investigations of the unit ongoing by the CQC at any time during the 12 months before this inspection. The unit was last inspected in March 2013, which found that the unit was meeting all standards of quality and safety it was inspected against.

Activity

- In the reporting period March 2016 to Feb 2017 there were approximately 10,316 patient dialysis sessions provided.
- There were three outpatient clinics per month held by the consultant nephrologists specifically for the unit's renal patients and supported by the unit manager. There were other clinics provided by the dieticians and or accompanying consultant nephrologists. The clinic patient lists were provided by the trust in advance of the clinic.

Chandlers Ford Dialysis Unit employed nine registered nurses, four renal assistants and one receptionist, as well as using the organisation's 'flexi bank' staff or approved agency to fill staffing gaps.

Controlled drugs (CDs) were not stored on site. The clinical manager was responsible for medicine safety.

Track record on safety

- The unit had zero never events in the reporting period March 2016 until February 2017
- There were five patient falls reported as clinical incidents in the reporting period.
- Zero incidents of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)
- Zero incidents of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- Zero incidents of hospital acquired Clostridium difficile (C.Diff)
- Zero incidents of hospital acquired E-Coli
- Zero complaints were submitted.

Services accredited by a national body:

Whilst there were no services accredited by a national body, the provider had 'ISO 9001 quality management system' and 'OHSAS 18001 H&S' accreditation.

- The ISO 9001 quality management system is a standard based on a number of quality management principles including a customer focus and continual improvement
- OHSAS 18001 is an Occupational Health and Safety assessment. It is an internationally applied British Standard for occupational health and safety management systems

Services provided at the unit under service level agreement:

- Clinical and or non-clinical waste removal through an external contract
- Environmental cleaning through an external contract
- Pathology and histology through the local NHS trust
- Transport- commissioned through the local NHS trust
- Interpreting services through the local NHS trust

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 issues that the service provider needs to improve:

- The duplication of records, relying on the transposing of information by staff and the inability of the staff to fully access the NHS record system presented a potential risk the accuracy and completeness of patient records.
- The unit staff initially completed safety risk assessments on the patients first dialysis session but there was no evidence of re-assessment and a lack of person centred care plans in relation to these assessments within the written records.
- There was a potential risk of patients receiving the wrong treatment, as there were no formal identification checks completed prior to the administration of medicines or the commencement of dialysis treatment.
- The flooring in the unit was damaged, and an infection control risk as it could not be cleaned effectively.
- The clinical waste compound was accessible through the railings. We also saw the clinical waste bins were unlocked.

However, we found the following areas of good practice:

- There was a well-embedded process for reporting incidents and learning from them**.**
- There was a good standard of compliance in mandatory training.
- There was effective, robust infection control, with high compliance in cleaning, hand hygiene, and strict segregation of high risk patients.
- There was an effective monthly audit programme to ensure standards were maintained.
- There was good business continuity and disaster planning.

Are services effective?

We found the following areas of good practice:

- Policies and procedures in use within the unit were based on some national guidance and all clinical policies had been regularly updated.
- The area head nurse monitored and benchmarked the unit's key performance indicators monthly, there were actions identified for any shortfalls.
- The unit's patient data was inputted to the renal registry through the commissioning NHS trust.

Summary of this inspection

- There was good access to renal dietician support and staff referred patients appropriately.
- All staff had an annual review of their practice competencies, assessing both knowledge and skills.
- Temporary staff within the unit had a work place induction.
- Staff could access many routes for training and education.
- There was an effective process for obtaining and recording patient consent for renal dialysis.

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

- The 'Nephro Care Good Dialysis Guide' was a detailed document referenced and supported by guidance. However, it was not fully reflective of all the current guidance available.

Are services caring?

We found the following areas of good practice:

- Staff treated patients with kindness and with consideration for their individual and cultural needs.
- The unit used a 'named nurse' system; we witnessed a good rapport between staff and patients who knew each other well.
- All patients who spoke with us were happy with their care and this was reflected in the positive patient satisfaction survey results.
- Staff regularly shared and explained patient's blood results with their patients.
- Staff, covering each other when one was busy, answered alarms and call bells promptly to prevent patients waiting.

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

- The patients' right privacy and to be treated dignity was not always considered when undertaking personal care.

Are services responsive?

We found the following areas of good practice:

- The unit provided assistance to patients wishing to go on holiday.
- The unit arranged on site clinic appointments around the patient's dialysis to prevent additional trips to the unit.
- There was no waiting list for the unit and patients experienced flexibility in rearranging timeslots.
- The unit had received no complaints within the past twelve months.

Summary of this inspection

Are services well-led?

We found the following areas of good practice:

- Staff and patients felt that the local leadership was visible and approachable, and felt well supported.
- Patients felt they were involved in decision making about their renal care.
- There was a monthly review of the unit's clinical dashboard to assess performance against other Fresenius Medical Care units.
- Staff recognised and understood the organisations core values.
- The unit was involved in a pilot of a new local risk register.
- The organisations human resources department had been actively involved in improving the retention of staff.
- The staff satisfaction survey had increased to 100% participation in 2016.

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

- Not all policies were current and some did not include reference to the most up to date guidance.
- The staff had not received any Duty of Candour training, although new training was just starting.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- The Fresenius clinical incident reporting policy, June 2016, outlined the staff's responsibilities and actions to take when incidents, accidents or near misses occurred. The policy described the process, how to protect people from further risks, who needed to be told about the incident and how to investigate incidents. The policy also defined incidents in terms of patient safety incidents (not related to clinical treatment), clinical incidents, near clinical incidents, never events and serious incidents. The organisation required that all incidents were reported electronically as a treatment variation. Staff we spoke with were aware of the process for reporting incidents and were able to describe when they would do so. They described receiving feedback from clinical incidents.
- The unit had reported zero never events for the reporting period March 2016 until February 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There had been five deaths of dialysis patients within the previous 12 months classed as clinical incidents; each was notified to the CQC as required under the conditions of their registration. Two of these were discussed at the coroner's court.
- The clinical manager investigated one of these jointly with the trust as a serious incident (SI). A detailed root cause analysis and report of the background to the patient's previous renal dialysis was shared with the trust and with the unit as part of the SI panel. There was evidence of shared learning from the incident, with actions to prevent recurrence and a clear audit trail within the document.
- The unit manager investigated and reported to the Fresenius Medical Care (FMC) both clinical accidents and incidents and non-clinical incidents. Between January 2016 and January 2017 there were five, of which four were patient falls. Two staff had needle stick injuries during the same time.
- There was shared learning across the organisation through their 'serious incident learning bulletin'. A review of minutes for the unit's staff meeting showed that this bulletin was bought to the attention of staff.
- Whilst most junior staff we spoke with understood their responsibilities regarding the need to be open and honest with patients in the event of an error or harm, the term 'Duty of Candour' or it's requirements was not familiar. The manager however, was able to describe their responsibilities relating to the Duty of Candour. The Fresenius clinical incident reporting policy, June 2016, procedures included being open with those affected, by applying the Duty of Candour.
- 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 that person.

Mandatory training

- Mandatory training was provided by a variety of ways, by face-to-face training, via e learning and via a dial-in system known as 'Same Time'. The organisation provided a location specific training and education matrix, which showed the training required for each role, its required frequency and method.

- The staff's compliance was monitored by the unit manager using this system which indicated when training was compete and when it was due. When viewed this showed the majority of staff were up to date with their mandatory training. For example, two of the ten training highlighted red were team leaders needing their annual e learning updates to 'Nephro care good dialysis', out of date since early 2016.

Safeguarding

- FMC had a safeguarding adults and children's policy (May 2015) which was available to all staff members. Although the clinic only treated adults, and patients were discouraged from bring children to the unit, it was acknowledged in the policy even "though a health professional may not be working directly with a child, they may be seeing their parent, carer or other significant adult and have knowledge which is relevant to a child's safety and welfare."
- Staff undertook safeguarding adult training, (there was no level of training identified) every three years; however, the matrix illustrated for two out of the 14 staff this was out of date in May 2016. The manager was aware and had plans to update the staff. Staff we spoke with could describe when concerns would need to be raised, and knew who their safeguarding lead was, this was displayed on the wall for easy access.
- Safeguarding children training was every three years, (there was no level of training identified but should be at Level 2), all staff identified as needing the training were in date. There was a once only 'radicalisation' training and all staff were compliant.

Cleanliness, infection control and hygiene

- When inspecting the unit we saw that the cleanliness of the unit was generally very good. The work surfaces, trolleys and patient dialysis areas were seen to be free from dust. However, the hard flooring surface looked worn with ingrained dirt throughout and with hazard tape in some areas to provide an alert to indicate an uneven surface; therefore, it would be difficult to clean effectively. We were told this had been raised by an unannounced annual FMC infection prevention and control audit, which was undertaken in January 2017. FMC had been awaiting the renewal of the service contract prior to replacing the flooring. The clinical manager told us quotations regarding the flooring replacement had now been sought.
- Throughout the inspection we saw staff actively cleaning equipment and using personal protective equipment (PPE) when indicated. This included the active cleaning of the dialysis machines, recliners, tables, and television and call bell handsets. We saw the decontamination of the dialysis machine by the required cycles, the frequent cleaning of blood pressure cuffs and any other equipment that was used between patients.
- The dialysis machines were surface cleaned thoroughly between patients using the recommended regime as per FMC policy, for example using a 1% solution of cleaning liquid. The machine disinfection cycle was observed running between patients as per policy.
- Patients were assessed for infection risk when referred to the unit, for example MRSA and MSSA status, Hepatitis B status was confirmed prior to them commencing dialysis and repeated when their status changed or following a holiday.
- We witnessed the use of strict segregation for dialysing infected or high risk patients. If patients were carriers of blood borne viruses such as Hepatitis B, then a machine was identified for their sole use. We also saw that a patient returning from holiday where they were dialysed was segregated for six weeks to ensure they would not cross contaminate other patients. Patients with Hepatitis C were not dialysed in the unit.
- The organisation undertook an annual unannounced infection prevention and control audit in January 2017. Result showed that there had been seven minor non-conformities and five recommendations. An action plan for all of these was reviewed, and on inspection we saw excellent adherence to sterile and clean techniques.
- The unit had a monthly hand hygiene and infection control audit; we saw the results and the action plans where required. On inspection, we observed staff consistently washing their hands appropriately, using PPE including splash visors when appropriate and disposing of waste appropriately. We observed that staff adhered to the uniform policy and wore clean uniforms and were bare below the elbows with minimal jewellery.
- The trust required an additional National Patient Safety monthly cleaning audit, results of which were used for the trust score; the latest nursing score for the unit was 95%.
- We saw good practice in the use of face masks for the staff members and the patients when setting up via a

long line rather than via a fistula. We also saw a glove being worn by the patient when having to press on the fistula after disconnection. These actions were to protect the patient from cross infection from microorganisms in their breath or on their skin.
- Domestic cleaning undertaken by an external company, we saw the results and action points from a quality audit, carried out in March 2017 when the standard achieved was 98.5%. The same cleaning company undertook deep cleans following infectious patients, although there was no process to ensure they were effective. However, no patients had acquired infections whilst having dialysis in the unit.

Environment and equipment

- On inspection, we saw that all electrical equipment had been safety checked and was in date for servicing. A register was kept on site confirming testing and was checked during the annual internal health and safety audit. Technicians using a maintenance and calibration plan maintained the dialysis machines, chairs and water treatment plant internally. Any additional specialist equipment had a maintenance contract with manufacturers or specialist service providers.
- There was a technician's room for maintenance of the dialysis machines and other equipment. The FMC employed technician was available via a logged call to FMC for repairs and maintenance via the maintenance and calibration plan. Dialysis machines were being replaced and expected in June 2017 for those machines who had been close to working for 40,000 hours.
- Water used for dialysis had to be specially treated to prevent risks to patients. There was a large water treatment room at the rear of the unit, trained and competent senior staff undertook daily quality checks and recorded their findings.
- There appeared to be very few blood pressure cuffs to connect directly with the dialysis machines. Staff were using the mobile blood pressure machine trolleys and frequently cleaning the cuffs between patients. This sometimes caused a slight delay in patients recording of observations, whilst the mobile trolley was located and moved to another station. This could cause a risk if one patient needed observations that are more frequent.
- There was an open drawered trolley being used for the storage of resuscitation equipment, this was not tamper evident. We fed this back to the senior team and on the unannounced inspection a recognisable resuscitation storage trolley had been obtained and was in the process of being adopted. Staff consistently completed documented checks of the equipment on a daily basis.
- The staff were trained in basic life support including the use of the automated defibrillator, however the resuscitation trolley contained items the staff would not be trained to use, no consideration had been given to this potential risk. We were informed that the stored extra kit was for the convenience of consultants or paramedics attending patients in an emergency. However, we were not aware that a risk assessment of having unfamiliar equipment stored in an emergency trolley had been undertaken.
- On inspection, the unit's portable suction unit was left unplugged, and one of the stored oxygen cylinders was registering almost empty but was stored as available for use. Although there could be 30 minutes of gas left, this would be used up quickly in an emergency. We raised these issues at the time as a safety risk. The unit had rectified these when we returned for the unannounced inspection.
- Each station had a dialysis reclining chair, these had armrests and a footplate for the patients comfort, each patient had a ceiling mounted television for use with earphones. There appeared to be a good space around each chair to enable access to patients in line with the Health Building Note 07-01, with a waste bin and sharps disposal bin for each station. Each patient was given a nurse call bell they could reach.
- The unit had well labelled segregated machines for the use with patients returning from a holiday in a 'high risk' location and another for a patient with a blood borne virus to prevent cross infection, we saw an additional back up machine for emergency use.
- There were no dialysis 'beds' in the unit and no blankets for patients; patients brought their own supply.
- In the outside waste compound at the rear of the unit, the large clinical waste bins were unlocked and could be potentially accessed and opened by the public through the wide metal railings. The unit team had not identified or considered this as a risk.

Medicines Management

- There were NHS trust led Patient Specific Directions (PSDs) in use for all of the patients. Agreed medicines and directions were pre-printed in line with the trust clinical guidelines. The prescriber would add the

patients name, date and authorising signature for use in certain situations. They included for example, oxygen therapy for use when it was indicated or additional intravenous fluids if the patient had a low blood pressure.

- The PSD did not include the Enoxaparin injection, normally given to patients during their dialysis to prevent blood clots. Medical staff prescribed this within a trust Patient Group Directive. There was also a prescription and administration chart which had a signed prescription with range of doses, the route and a space for staff to initial following the administration.
- There was a set process of a two-person check of the daily dialysis prescription (from the NHS) for the prescribed dose of blood thinning injections prior to the patient's arrival and being set up. Patients generally stayed in the same station each session. The syringes were left with the dialysis prescription at the patient's stations for fifteen minutes to an hour before a further two person check was made against the enoxaparin prescription (not the PGD) before administration. The patient was also shown the syringe(s) and advised when it was being given. Both staff who had checked the enoxaparin initialled the administration record.
- There were no storage facilities for patients own medicines. All patients were asked to bring their own medicines with them for self-administration. We observed this happening and saw that patients were happy to continue to administer their own medicines.
- There was no formal identification check as required by safe medicines administration, which could be a risk for unfamiliar staff or a new patient to the unit. The staff for example, had nothing to check the prescription against such as photo, ID band or lanyard and neither did they ask the patient. The FMC policy asked for the patient to be clearly identified.
- The clinic's clean utility room contained the locked medicines fridge, which had its temperature monitored daily. There were minimal medicines stored in locked cupboards although the main door key pad was unlocked.
- There was no unit-based pharmacist; however, staff had easy access to the trust renal pharmacy for advice on dialysis medicines or the FMC pharmacist at head office.

Records

- The unit used a combination of paper and electronic records, which caused some duplication. These were securely stored at the unit out of hours, brought out, and placed on the patient's station when in use. Patient records in use during the unit opening hours were stored out of sight in open plastic boxes under the desk, and locked away overnight, old records and archives were locked securely in cupboards.
- Patients used a 'card information system' this was an initialled 'credit card' used to record their weight and then inserted into the dialysis machine prior to their dialysis to upload their information. They were laid out on the counter top for patients to select when they entered the unit, patients with similar initials had additional initials added to prevent any confusion.
- The paper records were organised into sections including for example the daily dialysis prescriptions, PSDs, patient's risk assessments for moving and handling, mobility and skin integrity, copies of clinic letters and consent for treatment. The staff completed the daily dialysis prescription by hand and confirmed the condition of the fistula or line entry site after completion of dialysis. The staff member then manually up loaded this entry into the electronic system contemporaneously.
- The electronic system was an FMC record, which was updated regularly; and automatically transferred data to the trusts' clinical database. Information in the FMC system was accessible to both the unit staff and the NHS staff to review in the hospital and when visiting the unit for clinics. The trust may request patient's treatment changes or clinic visits following review of the results. The staff told us the trust's electronic system, did not interface fully with the FMCs electronic system; therefore staff at the unit had limited access to view the trust system. There was a potential risk of staff missing relevant information, although there was no evidence this had happened to date.
- The unit securely emailed the NHS consultant nephrologists a monthly spreadsheet containing all patients' blood results for their review.
- Patients were referred into the dialysis service with detailed transfer documentation; a mandatory quality check was made and signed off by staff to ensure that that the data was correct. This included checking the paper record between the FMC and the trusts system to ensure all was accurate and any discrepancies immediately rectified.

- Any medicine changes or clinic letters were sent automatically to the patients GPs by the trust, a copy of the letter was received by FMC and filed in the patient's paper record.
- There was a regular monthly audit of nursing documentation, which was undertaken by a senior team member. The teams also undertook a two patients audits themselves for learning. The December 2016 audit for example, showed that there was a gap in one member of staff's observations and access checks. The audit format should detail actions; however, this part was not completed.

Assessing and responding to patient risk

- The patient referral documentation was seen to contain a detailed referral, which was signed by the consultant. It contained a broad range of relevant information including for example, medical history, blood results and results of infection screening, observations and dialysis details. The unit staff would complete the admission checklist and admission assessment as a base line for the patient to help identify any changes in the patients' needs in the future.
- Unit staff assessed the patient's pre and post dialysis general condition; this included asking the patient about their general wellbeing. The patients weighed themselves at the beginning and end of dialysis.
- Formal observation and recording of the patients' temperature, pulse and blood pressure were undertaken prior to having dialysis and there were regular checks on their temperature, pulse and blood pressure before, during and after dialysis. This was part of the close monitoring of a renal patient needed to ensure that no complications were occurring, for example, a rise in their temperature might indicate early infection or sepsis, low blood pressure maybe because of fluid loss while dialysing.
- The organisation had adopted a tool for the recognition of infection in the central line site or fistula, which gave visual photographic indicators of the levels of potential infection in all ethnic groups, we saw that staff used this tool in handover and in their written records when there was a query of infection.
- Staff we spoke with told us that any concerns around potential infections or other medical issues were shared with the on call renal team at the trust, prior to commencing dialysis. The on call renal team would usually ask the patient to be seen at the nearest emergency department to ensure a fast medical review and appropriate actions took place. The staff would record the outcome of the call in the patient's records and as an incident in the FMC electronic system.
- FMC had a policy for the management of 'complications, reactions and other clinical events' this document dated 2016 contained clear visual flow charts for staff to follow in the event of patient deterioration or complications. This included for example, flowchart for chest pain, blood loss and high and low blood pressure.
- There had been eleven patients urgently transferred out of the unit to another health care facility in the period January 2016 until January 2017. Staff told us this was normally due to increasing risks of cardiac failure or other health care issues.
- If a patient had a 'do not resuscitate' decision, this was clearly marked on their record folder and shared in handover, and staff filed a copy of the original in their records. The transport drivers were advised that this decision was in place.
- On inspection, we saw the patient's initial admission risk assessments in the paper records; however, in the records we inspected risks were not regularly reassessed. For example, a patient who had recently fallen outside the unit had not had their risk assessment for mobility reassessed, despite being visibly injured. This was raised with the nurse caring for the patient at the time.
- There did not appear to be a separate risk assessment for patients at risk of falls, apart from a basic one within the mobility assessment, and we did not see any individualised care plans within any of the paper records we inspected relating to the assessments to lessen the risk.
- There were no pressure relieving cushions or mattresses for patients who were identified as a high risk of pressure ulcers despite these being available for the chairs, we were told that these could be obtained through a charity if required for a specific patient. Some patients indicated to us that they would have preferred to use a bed to allow for their knees to bend and relieve pressure on their sacrum.
- The unit operated under a named nurse concept and all patients and staff knew each other well due to the frequency of their dialysis at the unit and the length of time they had been attending. There was no formal or informal patient identification process in place to aid

temporary or new staff. The Nursing and Midwifery Council (NMC) Code requires nurses to practice safely to protect patients from harm due to errors. However, the unit had not reported any incorrect administrations of medicines or treatment due to a lack of identification within the unit.

Staffing

- There were, including the clinical manager, nine registered nurses and four dialysis assistants employed at the unit. The unit operated on one member of staff to three patients, with a skill mix of 70/30 registered nurses to dialysis assistants (Band 4s). For example, each team had one RN and a renal assistant to care for them. There were one and a half whole time vacant registered nurse posts at the time of the inspection, although slightly over by 0.8 whole time dialysis assistants.
- Any gaps in the rota were covered initially by using staff working overtime, then using the internal 'Flexibank' and finally via the approved agencies. Any temporary staff had a documented health and safety unit induction; this was completed and signed by the staff member. A registered nurse team leader acted as the unit coordinator on each shift.
- All of the staff employed worked full time, working 37.5 hours per week or 150 hours flexibly over four weeks. Staff worked an assortment of shifts according to the needs of the service. Shifts were available as day shifts, twilight shifts, half day or afternoon shifts. Staff received paid meal breaks.
- The organisation had tried hard to retain permanent staff by providing incentives for maintaining attendance over three months and one year with varied success. Clinical staff received long service awards after five years of service. Annual leave increased incrementally after five and ten years of service.
- The local trust's consultant nephrologists who commissioned the service supplied the medical support for the unit. This could be either by remote review of patients' blood results and changes in treatment plans, direct contact for advice, onsite clinic visits, and direct referral contacts.
- There were close links with the trust by the senior team and the unit's link nurses to the trust's anaemia and dietitian teams.
- The unit could request the support of technical staff via the facilities management help desk internal to the organisation. Individual units did not directly employ them.

Major incident awareness and training

- The unit undertook fire safety tests weekly, we saw in date fire extinguishers at strategic points in the unit and the assembly point in the event of fire. There were assigned fire marshals and each patient had a bespoke personal emergency evacuation plan in their records. This plan detailed any physical assistance the patient needed if evacuated. There were back up batteries on the machines to return blood to the patient in the event of power failure.
- The unit had 'disaster files' located prominently in the hallway. The folders included an emergency preparedness plan with all contact details of important services. These included, for example, council, security, wastewater, water and electricity. The unit had an emergency checklist for completion after or during an incident. The unit had a register of dangerous substances with associated safety data sheets.
- The clinical manager signed and submitted any non-clinical incidents or accident forms after completion.
- The manager was able to describe a recent loss of water incident and the actions taken to keep patients safe, they described a close working relationship with the supplier.

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

Evidence-based care and treatment

- The unit provided care led by NHS consultants and in accordance with the latest national guidance. They aimed for compliance with the Renal Association Standards to achieve quality patient outcomes.
- FMC had produced their own 'Good Dialysis Care' policy and procedure document for all units which was compliant with European Renal Best Practice (ERBP) and the Kidney Disease Outcome Quality Initiative (KDOQI) guidelines and dated 2016. The document provided staff with clear guidance on how to use the specific dialysis equipment. However, FMC had

extensively referenced the policy, although not all references were dated and the most recent appeared to be 2012. There did not appear to a reference relating to the most recent National Institute for Health and Care Excellence (NICE) Guidance for Renal Replacement for Adults 2016. The publication of an important guidance document would be expected to trigger an internal review.

- FMC had produced a separate medicines management policy (2016), which complied with the Nursing and Midwifery Council (NMC) Standards for Medicine Management (2007). Staff, for example leaving medicines unattended and no formal patient identification checks, did not adhere to these standards.

Pain relief

- There was no provision for pain relief medicines from the unit, patients were requested to bring their own medicines for self-administration with them to their dialysis session. Pain assessments were not seen.
- Some patients with arthritis told us that the inactivity whilst having dialysis caused them pain and stiffness in their joints, they accepted that it was inevitable but ensured that they brought extra blankets to keep their joints warm.

Nutrition and hydration

- Patients were offered a hot drink and a biscuit whilst on dialysis; most brought some form of snacks with them.
- There were two nutritional link nurses in the unit, and access to the dietician at the NHS trust was possible via phone. Dieticians had combined clinics on site every three months with the NHS consultants. Patients had access to a renal cookbook in the patient waiting area and the clinical manager had produced fact sheets on low potassium and low salt intake.
- Fluids were monitored and recorded whilst the patients were having dialysis. Taking into account the patient's weight and treatment protocols, there was a discussion and agreement between nurse and patient about fluid removal during the process. The nurse entered the details into the dialysis machine.

Patient Outcomes

- The Fresenius Medical Care (FMC) electronic record system provided a 'management' system to give reports and trends on patient outcomes so that the unit could make improvements in order to achieve the national standards. A report was shared with the NHS consultants on the unit's achievement of the quality standards.
- Other outcome audits, for example patient observations, dialysis vascular access, variances in treatments, and infection control interventions were also undertaken. A monthly clinic review captured the clinical effectiveness and any improvement areas. For example, the unit had more patients on the transplant list (98%) than the target of 60%. Actions included checking of the patient's status and updating the electronic system.
- The dialysis patients were part of the NHS trust's activity and their outcome data was entered into the Renal Registry by the trust rather than by the individual unit. For example, the staff assessed and monitored vascular access; and noted any issues on the daily dialysis prescription and inputted this into the FMC electronic record system. This data was submitted by the trust to the renal registry, therefore specific details of the unit were not available for the unit.
- Data specific to the unit was available via the management system in the FMC electronic database, this data was used to benchmark patient outcomes locally and nationally within all of the FMC units. Specific issues for this unit for example were highlighted as seven patients who did not complete their time, details and actions were identified. Another issue was increased water being used for each treatment, a new water treatment plant had used more than planned. The target for consumption was being reviewed.

Competent staff

- All of the unit staff had a training and education record. This contained paper records and certificates of induction, competencies and any yearly updates to maintain their competence.
- All new staff had a FMC induction, this comprised of classroom face-to-face, health and safety, and work or skill based learning. There was a detailed checklist of competencies and we checked individual training folders for compliance and completeness. New permanent staff were given protected supernumerary time whilst they undertook their organisational

induction and then were classed as probationary until their competencies were signed off. Staff then had supervised practice, followed by the consolidation of knowledge and skills.
- Basic life support and anaphylaxis training were mandatory every year and the unit staff were all compliant.
- Whilst there was no formal escalation process for sepsis, the unit staff monitored patients for any early signs of infection. Any abnormalities were promptly escalated to the on call renal registrar at the local NHS trust for advice, prior to commencing dialysis.
- There were different training routes used for training and education, for example face to face or classroom, e Learning, work or skill based learning and a new system of 'same time', which was a dial in system.
- There were two different haemodialysis competency documents for registered nurses and for dialysis assistants based upon the 'Nephro Care Standard Good Dialysis Guide'. The training records showed that all staff had completed these. The staff had an annual competency reassessment; the staff training records we reviewed showed that all staff were deemed competent. The staff's line-manager completed their practice and knowledge reassessments, to ensure staff continued to be competent and safe to practice.
- All staff had an annual appraisal undertaken and had access to study days, external training such as accredited renal courses, which contributed to the registered nurses NMC requirements for revalidation.
- Any new staff had a six-month review of their competencies and learning. The manager informed the human resources department if the member of staff had passed their probationary period after this review.

Multidisciplinary working

- The consultant nephrologists from the commissioning NHS trust had overall responsibility for the patients care. The unit staff recorded any communications to the consultants in the FMC system, which the trust could access. For example, the regular monthly blood results spreadsheet, allowed for a 'virtual patient' review by consultants, dieticians, specialist nurses and the dialysis unit staff.
- The consultants attended a minimum of three renal review clinics on site, there were other combined clinics with dieticians and specialist nurses utilising the clinical rooms in the unit. Patients had a minimum of a three monthly review with their consultant.
- There were paper copies of any communication with GPs, these reflected changes or updates to the patient's dialysis plan, there were also clinic letters and any other letters relating to the patients ongoing treatment, in and outside of the unit.

Access to information

- Whilst there was an active sharing of electronic patient data and information between the NHS, the dialysis service and the patients GP, it was 'one way' information moved from the unit to the trust and GP. However, there was limited access to the GPs and the trusts system, which could be a risk to the patient if critical information was not escalated or shared by a different route.
- All health professionals had password access to patient blood results; the patient had their monthly blood results explained by their named nurse or representative. They showed the patient and explained the detailed monthly record of their blood results. This illustrated the patient's blood results, with the ideal range and if any actions were needed. For example if an adjustment of their diet or fluids was required.
- Patients could request access to 'Patient View', which showed the latest test results, letters and medicines, plus info about diagnosis and treatment electronically. The clinical manager was available to assist patients in getting set up and logging in.
- The unit had face-to-face handovers twice a day, this ensured that information was shared relating to changes to patients' plans or clinic appointments.
- The unit provided patients with an individual 'credit card' that held their personal data, for example, their weight and daily dialysis plan. These were collected and used by the patient to self-weigh prior to and after their dialysis.

Equality and human rights

- There was specific patient information provided in different formats, which related to patients with differing cultural, physical or learning disabilities.
- There were different language options for the patient guide and interpreters were available via the NHS trust.

- There were individual patient specific evacuation risk assessments, which, in the event of fire, detailed any additional help the patient would need if they had disabilities.

Consent, Mental Capacity Act and Deprivation of Liberty

- Most staff understood the rights of a patient to decline treatment and the impact of someone with mental health conditions. We asked staff about caring for patients with a declining mental capacity or the understanding of treatment; such as those living with dementia. Staff we spoke with stated that these patients would not normally be considered suitable to have dialysis at the unit.
- Each patient had a 'consent to treatment' form in their paper records, it explained about the sharing of information for example blood results. The patients had all signed their documents; although some were signed a few years ago.

Are dialysis services caring?

Compassionate care

- We witnessed a friendly inclusive style in the unit, with all staff and patients greeting and addressing each other by name. The unit manager described their approach as a 'shared care'. The unit used a named nurse approach, where a single named nurse had a special link and relationship with the patient.
- The unit's most recent annual patient satisfaction score showed that 99% of patients would recommend the unit and 98% of patients were satisfied with the nursing staff. The results were seen displayed in the patient waiting area, with the actions for improvement. The improvements related to delays in dialysis and a lack of privacy when discussing treatment plans.
- We witnessed individual consideration of the patients' personal and cultural needs; there was a level of confidentiality regarding conversations related to their care. For example, discussions relating to the dialysis plan were held at the station between patient and nurse.
- Patients overwhelmingly fed back how kind, considerate and attentive the staff were, none of them had any concerns about their care and most felt it was friendly and staff gave good care 'like a club'.
- There were no curtains around the bed space and although mobile privacy screens were available we observed these were not routinely used. This could influence negatively the dignified care and experience of some patients. An elderly patient told us they had 'got used' to exposing their underwear for chest line attachment. A second patient declined the use of a mobile screen when it was offered. The unit told us they had trialled privacy curtains before, but patients had not liked them so they were removed.
- The manager told us they had discussed this with staff following our first visit and the privacy screens were now being used proactively.

Understanding and involvement of patients and those close to them

- The patients using the Chandlers Ford dialysis unit appeared to be fully informed and involved about their renal care. There were regular monthly reviews of their blood results, which were aimed at informing and educating the patient.
- We saw that there was little 'self-care' in place on the days we inspected, the team told us that most patients with the exception of self-weighing, appeared to be happy with the nurses looking after them whilst on dialysis. The registered manager explained that patients were educated and encouraged to self-care. For example assisting patients with medicines and self-injecting and setting them up by-self needling. The trust monitored the numbers of patient who were involved in self or shared care.

Emotional support

- We saw prompt response to any dialysis machine and patient alarm calls. Staff cross-covered each other when they were busy to ensure that patient calls or machine alarms were answered promptly. This ensured that patients were not anxious or worried about alarms on their machines.
- Patients described experiencing emotional difficulties when fellow patients died, feeling a real sense of loss and being uncomfortable when another patient took their 'space'. They stated the staff were 'wonderful' and recognised this when it happened and provided support to them.Staff could refer patients who needed help and support, although the trust did not have a renal counsellor it would fund a private counsellor if required.

Patients had access to the British Kidney Patient Association counsellor details via information leaflets in the waiting area, if they wanted to access them independently.

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

Meeting the needs of local people

- The NHS trust commissioned patient transport under a service level agreement with the regional NHS ambulance and patient transport provider. The unit fed back weekly to the trust any excessive waiting times or other issues, patients we spoke with mostly lived within a 15 minute drive. Although most accepted patient transport could take much more time due to the number of patients to drop off, some still complained of late arrivals and collections, which put pressure on the unit.
- There was a designated ambulance-parking bay close to the front entrance with ramp access for wheelchairs and patient with mobility issues.
- Due to the waiting times for transport, patients who were able drove themselves. There was adequate parking on site; they described needing to ensure that their fistula was well bound to avert any further bleeding when driving.
- The unit was not purpose built; but commissioned in an industrial unit in 2006. The unit was based on the ground floor with its own entrance; internally there were clear defined patient areas and staff only areas; patient treatment areas well-spaced still allowing for patient interaction. There had been no major refurbishment since 2006, and parts of the unit such as the flooring were looking worn out.
- There was only one patient toilet, which catered for both able, disabled and mixed sex access; it was located in the patient waiting area near the reception. The DoH guidance (2007) is for toilet facilities to be gender specific in health care facilities.
- Fresenius Medical Care (FMC) told us that the NHS trust had just confirmed an extension to the commissioning contract when we inspected. FMC had been waiting for this to be in place before making any significant environmental improvements. There was an expectation that the NHS trust may want some contractual changes relating to the provision of more outpatient clinic space. The dialysis stations spacing was important to maintain to prevent cross infection

Service planning and delivery to meet the needs of individual people

- There was no waiting time for admission to the unit, the trust referred patients based on clinical need and suitability. There was capacity available in the clinic for afternoon and evening sessions for any suitable patients.
- Patients had lots of information available to assist them in arranging holiday dialysis; the receptionist took a lead in helping to facilitate patient holiday dialysis. We saw a folder with many options for patients to look at whilst they were waiting to be called in for their session, both UK and overseas.
- One patient with mobility problems told us that the unit had accommodated her and adjusted her dialysis times by half an hour to suit her better.
- Any patient who was considering home dialysis was referred back to the trust as there was a team to support the patients but they operated from a different site.
- The patients receiving dialysis in the unit were not actively engaged in self-care. The senior team stated that despite encouragement patients appeared to feel unwilling to participate more fully in self-care. There was a training plan should the patient and carer decide to participate in shared or self-care.

Access and flow

- The unit's capacity over the past three months was 80%, there was no waiting list of patients and there had been no cancellations in the past twelve months.
- Patients spoke of the convenience of the unit's location, and being able to fit their dialysis around their lives. Most had arranged their preferred days and times right from the beginning, but others spoke of being able to change when a preferred slot became available. There was the ability to occasionally flex sessions to facilitate a patient's other commitments, sometimes even receiving dialysis back at the NHS trust to accommodate the request.
- The staff arranged any on site clinic appointments around the patient's dialysis attendance to prevent more visits to the unit.

Learning from complaints and concerns

- Patients participated in national and local patient surveys, results were shared in the waiting area, with a 'You Said -We Did' notice board.
- The service had not received any complaints during the past twelve months, although patients were aware of how to complain, most were extremely happy with their care. They told us that any small issues were quickly dealt with and resolved informally by the unit manager.
- FMC had a process for dealing with compliments, comments, concerns and complaints: mirroring the approach by the NHS.

Are dialysis services well-led?

Leadership and culture of service

- Fresenius Medical Care (FMC) organisational structure included a defined management structure, locally, regionally and nationally. The unit's leader managed the unit with the appropriate skills and knowledge. The staffing structure was a manager, deputy manager, team leaders and an administrator. Junior staff and patients felt well supported when the unit was open.
- The FMC area head nurse monitored the performance of the unit; they explained that a recent reorganisation was planning to provide additional senior roles to support practice education. The head nurses portfolio was adjusted to accommodate these changes.
- Staff and patients described the FMC managers as 'visible and approachable'; all patients knew the manager well and spoke of them affectionately. The staff meeting minutes showed that discussions took place regularly, with approximately 50% attendance of staff. There was a 14-point set agenda, which covered various topics, separated into four sections. These were 'the patient, the shareholder, the employee and the community'; these were also the four key FMC organisational objectives. We read in the minutes for example, of clinical updates, unit performance and encouragement for improvement in staff behaviours.
- The organisation had just commenced training staff on the Duty of Candour, and we saw the training log with the new training identified but not completed.
- The Workforce Race Equality Standard (WRES) is a requirement for organisations, which provide care to NHS patients. This is to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
- WRES has been part of the NHS standard contract, since 2015. NHS England indicates independent healthcare locations whose annual income for the year is at least £200,000 should produce and publish WRES report. Fresenius did not currently have or maintain a WRES report or action plan to monitor staff equality.
- FMC stated in the company handbook that, they 'are an equal opportunities employer and do not discriminate on the grounds of gender, sexual orientation, pregnancy or maternity, marital or civil partner status, gender reassignment, race, colour, nationality, ethnic or national origin, religion or belief, disability or age.' We saw on inspection that the workforce was a diverse cultural mix of staff.

Vision and strategy for this core service

- The organisational aim was to 'deliver high quality person centred care' through effective leadership, governance and culture. They stated they were committed to honesty, integrity, respect and dignity.
- The FMC vision (in brief) was to create a 'future worth living for dialysis patients working in partnership with its employees'.
- The core values were 'quality, honesty and integrity; innovation and improvement; respect and dignity'
- The FMC statement of purpose outlined the four key organisational aims and objectives. As the regular staff meeting agenda used these headings, staff were familiar with them and understood their role in their achievement.

Governance, risk management and quality measurement

- FMC had an organisational governance strategy, dated 2010 which detailed the strategic aims, these were:-
  - 'A framework where everybody assumes responsibility for the quality agenda.
  - Establish a positive, no blame culture.
  - Support staff to achieve their potential through lifelong learning and continual professional development.'

- The clinic manager was the local lead for governance in Chandlers Ford. Staff we spoke with were clear about their role boundaries and when to summon their team leader or manager to assist them.
- A representative, usually the manager attended the monthly governance meetings at the trust. Whilst there was a close working arrangement with the NHS trusts consultants, staff we spoke with told us that there had been little visible support from the NHS Trust. There had been no monitoring visits for some time despite visits being planned; they were cancelled by the commissioning trust due to the absence of the post holder. The manager was able to communicate freely with the trust by phone, but had not seen the senior nurse for some time.
- FMC had recently given the unit a set of objectives for 2017, which linked into the organisational corporate objectives, most were still unachieved and showing as red but had actions identified. These included for example, increasing the efficiency of the hepatitis log, increasing the staff uptake of the renal training course and increasing the employee retention rate.
- The FMC quality management system produced a monthly clinical dashboard, which was discussed with the area head nurse. This was a colour rated (red, amber, green) detailed analysis of the unit's performance against the key performance indicators (KPIs). Each of the indicators had an explanation and an action plan for improvements.
- The area head nurse monitored and reviewed key performance indicators at a clinic review; these were benchmarked against other units to ensure consistency and involved the trust consultants in the process.
- FMC had a clinical risk management policy dated 2009. This policy described the risk management principles and process for assessing risk. There was a new local risk register; the unit was piloting the system before other units. This contained details of 19 clinical, 23 technical and 11 operational risks; there were plans for lessening the three highest risks. Because this was a new system staff we spoke with were not familiar with it, we saw that most were historic risks with no dates for reassessment yet.
- FMC required each unit to have an annual health and safety audit as part of risk management.
- FMC reviewed policies and procedures yearly, in compliance with the requirements of the ISO quality management system (9001). However, we noted that the clinical risk policy and clinical governance strategy had not been updated since 2009 and 2010. We also found some polices did not reference to the must current guidance, for example the safeguarding policy (2015).

Public and staff engagement

- The unit had a compliments log, which summarised nine 'thank you' comments received during the past year, themes were, praise for the 'excellent care', kindness and 'wonderful' staff.
- We witnessed evidence of patients being involved in decision-making about their treatment plan. We saw in the staff meeting minutes a specific section related to issues around the patient, this was one of the corporate objectives.
- There was a 2017 objective to increase the number of responses in the patient satisfaction survey. The unit told us that the latest survey in October 2016 had a response rate of 99% this was an increase from 75% participants in 2015.
- The staff satisfaction survey had a local response rate of 83% in 2015; in 2016, this had increased to 100%. In 2015, there were actions to improve discrimination, harassment, bullying or abuse. The actions for the 2016 results received in January 2017 are yet to be agreed.
- The senior team told us there were two main issues that staff were concerned about, their salary and being supported by their senior team. Representatives for the HR team had been listening to staff and were working to promote staff retention.

Innovation, improvement and sustainability

- The manager had developed a welcome pack for new patients; this was available for them to take home and share with their family. It was available in different languages.
- There were plans for a phased replacement of older dialysis machines; some were due to arrive in June 2017.

Outstanding practice and areas for improvement

Outstanding practice

Overall, we saw outstanding infection control techniques, with strict adherence to hand hygiene, cleaning procedures, sharps, and clinical waste disposal within the unit. There was strict segregation for high risk patients and a process for segregation following off site holiday dialysis.

Patients were screened for infection before admission to the unit.

The unit had achieved 100% participation in the staff survey.

Areas for improvement

Action the provider MUST take to improve

- The provider must review the risks associated with the frequent transposing of information, from electronic to written and back again, and the inability to access the NHS electronic records.
- The provider must improve the process of reassessment of patients risks, and utilise individualised care plans to lessen the risks and to care for the patient safely.
- The provider must review the lack of patient identification checks, and establish a process for staff to check prescriptions against, thus conforming to their NMC Code of Conduct.

Action the provider SHOULD take to improve

- The provider should replace the flooring to enable effective cleaning to take place.
- The provider should risk assess the rear waste compound; for inappropriate public access and take any required action to ensure this area is safe.
- Should review the equipment provided on site to promote patient comfort for example, as there was no dialysis beds or pressure relieving mattresses available.
- Should promote shared or self-care more actively to encourage and maintain patients independence.
- The provider should review the lack of standard privacy curtains; to enable patients' privacy and dignity to be upheld without the patient having to request it.
- Staff should understand the requirements of the Duty of Candour.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met** The patients were not regularly being risk assessed for safety risks, care plans were not being used to lessen any risks There were no formal identification checks of the patient prior to dialysis or when administering medicines. Regulation 12(2)(a)(b)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** There were multiple duplications and transposing of information from paper to electronic systems, some of which were not fully accessible to the unit staff Regulation 17 (2) (b)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met**

This section is primarily information for the provider

Requirement notices

Staff had not yet received training and were not familiar with the requirements of the Duty of Candour

Regulation 20 (1)