Dearne Valley NHS Dialysis Unit

Quality Report

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South Yorkshire
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Website:

Date of inspection visit: 15 April 2017 (and unannounced 12 May 2017)
Date of publication: 09/08/2017

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

Dearne Valley Dialysis Clinic is operated by Fresenius Medical Care Renal Services Ltd an independent healthcare provider. The Fresenius dialysis unit at Dearne Valley is located within a 'standalone' dialysis unit / within the Mexborough, Montagu Hospital site. It is a 12-station dialysis unit. It is contracted by Doncaster and Bassetlaw Hospitals NHS Foundation Trust to provide renal dialysis to NHS patients. Patients are referred to the unit by the local NHS trust. The service commenced in 2010 with 12 stations (located in two bay areas and two side rooms) and provides haemodialysis for stable patients with end stage renal disease/failure.

There are on average 550-dialysis treatment sessions delivered a month. The service delivered 2338 haemodialysis sessions to adults aged 18 – 65 and 4196 sessions to adults aged 65+ in 2016/17. At the time of the inspection, there were 45 people in total using the service. The clinic does not provide peritoneal dialysis or services to children.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 25April 2017, along with an unannounced visit to the clinic on 12 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 issues that the service needs to improve:

- The process of incident reporting, investigation, escalation, and learning from incidents. We were not assured in regards to the grading of harm from incidents, the application of the duty of candour requirements and the learning from incidents to improve patient outcomes.
- The medicines management process including patient identification, in order to be in line with safe standards and national guidelines. There was no formal way for staff to identify patients prior to medication being administered.
- The process of identifying and managing risks on the risk register. We were not assured that the clinic had a current up to date risk register that reflected all of the current risks to the unit. The clinic showed us a risk register, however following inspection it was clear that this was a draft document.
- The process for ensuring deteriorating patients could be appropriately managed was not in line with best practice guidance and national standards. The clinic did not use a recognised early warning score system to support the recognition of the deteriorating patient.
- The emergency drug tray was located on the bottom shelf of the resuscitation trolley and the trolley was not sealed. This does not provide assurance that the correct medication would be available during an emergency.
- We were not assured that performance and audit information was used to benchmark performance against other dialysis clinics to improve patient outcomes including patient transfers and admissions into hospital.
- There was no process or protocol available to admit inpatients safely onto the dialysis unit to continue their dialysis treatment whilst they were an inpatient in the neighbouring organisation.

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

- We found that the clinic was visibly clean and well maintained.

Summary of findings

- We observed that staff caring for patients were compassionate, caring and passionate about providing high quality dialysis care.
- Nursing staff were experienced in providing dialysis care and training and competence records we reviewed showed that staff were well trained and competent to level the level of care expected.
- Patients we spoke with were consistently positive about the level of care they received.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Overall summary

Dialysis was the only service provided. 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.

We found the following issues that the service provider needs to improve:

- We were not assured in regards to the grading of harm from incidents, the application of the duty of candour requirements and the learning from incidents to improve patient outcomes. The classification of clinical and non-clinical incidents should reflect the level of harm. Incidents were not reported clearly to ensure that the requirements of duty of candour regulation were met for example the non-clinical incident reporting form did not trigger duty of candour requirements for example patients falling and receiving an injury.
- There was no formal way for staff to identify patients prior to medication been administered. We acknowledged that most patients were well known to the clinical team, however nursing staff must always adhere to Nursing and Midwifery Council (NMC) standards for medicines management. This includes being certain of the patients identity, checking the allergy status of the patient and expiry date of the medicines.
- We were not assured there was an effective governance framework in place. Systems were not in place to effectively manage risk and safety. There was evidence incidents had not been reported or investigated effectively and as such, duty of candour requirements had not been implemented.
- We were not assured that the clinic had a current up to date risk register that reflected all of the current risks to the unit. The clinic showed us a risk register, however post the inspections it was clear that this was a draft document. Failure to place risks on the register results in risks not being rated and the possibility of no one taking responsibility for taking actions forward.
- The emergency drug tray was located on the bottom shelf of the resuscitation trolley and the trolley was not sealed. This does not provide assurance that the correct medication would be available during an emergency. It had been noted on the checklist that the drug box was not sealed as a point of observation by the pharmacist and staff, but no actions taken.
- The clinic did not use a recognised early warning score system to support the recognition of the deteriorating patient. There was no sepsis policy and staff had not received training to recognise or manage this life threatening condition.
- There was no process or protocol available to admit patients safely onto the dialysis unit to continue their dialysis treatment whilst they were an inpatient in the neighbouring organisation.
- There was no process for audit of medicines management in the clinic. The policy did not outline that audit should be performed by the clinical team.
- We were not assured that all performance and audit information was used to benchmark the unit's performance against other dialysis clinics to improve patient outcomes including patient transfers and admissions into hospital.

Summary of findings

- The average number of patients with the recommended haemoglobin levels was 48.6%, April 2017. This meant that a number of patients had haemoglobin levels outside of the recommended range. Anaemia can be a complication of renal failure and dialysis associated with increased risks of mortality and cardiac complications.
- There was no evidence the unit met National Institute for Health and Care Excellence (NICE) quality standards about patients being collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis.
- There was no unit patient involvement group where patients could make suggestions about the service or care of patents on the unit, or where staff could share information about the service with patients.
- We saw none of the corporate policies had review dates on them. This meant up to date guidance and legislation may not be incorporated into the organisations policies.

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

- We found that the clinic was visibly clean and well maintained.
- Staff worked flexibly and the rota was planned to ensure safe numbers of staff were available to meet patients' needs.
- Nursing staff were experienced in providing dialysis care and training and competence records we reviewed showed that staff were well trained and competent to level the level of care expected.
- We saw that policies and procedures were developed in line with guidance and standards from the UK renal association and these had been incorporated into the organisations standard for good renal care.
- We observed that staff caring for patients were compassionate, caring and passionate about providing high quality dialysis care.
- Patients we spoke with were consistently positive about the level of care they received.
- The clinic provided a local satellite service, with flexible appointments for patients requiring dialysis. We observed a responsive approach to arranging appointments and the individual needs of patients.
- The building met the core elements of provision for dialysis patients. This included level access and dedicated parking facilities.
- The unit operated at around 94% capacity and so had spaces to accommodate for holiday treatment sessions for people staying in the local area, provided this had been approved and the patient accepted.
- The registered manager was knowledgeable about the service, knew all the staff by name, and was clearly passionate and dedicated to the unit. The staff we spoke with spoke very positively about the registered manager and said that they felt able to speak with the manager and raise any concerns that they may have about the service. Staff also said the registered manager was visible and accessible and that they could speak with them at all times. Staff we spoke with also said they when they raised concerns that they felt listened too.
- There was an overall organisation vision and strategy used in the unit. The unit had specific business objectives to achieve. The staff understood the organisational vision of “delivering the right care to the right patient at the right time”.

Summary of findings

Contents

Dearne Valley NHS Dialysis Unit

Services we looked at
Dialysis Services

Summary of this inspection

Background to Dearne Valley NHS Dialysis Unit

Dearne Valley Dialysis Clinic is operated by Fresenius Medical Care Renal Services Ltd an independent healthcare provider. The hospital/service opened in August 2010. It is a private dialysis clinic in Mexborough, South Yorkshire. The hospital primarily serves the communities of the South Yorkshire. It also accepts patient referrals from outside this area.

The clinic has had a registered manager in post since August 2010.

Our inspection team

A CQC lead inspector led the inspection team. The inspection team also included a second CQC inspector, and a specialist advisor with expertise in dialysis services. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspection.

Information about Dearne Valley NHS Dialysis Unit

The unit has six stations in a main treatment area, four in a small bay area and two isolation rooms. The main referring unit is the Doncaster Royal Infirmary, which is part of Doncaster and Bassetlaw NHS Hospitals Trust. This trust provides the renal multidisciplinary team (MDT), with a consultant nephrologist visiting the dialysis unit once a week. MDT meetings are held every month where Consultants, Dietician, Clinic Manager reviewed patient outcomes, blood results and any patient concerns can be raised by names nurses.

There are two 'treatment sessions' of patients dialysed on Monday, Wednesday and Friday, usually, with 12 patients dialysed in the morning and 12 in the afternoon. There are two 'treatment sessions' of patients dialysed on Tuesday, Thursday & Saturday, with about 12 patients dialysed in the morning and 12 in the afternoon.

The unit was registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.

During the inspection, we visited all areas of the unit. We spoke with seven members of staff including, registered nurses, dialysis assistants and senior managers. We spoke with five patients. We also received eighteen 'Tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed five sets of patient records.

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection. The clinic has been inspected four times, and the most recent inspection took place in December 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (April 2016 to March 2017)

- In the reporting period April 2016 to March 2017, there were on average 550 dialysis sessions delivered every month.
- The service delivered 6,534 sessions in the same reporting period, with 2338 sessions delivered to adults aged 18-65 and 4196 sessions to adults aged over 65.
- At the time of the inspection, 45 people were using the service, 16 aged 18-65 and 29 aged over 65.

Summary of this inspection

- During this period, there has been one notification to the CQC. Another notification was received following this reporting period.
- The unit employed six registered nurses, one-dialysis assistant and one receptionist. As part of the contract dietitians, clinicians and specialist nurses were available to support patients. The unit did not employ any medical staff.

Track record on safety (April 2016 to March 2017)

- There had been no reported never events.
- One clinical incident and two non-clinical incidents were reported. We saw that one incident had been reported which due to the level of harm reported on the incident form should have triggered the duty of candour requirements, we were not assured that the requirements had been met following this incident occurring.
- One in service death had occurred in the reporting period.
- There were no reported incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or Escherichia-Coli infections.
- There were no complaints received during the reporting period by the unit, CQC or Parliamentary Health Services Ombudsman or the Independent Healthcare Sector Complaints Adjudications service.

Services accredited by a national body:

- The clinic was accredited against ISO 9001 and ISO 14001, quality management system and are therefore subject to regular audit and review.

Services provided at the clinic under service level agreement:

- Counsellor provided by a local trust.
- Clinical and domestic waste provided by a private company.
- Cleaning provided by a private company.
- Patient refreshments provided by a private company.
- Security services provided by a private company.

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:

- We were not assured in regards to the grading of harm from incidents, the application of the duty of candour requirements and the learning from incidents to improve patient outcomes. The classification of clinical and non-clinical incidents should reflect the level of harm. Incidents were not reported clearly to ensure that the requirements of duty of candour regulation were met for example the non-clinical incident reporting form did not trigger duty of candour requirements for example patients falling and receiving an injury.
- There was no formal way for staff to identify patients prior to medication been administered. We acknowledged that most patients were well known to the clinical team, however nursing staff must always adhere to Nursing and Midwifery Council (NMC) standards for medicines management. This includes being certain of the patients identity, checking the allergy status of the patient and expiry date of the medicines.
- The clinic did not use a recognised early warning score system to support the recognition of the deteriorating patient. There was no sepsis policy and staff had not received training to recognise or manage this life threatening condition.
- There was no process or protocol available to admit patients safely onto the dialysis unit to continue their dialysis treatment whilst they were an inpatient in the neighbouring organisation.
- The emergency drug tray was located on the bottom shelf of the resuscitation trolley and the trolley was not sealed. This does not provide assurance that the correct medication would be available during an emergency. It had been noted on the checklist that the drug box was not sealed as a point of observation by the pharmacist and staff, but no actions taken.
- There was no process for audit of medicines management in the clinic. The policy did not outline that audit should be performed by the clinical team.

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

- We found that the clinic was visibly clean and well maintained.
- Staff worked flexibly and the rota was planned to ensure safe numbers of staff were available to meet patients' needs.

Summary of this inspection

Are services effective?

We found the following issues that the service provider needs to improve:

- We were not assured that all performance and audit information was used to benchmark the unit's performance against other dialysis clinics to improve patient outcomes including patient transfers and admissions into hospital.
- The average number of patients with the recommended haemoglobin levels was 48.6%, April 2017. This meant that a number of patients had haemoglobin levels outside of the recommended range. Anaemia can be a complication of renal failure and dialysis associated with increased risks of mortality and cardiac complications.
- There was no evidence the unit met National Institute for Health and Care Excellence (NICE) quality standards about patients being collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis.

However we also found the following areas of good practice:

- Nursing staff were experienced in providing dialysis care and training and competence records we reviewed showed that staff were well trained and competent to level the level of care expected.
- We saw that policies and procedures were developed in line with guidance and standards from the UK renal association and these had been incorporated into the organisations standard for good renal care.

Are services caring?

We found the following areas of good practice:

- We observed that staff caring for patients were compassionate, caring and passionate about providing high quality dialysis care.
- Patients we spoke with were consistently positive about the level of care they received.

Are services responsive?

We found the following areas of good practice:

- The clinic provided a local satellite service, with flexible appointments for patients requiring dialysis. We observed a responsive approach to arranging appointments and the individual needs of patients.

Summary of this inspection

- The building met the core elements of provision for dialysis patients. This included level access and dedicated parking facilities.
- The unit operated at around 94% capacity and so had spaces to accommodate for holiday treatment sessions for people staying in the local area, provided this had been approved and the patient accepted.

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

- There was no unit patient involvement group where patients could make suggestions about the service or care of patents on the unit, or where staff could share information about the service with patients.

Are services well-led?

We found the following issues that the service provider needs to improve:

- We were not assured there was an effective governance framework in place. Systems were not in place to effectively manage risk and safety. There was evidence incidents had not been reported or investigated effectively and as such, duty of candour requirements had not been implemented.
- We were not assured that the clinic had a current up to date risk register that reflected all of the current risks to the unit. The clinic showed us a risk register, however post the inspections it was clear that this was a draft document. Failure to place risks on the register results in risks not being rated and the possibility of no one taking responsibility for taking actions forward.
- We saw none of the corporate policies had review dates on them. This meant up to date guidance and legislation may not be incorporated into the organisations policies.

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

- The registered manager was knowledgeable about the service, knew all the staff by name, and was clearly passionate and dedicated to the unit. The staff we spoke with spoke very positively about the registered manager and said that they felt able to speak with the manager and raise any concerns that they may have about the service. Staff also said the registered manager was visible and accessible and that they could speak with them at all times. Staff we spoke with also said they when they raised concerns that they felt listened too.

Summary of this inspection

- There was an overall organisation vision and strategy used in the unit. The unit had specific business objectives to achieve. The staff understood the organisational vision of “delivering the right care to the right patient at the right time”.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- 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. During the reporting period, April 2016 to April 2017 there had been no never events reported within the unit.
- Serious incidents are incidents that require further investigation and reporting. There were no serious incidents reported within the unit during the reporting period April 2016 to April 2017.
- The unit had a policy for the reporting of incidents, near misses and adverse events. Staff we spoke with could explain the process for reporting incidents on the electronic clinical incident report form. Staff had many different ways of how to report incidents for example, clinical and non-clinical incidents, unit variance and patient variance reports. Once reported these incidents were sent to different teams for information and or investigation. The corporate nursing team monitored clinical incidents centrally and a different team monitored non-clinical incidents. However, from records we reviewed non-clinical incidents included patient falls even if the fall was in the clinical area and resulted in patient harm. We were not assured that themes and trends from all incidents could be identified and used as learning tools to improve patient outcomes.
- We saw two non-clinical incidents reported from August 2016 to March 2017 and one clinical incident reported (June 2016). We did not see that the service had a benchmark of expected numbers of incidents for the size of the unit, so we were unable to state whether this number showed high or low levels of reporting.
- We were not assured that all incidents were reported correctly to enable sharing of lessons learned and to improve patient outcomes. From data, we reviewed only one clinical incident (a medication prescribing error) had been reported in the 12 months prior to the inspection. The unit carried out regular water testing and in the weeks prior to inspection to unit had failed one of the tests carried out on the water systems. The unit had taken corrective actions e.g. moving patients onto a different type of dialysis and had completed a unit variance report; however, there was no expectation to complete an incident form. This issue had not been highlighted on the risk register.
- Staff we spoke with said that incidents that occurred in the clinic were discussed informally amongst the team. These discussions would be documented in the communication book or diary and shared in the monthly team meeting. From the two incidents we saw reported, we saw examples of learning from incidents for example, improvements in medication prescribing and in access to the unit. We saw some evidence of clinic updates and learning bulletins distributed by the chief nurse team to support lessons learned from clinical incidents across the organisation. However, it was not always clear how the themes and trends of all the incidents for example unit variances reports were shared from the different units to staff.
- 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.
- The unit had a policy that stated any incident categorised as moderate or above would trigger the duty of candour process however, we saw during inspection that falls were classified as non-clinical incidents and as such, there was no requirement on the

form completed to prompt staff to consider duty of candour requirements. We reviewed a root cause analysis where a patient suffered harm because of the fall and although reported we did not see that duty of candour requirements had been implemented, nor did we see an apology was provided to the patient for the injury caused. In the provider information request during the inspection, the unit said that they had not triggered duty of candour in the previous 12 months; however, in the clinical incident we reviewed it stated that duty of candour requirements had been implemented.

- Staff we spoke with understood the concept of the duty of candour requirements and described it as being open and honest with patients and their family. However, from evidence we reviewed we did not see application of the requirements in practice.
- The clinic monitored performance against patient harms, they reported against the number of falls that occurred on the unit. In the reporting period, April 2016 to March 2017 there had been one reported patient fall on the unit.

Mandatory training

- Mandatory training was delivered as both face-to-face training sessions or via e-learning programmes.
- The corporate target for mandatory training completion was 100% compliance; training data we reviewed showed an overall training compliance rate for the clinic of 100%.
- New staff received a corporate induction, which included some aspects of their mandatory training such as fire, health and safety issues.
- The mental capacity act (MCA) was included in mandatory training.
- The flexibank administrators monitored mandatory training records for agency nursing staff to ensure training was always up to date. If training lapsed the member of staff was suspended from shift allocation until evidence of completion was received. Flexibank training records were retained centrally.
- Senior staff could monitor training compliance rates for training by reviewing the training database and gave prompts to staff when training was due to be renewed.
- Staff we spoke with told us that the training available was very good. They had good access and felt supported to attend or access mandatory updates.
- Basic and intermediate life support training compliance showed 100% compliance in April 2017.

Safeguarding

- The registered manager was the designated safeguarding co-ordinator and designated safeguarding lead for the clinic. Part of this role was to report any safeguarding issues to the chief nurse. Level four training was available within the organisation as detailed in the safeguarding children and young people: roles and competences for healthcare staff Intercollegiate document March 2014.
- Staff received training in the safeguarding of vulnerable people. We reviewed staff training records and saw that 89% of staff had received safeguarding adults training, we asked the provider to clarify whether this met level two safeguarding training, however, they were unable to confirm this.
- There was a corporate safeguarding and protecting vulnerable people policy and procedure, which included guidance on safeguarding adults and children. Training requirements and examples of when to raise a safeguarding concern were included. This document did not refer to female genital mutilation or PREVENT (anti-terrorism) training programmes, which includes the recognition and protection of vulnerable individuals from risk of grooming and involvement in terrorist activities or supporting terrorism we saw however a training session entitled radicalisation was available.
- There were no safeguarding concerns reported to the CQC in the reporting period April 2016 to March 2017. The clinic had reported one safeguarding concern to the local authority in the previous year.
- The clinic had systems in place for the identification and management of vulnerable adults. There was access to information about vulnerable people but the information on the unit noticeboard had not been updated since 2011.
- Staff we spoke with could describe their roles in relation to reporting and taking action as required when safeguarding issues were identified. Staff could provide examples of safeguarding issues.

Cleanliness, infection control and hygiene

- The unit had an overarching infection prevention and control (IPC) policy, this encompassed various aspects of IPC such as cleaning, decontamination and IPC practices. During the inspection, we observed that staff

were compliant with bare below the elbows and personal protective equipment practices. The registered manager in conjunction with the area head nurse audited standards on an ongoing basis.

- The chief nurse was the lead for infection prevention and control and had overall responsibility for providing infection prevention and control advice. The director of infection prevention was the organisational medical director with the chief nurse deputising as appropriate. On site there were IPC link nurses, staff we spoke with said they received training to enable them to carry out the role, we asked the provider to clarify what training link staff received, however they were unable to confirm this.
- We reviewed hand hygiene audit data, which showed 87% average compliance in the reporting period January 2017 to April 2017. During the inspection, we saw hand hygiene compliance data displayed on the unit. Alcohol hand sanitiser was available at every dialysis station and during the inspection; we observed staff perform hand hygiene at appropriate times.
- Protocols were in place to screen patients returning from holiday to high risk of infection regions for blood borne viruses, methicillin resistant staphylococcus aureus (MRSA) and methicillin sensitive staphylococcus aureus (MSSA). The clinic had reported zero cases of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or Escherichia-Coli infections in the reporting period April 2016 to March 2017. The clinic did not have a policy for screening patients for carbapenemase-producing Enterobacteriaceae CPE when patients returned from receiving healthcare treatment abroad or when they returned from being an inpatient in UK hospitals known to have had problems with the spread of CPE. Procedures were in place to assess carriers of blood borne virus (BBV) such as hepatitis B and C, staff were able to describe the correct isolation requirements and actions required to mitigate the risk of BBV cross infection.
- Staff had access to two isolation rooms for nursing patients with a known or suspected infection. Both were visible from the nurses station, We observed good practice in isolation of patients in two separate rooms that were accessed via separate lobbies, from the main clinic. We observed patients who were immunocompromised being isolated appropriately. Any patient with a known or suspected infection risk were booked for dialysis in afternoons to allow for deep cleaning of the room overnight.
- The unit was visually clean and we saw the unit IPC environmental cleanliness audit scores displayed these showed 97% average compliance in the reporting period January 2017 to April 2017. The unit also participated in the Fresenius national patient survey 2016 that measures the patient's experience of care at Dearne Valley. The response rate was 64% better than the national average of 55%. The survey asked patients whether the treatment rooms were clean and 92% said that they were.
- During our inspection, we observed good aseptic (no touch) technique processes when staff were connecting and disconnecting patients to and from dialysis machines.
- We observed staff performing cleaning and disinfection of dialysis machines between each patient. These followed manufactures and organisational guidance. Single patient use lines were used and disposed of appropriately at the end of each dialysis session.
- We inspected 12 pieces of equipment at both the bedside, in storage and treatment rooms including dialysis stations and suction pumps; all items were found to be visibly clean and ready for use. There was a cleaning rota system for nursing staff to routinely clean items of equipment as well as cleaning after patient use. We observed good sign off from staff and senior staff reviewed and signed off the cleaning process for assurance.
- The registered manager had overall responsibility for managing the domestic contract. We observed the cleaning schedules and there was a good system in place to ensure the unit was clean. We saw examples of when cleaning standards had fallen below target and action plans with the senior nurse were agreed with the domestic team. Domestic staff cleaned the unit overnight and there was a communication system to inform the domestic of any increased infection risk or need for deep cleans to isolation rooms. We noted that the clinic had disposable curtains around each bed space. These were all dated and replacement dates were clearly written on the curtain label.
- Staff were knowledgeable about the surveillance of water systems for presence of bacteria, and staff we

spoke with were able to explain the procedures required to test water samples and were able to explain the procedure if a water sample came back as contaminated. During our inspection, the unit had failed monthly water quality tests. The unit had taken corrective actions, and was unable to provide haemodiafiltration so this treatment was suspended and staff had moved all patients onto haemodialysis treatment. However, we did not see this identified on the risk register.

- Staff had access to clinical and non-clinical waste facilities; staff were able to dispose of waste at the point of use. Staff were observed to use appropriate segregation of waste and the clinic had targets for waste management, which were being met. The ten sharps disposal bins inspected were assembled correctly and used as per policy.
- Staff received training on infection, prevention and control via e learning. IPC training compliance rates for the unit showed 100% compliance.

Environment and equipment

- The unit was spacious, had natural light and appeared warm and welcoming for patients and visitors on the day of inspection. The unit had 12 dialysis stations in four different areas. A four bedded area was available, two isolation rooms and a main area consisting of six stations. All areas were separated by glass partitions, which facilitated the close observation of patients.
- The clinic was accessed via a single entrance and via an intercom system to reception as a security measure. Entrance to the main treatment area from the main waiting area was via a digital lock and all clinic and storerooms were kept locked. There was good access, parking just outside the premises and disabled bays near to the entrance.
- Maintenance of dialysis machines and chairs were scheduled and monitored using a maintenance and calibration plan. This detailed the dialysis machines by model type, serial number along with the scheduled date of maintenance. A similar plan existed for dialysis chairs and other clinical equipment for example; patient thermometers, blood pressure monitors and patient scales. We observed that all 12 items of equipment checked were labelled as per policy.
- The unit was in the process of updating dialysis machines, and it was planned to have this completed by October 2017. The unit were going to implement the new machines when all staff had received training.- spare dialysis equipment
- Organisational technicians maintained the dialysis machines, chairs, beds and water treatment plant. Records were maintained relating to the maintenance and calibration of all equipment used at the clinic. From records we reviewed this provided assurance that equipment used was calibrated and maintained appropriately.
- There were two dialysis machine available to be used in the event of breakdown, these were clean and ready for use.
- An in-house team provided planned and reactive maintenance. This decision had been implemented in January 2017. Staff we spoke with knew how to log a call with the help desk regarding any facilities issues. The help desk allocated a job number and priority level (priority 1 = most urgent to priority 4 least urgent) to the call and requested a contractor to attend the unit. We saw evidence of this system in the communication diary where staff had documented minor faults for logging in the system and updated progress against any issues. Annual electrical testing was also part of the planned preventative maintenance schedule. A register was available on-site confirming testing had taken place and this was checked during the annual health and safety audit.
- We noted that fire extinguisher checks were carried out routinely.
- The resuscitation trolley and equipment we checked was well stocked, there was a good system for checking in place and evidence of staff signing to state that the trolley had been checked for the previous three months. All necessary equipment was available and easy to access in the main clinic. The suction system and defibrillator was in working order and had been checked on a maintenance programme. Oxygen was available and the bottle was full. Oxygen stores were in a locked area directly outside of the clinic. All single use items were in date and stock levels were good.
- Staff we spoke with said there were adequate stocks of equipment and we saw evidence of good stock rotation. The system for segregating supplies of fluids for treatment was very good. The local team had introduced a system of using separate locations in the

storage room for different concentrate of treatment fluids to reduce the risk of using the wrong fluids, as the bottles were the same for all concentrates. Senior staff we spoke with planned to colour code posters to further improve identification of each type of fluid. There had been no incidences reported of using the incorrect fluid.

- We observed that the patients had pressure relieving additional mattresses that they could have for comfort if they chose to or were at greater risk of developing a pressure ulcer. The mattresses were checked regularly and this was evident on the cleaning checklist. Any that had a break in the material would be taken out of service and replaced; we observed visibly clean but condemned mattresses awaiting collection in a locked storeroom. The mattresses had been supplied from charitable funding.

Medicines

- Lead responsibility for the safe and secure handling and control of medicines was the registered manager.
- The nurse in charge held the keys for the medicines cabinet and was identified on the rota. The nurse in charge varied dependant on shift patterns, but it was always a senior member of staff.
- There were a small number of medicines routinely used for dialysis, such as anti-coagulation and intravenous fluids. The clinic also had a small stock of regular medicines such as EPO (erythropoietin – a subcutaneous injection required by renal patients to help with red blood cell production). Stock medication was ordered from Doncaster Royal Infirmary.
- Pharmacy support was available from the local NHS trust pharmacy for advice and guidance. Staff also had access to a corporate pharmacist based at head office.
- The patient's consultant prescribed all medicines required for dialysis. Staff we spoke with told us that there was regular review and good access to the consultant for prescription changes. Therefore, there was minimal need to access out of hours support; however, the nursing staff could contact the local trust doctor on call for any urgent prescription changes or advice.
- Medicines were stored in a clean utility room; all cupboards containing medication were locked. We did not observe any medications unattended during our visit.
- Medicines requiring refrigeration were stored in a fridge, the fridge was locked and the temperatures were checked daily and staff were aware of the action to take if the temperature recorded was not within the appropriate range.
- Emergency medicines were readily available and they were found to be in date. The pharmacist had checked all medications and this was recorded in the folder kept on the trolley alongside other routine safety and stock checks. It was written on the checklist that the emergency drug box was not sealed as a point of observation by the pharmacist and staff, but no actions taken. This does not provide assurance that the correct medication would be available during an emergency.
- Controlled drugs are medicines, which are stored in a designated cupboard, and their use recorded in a special register. No controlled drugs were stored or used on the unit.
- We looked at the prescription and medicine administration records for five patients on the unit. These records were fully completed and were clear and legible.
- Staff did not identify patients formally prior to medicines been administered. The unit did not use patient wristbands, lanyards or photographic identification. Following our inspection, we asked for evidence of the patient identification (ID) policy. We were told the company did not have a policy for this; they would normally follow the respective NHS trust on such key policies. The lack of a patient ID policy was entered onto the risk register following our inspection. We acknowledged that most patients were well known to the clinical team however, no positive identification was used. This meant that nursing staff did not always adhere to Nursing and Midwifery Council (NMC) standards for medicines management this includes being certain of the patients identity, checking the allergy status of the patient and expiry date of the medicines.
- During the inspection, we saw changes in practice following a medicines incident. Staff had improved communication about medicines and had improved attendance by medical staff to the unit. This improvement ensured that all medicines were prescribed correctly.
- Medicines changes were discussed at the patient's multidisciplinary meeting and shared with the patient and the patients GP.

- There was an organisational medicines management policy; however, this did not include identification of patients or arrangements for medicines audit.

Records

- The unit recorded patient data on the organisation patient treatment database this system automatically transferred patient data into the local NHS trust clinical database system. The paper records included the dialysis prescription, patient, and next of kin contact information and GP details. There were also nursing assessments, medication charts, and patient consent forms. Paper records were stored with the patient during dialysis and then stored in a locked cupboard once they had completed this treatment. Electronic care plans we reviewed had been updated regularly.
- The clinic manager ensured the named nurses, and dietitian signed all clinic letters. Medication changes were posted to the patient's GP following the multidisciplinary meeting each month. All medication changes that were needed for the patient's dialysis were changed on the day of the meetings by the consultants. Named nurses could contact the GP services by telephone if they felt patients' needed to be referred for extra care i.e. chiropody, or wound dressing clinics.
- On receipt of new patient transfer documentation, staff ensured that the information received was correct. Any discrepancy and actions taken to rectify was also documented as applicable.
- Each registered nurse held a caseload of dialysis patients. Staff updated patient records and care plans for patients on their caseload. We observed thorough documentation of individualised care and it was clear that staff had taken time to document detailed plans for patients.
- We reviewed three complete sets of patient records and saw entries made pre, middle and post dialysis as well as entries made for any variances during the period of dialysis. These entries were made at appropriate times in relation to the patient pathway. We also reviewed the three corresponding patient paper records including care plans and pathways and saw that these had been regularly reviewed and updated.
- Patient's needs were assessed and treatment was planned and delivered in line with their individual care plans. There was a comprehensive care pathway in the three care plans we reviewed. Records contained a current dialysis prescription, dialysis summary charts and risk assessments, i.e. moving and handling and Waterlow score
- Documentation audits were carried out on a monthly basis. Twenty-seven aspects of documentation were looked at each time; (for example legibility, signature, clear prescription, care plan in place). Results we reviewed from January 2017 to March 2017 mainly showed compliance; however, the sample size in the audits was small. Two of the audits only showed three patients being reviewed. These results were shared with staff at team meetings.

Assessing and Responding to Risk

- Only stable patients were dialysed on the unit. If someone was acutely ill with renal problems, they were treated at a main NHS hospital. This was to ensure that patients who required additional support received their treatment at the local NHS trust where medical staff were available 24 hours a day.
- Patients weighed themselves before treatment began. They inserted an electronic card, which identified them, into the electronic walk on weighing scales. This was to establish any excessive fluid, which had built up in between treatments.
- Observations of vital signs such as blood pressure and pulse were recorded before, during and after dialysis treatment. There was no regular record of respiratory rate on the observation chart, although the care plan did direct the recording of this physiological parameter. Temperature was recorded routinely when patients received dialysis through an intravenous line, pre and post treatment.
- The clinic did not use an early warning score system to identify the deteriorating patient. Nursing staff we spoke with were experienced and able to articulate the clinical condition of a deteriorating patient, however they had not received any specific training about national early warning scores (NEWS) and could therefore not describe the recognition of the patient deteriorating in the same context. Staff could describe how they would support and escalate concerns in the absence of a NEWS system. There was a guidance document, 'complications, reactions, and other clinical event pathway' but no

system was in place to ensure that care was delivered in line with national guidance. This meant there was a risk that deteriorating patients may not be managed appropriately.

- There was no sepsis toolkit or pathway in use at the clinic. (Sepsis is a life-threatening illness caused by the body's response to an infection). This was not in line with the National Institute for Health and Care Excellence (NICE) guideline (NG51) for recognition, diagnosis, or early management of sepsis. Staff we spoke with were not knowledgeable about sepsis pathways. Staff could describe what would happen if a patient deteriorated and could describe signs and symptoms of infection. Staff were aware that they could make improvements by implementing a sepsis pathway, but recognised that this needed to be as part of an overall approach from Fresenius. Following our inspection, we were provided with information that the company did not have a sepsis policy; they would normally follow the policy from the local NHS hospital. The lack of a sepsis policy was placed on the risk register after our inspection.
- There was an agreement with the local NHS trust that patients who became ill would be transferred to the hospital. There were 53 patient transfers to another healthcare provider in the 12-month reporting period. There was no benchmark used within the organisation to inform whether this was a high or low number of patient transfers or whether these were planned transfers or unplanned emergency transfers.
- Staff were provided with a full medical history for patients that were referred from the parent NHS trust. This included personal details and blood results. Staff in the clinic then contacted the person initially by phone to prepare them for their first visit. The clinic manager said that there were specific appointments available for pre-dialysis patients to visit the unit.
- We observed staff monitoring alarms on equipment in the unit. Staff we spoke with were knowledgeable about equipment and setting alarm parameters.
- Staff recorded variances during the period of dialysis in the electronic patient records, for example falls risks, mobility post dialysis and changes in vital signs measurements. Staff used this information to help plan the next dialysis session and to identify any themes occurring during dialysis.
- There was a clear clinic policy in place for the emergency management of cardiopulmonary resuscitation. Staff we spoke with could describe the management of escalation of an acutely unwell or deteriorating patient, including arrangements for transfer to the acute trust.

Staffing

- At the time of the inspection, the clinic had six whole time equivalent (WTE) registered nursing posts and one dialysis assistant. One receptionist supported them. The unit currently had no vacancies for any grade of staff. In the previous 12 months to inspection staff said that one staff member had left the service and two staff had been recruited.
- Dearne Valley Clinic worked to a predetermined ratio of one nurse to four patients, as defined by the local NHS trust. Clinic staffing ratios were based on 67% registered nurses to 33% dialysis assistant ratio and staff worked on a ratio of two qualified staff and one dialysis assistant per shift.
- The clinic senior team ensured compliance with staffing ratios through the application a rota system. The registered manager completed these eight weeks in advance and forwarded to the regional business manager for approval. Staff we spoke with did not raise any concerns over their duty rotas.
- The clinic manager reviewed duty rotas on a daily basis to assess staffing levels based on the actual number of patients attending for dialysis and also for unexpected staff shortages caused for example by sickness and personal issues. These were reported by the team as 'on occasion be unavoidable'.
- When staff shortages were identified action was taken, including rearranging shifts with the cooperation of clinic staff. Where staffing levels could not be maintained the unit used staff from the organisations renal flexi bank. Where the flexi bank could not cover shifts, these were covered by external nursing agencies. The clinic had not used dialysis nursing bank and agency staff in the three-month period prior to our inspection visit.
- Substantive clinic staff completed a health and safety training record and an employee notification of risk induction with all temporary, bank or agency staff. As they had not used any agency staff in the previous three months we did not see any of these forms completed.
- We reviewed three weeks duty rotas over a three-month period, we noted that staffing levels were met on every shift and at no time did levels fall below the expected.

- The team had introduced the use of a handover communication book and staff would use this daily to support handover of essential information about patients attending for dialysis treatment. We saw examples in the book of clinical issues for handover in addition to information about social and psychological support of patients. The unit did not employ directly any medical staff. Consultants were contactable via telephone, e-mail, through the consultant's secretary or hospital pager. Out of hours, the on call consultant was contacted via hospital pager. All clinic staff we spoke with were aware of how to contact a patient's consultant.
- Consultant staff reviewed patients on a monthly basis at the multidisciplinary team meetings and ad-hoc as required.
- Staff we spoke with told us that they had good working relationships with medical staff visiting the unit and could access on call medical staff at the local NHS trust when needed. Staff confirmed the consultant staff were visible and accessible. Patients we spoke with also confirmed that the consultant was available outside of clinic appointments and would visit the unit to review patients.

Emergency awareness and training

- The clinic had a business continuity plan; this detailed the plans for the prevention and management of potential emergency situations, such as fire, loss of electricity or water leaks. All staff were aware of this plan, and there was a requirement within it for training and site evacuation drills. The plan included defined roles and responsibilities; emergency contact details for emergency services, public services and utilities, key headquarter personnel, and neighbours. The plan addressed a number of situations that could arise including fire, loss of services and systems.
- Patients records we reviewed had personnel emergency evacuation plans applicable to patients whilst on and off dialysis. This included specific reference to their mobility needs during evacuation. Staff on a regular basis updated these plans.
- A simulated cardiac event scenario had taken place in January with a further one being planned for May 2017. A simulated evacuation drill had taken place in February 2017.
- We saw evidence of provision of emergency equipment in the clinic for example firefighting equipment.

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

Evidence-based care and treatment

- We saw that policies and procedures were developed in line with guidance and standards from the UK Renal Association and had been incorporated into the organisations 'NephroCare standard for good dialysis care'.
- Clinical care was led by NHS consultant nephrologists. The unit was nurse led based on plans and pathways individual to the patients. The team spoke with us about the expectations to work in line with the UK Renal Association Standards to dialysis quality outcomes.
- The unit used an International Standards Organisation ISO accredited Integrated Management System (9001) to ensure all policies and procedures supported best practice evidence. An annual review was completed to ensure that the evidence remained current. However, we looked at 11 policies, these all included a date they became effective, but did not have a date to indicate when the policy expired or would be revised. Policies were stored on an online achiever system and staff we spoke with said they were able to access them.
- Individual care pathways and treatment prescriptions were available for dialysis patients. These were based on relevant national guidance. We saw evidence of a range of standardised, documented pathways and agreed care plans that had been individualised for patients by named nursing staff, examples of these included pressure care and falls care plans.
- The local NHS trust was responsible for the creation of fistulas; staff at the clinic were responsible for monitoring them. A fistula is a special blood vessel created in a patients arm, called an arteriovenous fistula (AV fistula). The blood vessel is created in an operation by connecting an artery to a vein, which makes the blood vessel larger and stronger. This makes it easier to transfer the patients' blood into the dialysis machine and back again. AV fistulas are regarded as the best form of vascular access for adults receiving haemodialysis. This is because they last longer, and have less risk of complications than other types of vascular access. The unit monitored the AV fistulas, which forms part of the National Institute for Health and Care Excellence (NICE) quality standard.

- In the 12 months before our inspection, the average number of patients with an AV fistula was 86.4% this was better than the renal association guidance of 85%.
- The clinic had a local audit programme; the clinic took part in nursing audits, for example, infection prevention and control practices, medication and pressure area care. There was no requirement from an organisational level for a dashboard, comparing and benchmarking the results with other units.
- Monthly multidisciplinary meetings were held, staff we spoke with said that all patients' blood results were reviewed; progress and general condition was discussed. The named nurses and dietician discussed outcomes and changes with all patients. Staff we spoke with were very clear about the changes for patients in their care. Written information was also provided as standard to ensure the patient has an ongoing record of their treatment outcomes. Patients we spoke with were very clear about their treatment and care plans.
- The unit took part in integrated management systems audits. These audits looked at unit performance. Following one of the reviews in June 2016 the unit had been issued with one major non-conformance, this was for weighing patients. The unit had made changes to improve compliance and were due to be re-audited during the following six months.
- In the 12 months before our inspection, the average number of patients with an AV fistula was 86.4% this was better than the renal association guidance of 85%.

Nutrition and hydration

- Patients were welcomed to bring their own food and drinks in during treatment and we saw were this was supported. We also saw staff offer patients regular drinks and sandwiches if required.
- Staff referred patients to dietitian if this was required. The dietitian reviewed patients routinely as part of MDT care and review.

Pain relief

- Staff used a number of different medicines for relieving pain such as medication and ice packs.
- We saw that patients were offered pain relief, prior to dialysis. Patients we spoke with said they were offered pain relief if required and staff checked that pain relief administered had been effective.

Patient outcomes

- The unit did not directly submit data to the UK Renal Registry; the 'parent' NHS trust undertook this. The data from the Dearne Valley unit was combined with the NHS trust data and submitted as one data set. This data set included patients under the direct care and supervision of the trust i.e. it would not include for example those patients undergoing dialysis away from either the trust or the unit. As the UK Renal Registry data was representative of all parent NHS trust patients, this did not permit the organisation to review patients performance and outcome trends.
- Clinical outcomes for renal patients on dialysis can be measured by the results of their blood tests. The blood results were monitored on a monthly basis as directed by the NHS trust. Results were collated on the electronic patient database used at the unit. The data was available for the clinic manager and consultant to review so they could see individual patient outcomes. Changes in treatment were planned as a required. This information was shared monthly with the area head nurse who worked with the clinic manager to address improvement areas. Unit specific information was also shared with the respective NHS trust clinicians.
- On reviewing the clinic review reports we saw that overall performance was lower than expected for certain performance criteria. The report showed performance against 13 criteria including adequacy of dialysis management, nutrition management and other patient outcomes in February 2017. Four areas were highlighted as good (green performance), five areas as average (yellow performance) and two areas requiring improved performance (red). One of the red areas requiring improvement was overall performance against compliance with nutrition management 18.9% of patients achieved the outcome with the compliance rate of 50%. Actions to improve included improvements of blood result review by dietitian. Another action requiring improvement was anaemia monitoring 48.6% unit compliance against a compliance rate of 70%. Actions were again available to improve compliance.
- In the 12 months before inspection, we saw that 59.5% (February 2017) of patients who attended three times a week were dialysed for the prescribed four hours treatment time minimum standard. This was lower than the minimum standard of 70%. It also meant that 40%

of patients attending did not have the prescribed four hours of treatment. Staff we spoke with said that there was a variety of reasons for this; actions were again available to improve compliance.

- NICE quality standards (QS72- standard 6) indicate that adults using transport services to attend for dialysis are collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis. The quality standard indicates dialysis providers should collect evidence at unit level to ensure the standard is being met. There was no evidence the unit met NICE quality standards about patients being collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis. We acknowledge that the transport service was commissioned by the local CCG to provide transport to renal patients.

Competent staff

- Staff we spoke with said that they felt they were experienced and competent to carry out their role. The unit used competency assessments during their probationary period and records we reviewed showed that staff had been signed off by senior staff as competent. Staff we spoke with corroborated this process. Staff also completed a self-declaration of competence on an annual basis.
- In the 12 months reporting period prior to inspection, 100% of dialysis nurses had received an appraisal and all registered nurses had their professional Nursing and Midwifery Council (NMC) registration checked by the clinic manager. All staff we spoke with said they had received an appraisal in the last year and thought these had been beneficial. Nurses we spoke with said that they had been supported through the revalidation process.
- The in-house renal flexi bank staff had undertaken a company induction programme with training and competency assessment to the same standards as full-time staff. Senior staff we spoke with said that this improved unit induction time. Job functions of agency nurses mirrored those of substantive staff, and unit staff provided a short induction to local working practices and requirements of the unit.
- The senior management team said that they were committed to the development of competent staff. We saw evidence that all staff had undertaken an induction into their clinical area including emergency procedures. The unit used competency assessments during their probationary period and records we reviewed showed that staff had been signed off my senior staff as competent. Staff we spoke with corroborated this process. Staff also completed a self-declaration of competence on an annual basis.
- New starters had a supernumerary period and period of probation and supervised practice. Staff we spoke with corroborated this. Staff working on the unit received six weeks supernumerary period during induction and a six-month preceptorship period. During this time, staff had a significant number of competences to complete. Staff we spoke with said that supernumerary periods could be altered and increased if the member of staff or the mentor felt that this period needed to be longer. Newly qualified staff had a period of preceptorship following employment; during this period, staff were to complete specific competencies for example the administration of medication and the use of resuscitation equipment. Preceptors trained new staff and recorded their training in their integrated competence document.
- The organisation offered various continuing professional development opportunities for staff, access to external training i.e. accredited renal courses and dialysis specific study days, e-learning and virtual classroom training. Staff we spoke with corroborated this. Some said that training opportunities were excellent and were offered in a variety of methods, delivered locally by the senior nurse or online or classroom based. External training was supported where applicable.
- There were two qualified nurses with additional specialised renal qualifications.
- The clinic had procedures detailing how to report suspension or unfitness to practice on clinical or professional grounds to the regulators and a process for monitoring qualified nurse registrations. They also had internal performance management systems to manage staff were not performing to the expected standards.
- The senior nurse had mentorship qualifications in order to support student nurses learning. Students were allocated placements at the clinic and evaluations were reported as positive.

- The unit was in the process of updating dialysis machines; two members of staff had undertaken training and had been declared competent. These two members of staff were cascading the training to staff within the unit.
- We reviewed three personnel files and noted good compliance with recording of training undertaken and competency assessments.

Multidisciplinary working

- Staff we spoke with told us the renal consultant had overall responsibility for patient care and visited the unit every month to carry out a clinical review of patients.
- There were established multi-disciplinary team (MDT) meetings for discussions of patients on dialysis pathways. MDT meetings included attendance from dietitians, the renal social worker and vascular specialist nurse as well as members of the medical and nursing teams.
- Clinical nurse specialists from the parent NHS hospital attended the unit to provide clinical expertise and review patients if needed.
- Whilst on the unit we observed good communication and support between members of the team, nursing staff and patients we spoke with described good working relationships amongst all staff involved in care and treatment, including clinical and ancillary staff and transport services.
- Nursing and medical staff referred patients to dieticians. Dietitians attended the unit on a monthly basis.
- The neighbouring trust Vascular Access nurse attended the unit to review patients and ran pre-assessment clinics at the unit to enable patients requiring new vascular access to be seen at the clinic rather than attending the referring hospital.

Access to information

- Staff we spoke with said they had all the relevant information they required to look after patients safely.
- The organisation patient database automatically shared patient information with the parent trust patient database. Staff we spoke with did not highlight any issues with this system.
- The service was able to offer dialysis to patients from out of area who may be on holiday. Arrangements for referrals were through the Fresenius head office or the patient's own clinic to the dialysis unit. Once all the relevant information had been collated, the clinic manager reviewed and ensured medical acceptance was sought.
- During the inspection, we saw that staff recorded information about patients in paper format and on a computer based administration systems. Staff we spoke with did not report any issues with the system or access to it. Handover reports were electronic and contained relevant information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing and medical staff obtained consent using both verbal and written routes. The staff we spoke with were aware of how to gain both written and verbal consent from patients and their representatives. We observed staff obtaining verbal consent before undertaking clinical procedures. We reviewed three patient consent to dialysis forms and saw that these were completed accurately and in line with professional guidance; they were renewed and re-written when treatment changes were made.
- Where patients lacked capacity to make their own decisions, staff we spoke with said they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. Staff said that where this was not possible staff had to make best interest decisions. There was no opportunity to review this in practice during the inspection.
- Although training was provided to improve awareness for staff of dementia care, the Mental Capacity Act (MCA) 2005, consent and Deprivation of Liberty Safeguards (DoLS) during the inspection, we found that due to limitations on frequency of experience of patients requiring this additional support, staff were not able to give examples of application in practice. At the time of the inspection, the clinic did not have any patients subject to a DoLS authorisation.
- Training records for the clinic for April 2017 showed 89% of staff had undertaken MCA and DoLS training. This was worse than the provider's own target of 100%.

Are dialysis services caring?

Compassionate care

- We spoke with five patients during the inspection. We observed consistent positive interactions between patients and staff. All patients we spoke with were very happy with the care they received and the relationships they had with the team.
- We received 18 "tell us about your care" comments cards and these were consistently positive.
- The unit participated in the Fresenius national patient survey 2016 that measures the patient's experience of care at Dearne Valley. The response rate was 64% better than the national average of 55%. The survey asked patient's did they have complete confidence in the nurses and 88% said that they did. The survey also asked whether patients thought the unit was friendly and happy and 100% patients responded that it was.
- The unit had consultation rooms where patients could have confidential discussions about their care with any members of the multidisciplinary team should they so wish.
- During the observation, all patients in the unit were treated with dignity and respect. We noted that patients knew all the nursing staff by name and a professional caring approach was evident during the discussions between staff and patients.
- All patients we spoke with were happy with the standard of care they received, Drinks and call buzzers were located within easy reach. Staff moved the call buzzer to the opposite side from where the patient was receiving dialysis, this ensured patients were able to call for help if they required. During the inspection, we saw that staff answered call buzzers promptly and attended to staff requiring assistance with warmth and compassion.
- The privacy and dignity of patients was prioritised. The curtains were available around the bed space. All patients we spoke with said that staff ensured that the patient's dignity and privacy was maintained.
- The unit used a named nurse approach to care; the named nurse updated care plans, care pathways and individualised dialysis prescriptions in detail.
- We learnt from patients that close working with the local kidney association supported arrangement of charity trips and social events, such as bingo, quiz nights, Christmas parties and trips to local resorts. Staff and relatives or carers were involved.
- We observed the nurses assisting patients with mobility problems in a patient and caring manner.

Understanding and involvement of patients and those close to them

- Patients we spoke with said that they had been fully involved in their care decisions. This included discussion of the risks and benefits of treatment.
- Patients said they would know who to approach if they had issues regarding their care, and they felt able to ask questions, however they were clear about having no issues or concerns.
- The five patients we spoke with were aware of their discharge arrangements and actions that were required prior to leaving the unit.
- On the day of inspection, we saw that the senior nurse was visible in the unit and had a close relationship with patients and staff. Relatives and patients were able to speak with the senior nursing staff if required.
- The unit collected feedback through 'Tell us what you think'. This was an anonymous leaflet system which allowed patients to comment on the services received directly to the head office. This feedback was shared with the regional business managers and they determined follow up actions with their units where necessary.
- Staff we spoke with said that as many of their patients attended the unit over a long period of time, staff build up a good relationship with the patients and they got to know patients very well and understood any changes in the patients emotional, social, cultural, spiritual, psychological and physical state.
- Staff we spoke with also said that they engaged regularly with their patients keeping them informed about their care, involving them and their families in decisions and ensuring that they have the opportunity to participate in their own care through 'shared-care concept'. During the inspection, we heard patients being offered opportunities to be involved in their own care for example, removing needles, how they wanted to be removed from their dialysis. A comprehensive shared care checklist and booklet was also available.
- During treatment, there were activities available, albeit there were recognised limitations on what could be undertaken during dialysis. We observed patients using television, radios and internet access on their own electronic portable devices. Patients had newspapers

and magazines or books that they accessed and most patients were sleeping during treatment. Staff made efforts to keep noise levels low, respected the patients privacy and gave additional pillows where needed.
- The use of the named nurse approach and nurses holding a caseload of patients allowed relationships to build over a long period. The named nurse was responsible for updating the patient about changes in treatment following MDT meetings.
- Patients we spoke with said that they had been supported in accessing holiday dialysis services as required.

Emotional support

- Staff at the unit worked in partnership with the renal consultant of the renal unit at the local NHS hospital Staff we spoke with knew how to access their unit and their renal doctor.
- A dedicated renal social worker employed by the organisation would arrange for the relevant support for patients.
- Clinical nurse specialists (CNS) were available from the vascular service to provide support and advice to patients and staff.
- As the patients had a long-term relationship with the staff working on the unit, staff were able to identify emotional changes in the patient and to offer support. Patients had access to a counselling service prior to and during dialysis.

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

Service planning and delivery to meet the needs of local people

- The unit provided dialysis treatment for the patients of the Dearne Valley area. The unit had 12 dialysis stations located over four different areas.
- Dialysis services were commissioned by the local parent organisation. The contract for the unit was renewed in April 2017, and the acute NHS Hospital trust renal team defined the service specification. Patients were referred to the unit for their haemodialysis treatment from the parent NHS trust renal unit. The unit had eligibility criteria to ensure that patients were physically well enough for satellite treatment and lived in the local area. The clinic provided a flexible service to local patients.
- Senior clinic staff attended business meetings at the parent NHS trust to manage the service and ensure that key performance indicators were being met.
- Services did meet patients' needs. The unit had effective processes to avoid unplanned reductions in activity and were fully aware of all the services they needed to provide to meet the demands of the population.
- The clinic did not have a patient transport user group.

Meeting people's individual needs

- Staff we spoke with said that they encouraged and supported patients to arrange dialysis away from base and would welcome patients to the unit for temporary 'holiday treatment' providing medical approval was given and there was dialysis session availability. We spoke with a patient who said that arrangements had been made for them to use dialysis services across the UK.
- The unit provided haemodialysis treatment to patients following an individualised treatment prescription. Changes to prescriptions were made during multi-disciplinary meetings. The outcome of these meetings and changes to care were discussed with the patients. Consent for treatment changes was documented at all stages with patients.
- Patient information was available in four main languages but staff we spoke with said they were able to obtain information in other languages if required, Access to translation services was arranged via the parent unit. We spoke with staff who had arranged interpretation services through the GP. Staff also said that they could use telephone translation services.
- The unit had an acceptance criteria and policy. The unit accepted patients who were over 18 years, had functioning haemodialysis vascular access and who medical staff had declared were clinically stable to receive dialysis treatment in a satellite unit.
- The unit was accessible for people with limited mobility and people who used a wheelchair. Disabled toilets were available.
- The unit accepted people living with dementia and learning disabilities.
- Patients were offered visits to the unit as part of the pre-assessment process prior to commencing dialysis.

- There were links between specialist nurses and unit staff to ensure continuity of care and support for patients.
- All nursing staff we spoke with said that when offering patients dialysis times appointments were given which considered a patient's social needs and work commitments. These included length of journey, transport required and number of days and times of dialysis required.
- Clinic performance in safety audits was displayed for patients in the waiting area for example performance in IPC and health and safety audits. However, overall performance benchmarking the clinic with other clinics was not displayed.
- Ranges of leaflets were available for patients within surgical wards and departments for example prevention of pressure ulcers, carers information and condition related information.
- Patients that we spoke with said that staff did not take long to answer call bells or equipment alarms; during the inspection, we did not hear call bells or alarms ringing for long periods.
- We noted that preference and consent to receiving treatment in a mixed sex bay was taken into consideration as part of initial assessment and consent. Patients' needs and preferences were taken into consideration.
- We observed that the patients comfort was prioritised and use of additional mattresses on beds and adjustable reclining bed controls were used to advantage whilst patients either slept or watched television during treatment.

Access and flow

- The unit used an appointment system which staff we spoke with said ensured structure, timeliness and minimised delays as far as possible. The unit offered a flexible approach to the patient's dialysis sessions changing dialysis days and or times as far as possible to accommodate external commitments/appointments or social events the patients may have. Sometimes this may necessitate a dialysis session being relocated to the referring hospital.
- The local NHS trust informed the clinic when they had new patients that they wanted to admit into Dearne Valley Dialysis Unit.
- There was no waiting list for treatment at the clinic and staff we spoke with said that this was consistent.
- The utilisation of capacity in the unit in the three month reporting period was: November 2016 94%, December 2016 92% and January 2017 94% and so had spaces to accommodate for holiday treatment sessions for people staying in the local area, provided this had been medically approved and all relevant information was available. The unit had not cancelled or delayed any dialysis sessions for non-clinical reasons in the 12 months prior to the inspection.
- There had been 53 patient transfers to the NHS in the reporting period April 2016 to April 2017. Staff we spoke with said that all the transfers were necessary however, we did not see any incident forms completed for the transfers and there was no detailed analysis or benchmarking of this information.
- Access to the clinic was good, and patients could park directly outside the unit.
- Transport of patients was via a specific contract and patients we spoke with did not highlight any issues with transportation and during the inspection, we did not see patients waiting for long periods for transport. We did not see any evidence that patient's arrival or pick up times post dialysis were monitored.

Learning from complaints and concerns

- The unit had a process and complaints policy that addressed both formal and informal complaints that were raised to the unit manager. The senior management team told us they were committed to dealing with the '4 Cs' (compliments, comments, concerns and complaints) in a sympathetic and understanding way.
- In the reporting period, April 2016 to April 2017 the unit had received no formal or informal complaints and five compliments. 'Tell us what you think' leaflets were available for patients and these encouraged patients to make comments, raise concerns or compliments to be shared. As there had not been any complaints received by the unit. We were unable to assess whether people received apologies or acknowledgements when things did not go according to plan.
- It was the responsibility of the clinic manager or deputy manager to ensure all complaints were sympathetically dealt with within maximum 20 working days.
- Staff we spoke with could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required.

- Staff we spoke with said if they did receive any complaints they were shared with staff via team meetings and individual conversations.

Are dialysis services well-led?

Leadership and culture of service

- The unit had a clear leadership structure, which mirrored the organisations leadership structure. The unit manager with the support of the area head nurse and regional business manager ran the clinic on a day-to-day basis.
- From our discussions with staff, all nursing staff said that senior nurse leadership was good. Staff we spoke with said that the clinic manager was visible daily in the unit and senior management team regularly visited and were accessible if needed. Staff we spoke with said they had positive working relationships with the senior management team.
- The area head nurse spoke with us about regular meetings and discussions with the clinical manager. These meeting were not documented.
- We saw cohesive leadership between the senior management team. From our discussions with nursing staff, they said that senior leadership were supportive. They also spoke about their confidence in senior leadership and the responses they had received when raising concerns.
- The unit had staff meetings that were managed monthly by the senior nurse. We reviewed two sets of meeting minutes and saw, good attendance from the nursing team at both meetings and discussion was held on staff concerns and improvements required from recent IPC and documentation audit results.
- The clinic manager had 70% management time rostered into workforce management plans.
- Staff we spoke with described the moral of the unit as good and staff said they felt supported.
- Staff described their peers in a positive way and spoke about them supporting each other. The senior management team said they were proud of the staff working within the unit.
- The culture and leadership within the clinic represented the vision and values of the organisation, encourage openness, transparency, and promote quality care. At ward and department level, staff we spoke with described the culture as open and supportive.
- During and prior to the inspection we did not receive any whistleblowing enquiries.

Vision and strategy for this this core service

- The unit had a corporate vision for the service to improve the quality of life for renal patients. The unit also had a culture and quality statement. This was displayed on the walls of the waiting area.
- The senior management team were aware of the strategy and values, staff we spoke with could describe in their own words the values of the unit.

Governance, risk management and quality measurement

- Governance is a term used to describe the framework, which supports the delivery of the strategy and safe, good quality care.
- At the announced inspection, the senior management team said that there was a new risk register in place. This was shared with us and we saw that risks were separated into clinical, operational and technical risk. We observed that the risk register did not reflect all of the current risks relevant to the operational effectiveness of the unit. For example; failed water samples, equality and diversity information, patient identification and the lack of a sepsis policy were not recorded on the risk register. In addition, we also found that not all of the senior management team were aware of how to escalate items onto the risk register and no dates for recording the risk on the register were available. Senior staff were not able to identify the top three risks for the unit. Following the inspection, we learned that this was a draft risk register and as such had not been implemented or embedded. Systems were not in place to effectively manage risk and safety.
- We requested to review the organisational board minutes to understand how the issue of the unit had been shared with the board; we were not supplied with any. We requested to review clinical governance meetings and were supplied with the multidisciplinary team MDT minutes from the blood review meetings. The unit did not hold separate governance meetings despite this being expected as part of the clinical governance policy; however, they did participate in clinical governance meetings of the neighbouring NHS trust. We requested to review the minutes from attendance at the NHS parent organisation governance minutes to

understand how the risks of the unit were shared and we were provided with action points. From these we were not able to identify which issues related to the parent organisation and which issues related to the unit.

- The unit did have a clear management structure and the senior management team appeared to have an understanding of the issues facing the unit, however this was not formally documented. We were provided with information before the inspection which said that the clinic manager monitored and led on governance and quality monitoring within the dialysis unit, supported by the wider organisational team, including the area head nurse and regional business manager. We were not assured there was an effective governance framework in place.
- Quality systems used for reporting and learning from incidents lacked organisational overview, to ensure that this information was used to improve patient outcomes and prevent further incidents from occurring.
- We were unable to review personnel files of staff employed, as this information was stored at a corporate level. However, during the inspection we obtained information from staff, which showed that the organisation does not re-check disclosure and barring service checks during employment. We shared this with the provider and following the inspection they provided information that this had been escalated onto the risk register.
- We saw none of the corporate policies had review dates on them. This meant up to date guidance and legislation may not be incorporated into the organisations policies. For example, the FMC medicines management policy referred to NMC guidance which had been updated eight years previously.
- As part of our inspection, we asked for evidence that the unit met the 'Accessible Information Standard'. From 1st August 2016 onwards, all organisations that provide NHS care were legally required to follow the Accessible Information Standard.
- The standard aims to make sure that people who have a disability, impairment, or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services.
- Senior staff told us the unit had no evidence of meeting this legal standard. After our inspection, the lack of an accessible information standard was placed on the risk register.
- The Workforce Race Equality Standard (WRES) is a requirement for organisations, which provide care to NHS patients. 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 have a WRES report. This means the unit should publish data to show they monitor and assure staff equality by having an action plan to address any data gaps in the future.

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. We acknowledged the local area had low numbers a of black and minority ethnic population (BME). However, the unit did not have a WRES report or action plan available.

Patient and staff engagement

- The unit participated in the Fresenius employee satisfaction survey 2016 that measured the staff's satisfaction at Dearne Valley. The unit compared the results against the average NHS staff satisfaction data. A greater number of staff, 80% would recommend the unit to friends and family requiring dialysis, against 69% recommendation rate in the NHS. A larger number of staff would recommend their dialysis unit as a place to work 80% greater than the NHS 59% score for the same question.
- The unit participated in the Fresenius national patient survey 2016 that measured the patient's experience of care at Dearne Valley. The response rate was 64% which was better than the national average of 55%. The survey also asked did the patient have complete confidence in the nurses and 88% said that they did. They survey asked whether patient thought the unit was friendly and happy and 100% patients responded that it was. The registered manager was required to take three issues from the negative results and identify actions for improvement on an action plan.
- No patient representative was available on groups or committees within the unit. However, the clinic manager worked closely with local renal groups and representatives from the clinic were members of these groups.
- The clinic manager organised social outings for clinic patients, patients, staff and their families attended these.

Innovation, improvement and sustainability

Dialysis Services

- The unit were in the process of replacing the dialysis machines with a newer version.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that they assess, monitor and mitigate risks to improve the quality and safety of the services they provide, especially in relation to learning from incidents and investigations to enable trends and themes to be identified to improve patient outcomes. This should include the application of the duty of candour requirements for all incidents, which trigger implementation.
- The provider should ensure that performance information that is collected is used for benchmarking performance with other units to improve patient outcomes.
- The provider should ensure that all risks relevant to the unit are recorded on the risk register, this should include appropriate mitigating actions, progress and review dates.
- The provider should ensure that the workforce and race equality standards (WRES) are implemented appropriately.
- The provider should ensure there is a system in place to allow staff to identify patients receiving care and treatment including the arrangements for administration of medications.
- The provider should ensure that there is a formal process for eligibility of acceptance to the unit for current in-patients to receive dialysis on the unit.
- The provider should ensure that a recognised early warning score reflecting the risks of the dialysis patient is implemented to prompt recognition of the deteriorating patient.
- The provider should consider the value and implementation of sepsis toolkits and specific pathways.