Renal Services (UK) Ltd - Grantham

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Renal Services (UK) Ltd - Grantham is operated by Renal Services (UK) Limited. The service at Grantham has eight treatment stations including one side room and is open Monday, Wednesday and Friday 7am to 6pm and Tuesday, Thursday and Saturday 7am to 1pm.

There is a Service Level Agreement with University Hospitals of Leicester NHS Trust to provide haemodialysis (HD) to adults over the age of 18. Haemodialysis is a type of renal replacement therapy offered to patients with chronic kidney disease and is the most common form of renal replacement therapy.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 May 2017, along with an unannounced visit to the service on 22 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?

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

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

We found the following areas of good practice:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons from incidents were learned and communicated throughout the team.
- Performance showed a consistently good track record in safety, patient outcomes and access to treatment.
- Staffing levels were of an appropriate number for the unit and staff were suitably skilled, including senior managers.
- Patient's care and treatment was planned and delivered and clinical outcomes monitored in line with evidence-based guidance, standards, best practice and legislation. This included the management of a patient's pain, nutrition and hydration needs and individual physical health needs.
- There was effective multidisciplinary working. Staff worked well together and there was high morale and staff satisfaction.
- Staff were committed to 'doing the best' for their patients and passionate about delivering high quality care, a culture of putting the patient first was evident throughout the unit.
- Feedback from patients was consistently positive about the way staff treated them. The unit had received no complaints in the past year.

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

- Staff did not fully follow the provider medicine management policy for the positive identification of patients when they were administering medicines.
- On-going competency-based assessments to ensure staff were up to date with using, for example, dialysis machines was undertaken informally but not documented.
- A Workforce Race Equality Standard (WRES) report was not produced at this location.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

Heidi Smoult
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis Services		Renal Services (UK) Ltd - Grantham is operated by Renal Services (UK) Limited. The service has eight treatment stations and provides haemodialysis services six days a week. At the time of inspection these services were commissioned by a local NHS trust. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 May 2017 along with an unannounced visit to the service on 22 May 2017. 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. Patients' were protected from avoidable harm and abuse. Performance showed a good track record in safety; there was an open culture in which staff were open and transparent when raising incidents and near misses and changing risks to patients were identified and responded to appropriately. Staffing levels were of an appropriate number for the unit and staff were suitably skilled. Patients received effective care and treatment that met their needs; patient's care and treatment was planned and delivered and clinical outcomes monitored in line with evidence-based guidance, standards, best practice and legislation, outcomes for patients were consistently positive and there was good multidisciplinary working with the unit. Patients were supported, treated with dignity and respect and were fully involved in their care. Feedback from patients was consistently positive about the way staff treated them. Patients' needs were met through the way services were organised and delivered; patients could access dialysis treatment at the right time. The unit did not have a waiting list and there had been no delays or cancellations to treatment in the last year.

Summary of findings

The leadership, governance and culture promoted the delivery of high-quality patient-centred care; local leadership at this unit was effective and all staff were committed to 'doing the best' for their patients and passionate about delivering high quality care.

Summary of findings

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Dialysis Services

Summary of this inspection

Background to Renal Services (UK) Ltd - Grantham

Renal Services (UK) Ltd - Grantham is operated by Renal Services (UK) Limited and has not been inspected since registration in October 2015. This location is registered to provide the following regulated activity:

- Treatment of disease, disorder or injury

Renal Services (UK) Ltd - Grantham is an independent single specialty provider of dialysis in Grantham, Lincolnshire. The unit primarily serves the community of Grantham. It also provides haemodialysis for those patients from outside the area who may be on holiday. The referring NHS acute trust provides a multidisciplinary team including a consultant nephrologist. Unit staff are employed by Renal Services (UK) Limited.

The unit has had a registered manager in post since October 2015. At the time of our inspection the unit was in the process of submitting an application for change of a registered manager.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 May 2017. along with an unannounced visit to the service on 22 May 2017.

Our inspection team

Our inspection team was led by Michelle Dunna, Care Quality Commission Inspector.

The team included one other CQC inspector, a specialist advisor with expertise in dialysis services and an expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them, for example as a carer.

Information about Renal Services (UK) Ltd - Grantham

Renal Services (UK) Ltd - Grantham is an independent single specialty provider of dialysis and is registered to provide the following regulated activity:

- Treatment of disease, disorder or injury

During the inspection we spoke with all four staff who worked for Renal Services (UK) Ltd – Grantham. We spoke with 16 patients (seven face to face and nine by telephone). We also received 13 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed seven sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. Neither had the service been the subject of an external review or investigation since registration. This was the service's first inspection since registration with CQC.

Renal Services (UK) Ltd - Grantham employed three registered nurses. At the time of our inspection the unit was run by the unit sister with the support of the registered manager. The future plan was that the unit sister was to be the new registered manager.

Activity

- At the time of our inspection the service had 20 patients receiving care on a regular basis. All patients treated are over 18 years of age.
- In the reporting period February 2016 to April 2017 there were 4,454 dialysis sessions recorded at this unit; all were NHS-funded.
- In the reporting period May 2016 to April 2017 there were no patients who required transfer from the service to another health care provider.
- In the reporting period February 2016 to January 2017 there were no patients on the waiting list for dialysis treatment.

Summary of this inspection

- There were no planned dialysis sessions cancelled for a non-clinical reason in the 12 months preceding this inspection.
- There were no planned dialysis sessions delayed for a non-clinical reason in the 12 months preceding this inspection.

Track record on safety

- In the reporting period May 2016 to April 2017 there had been no never events.
- In the reporting period February 2016 to January 2017 14 clinical incidents had been reported. All had been classified as low harm.
- During the period May 2016 to April 2017 there had been no serious incidents requiring investigation.
- During the period May 2016 to April 2017 there had been no incidences of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- During the period May 2016 to April 2017 there had been no incidences of healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- During the period May 2016 to April 2017 there had been no incidences of healthcare acquired Clostridium difficile (c.difficile).
- During the period May 2016 to April 2017 there had been no incidences of healthcare acquired surgical site infection.
- During the period May 2016 to April 2017 there had been no complaints.

Services provided at the unit under service level agreement:

- Dietetics
- Patient transport
- Domestic services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We found the following areas of good practice:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons from incidents were learned and communicated throughout the team including opportunities to learn from safety incidents that had occurred in other dialysis units across the organisation.
- Performance showed a good track record in safety. There were clearly defined systems, processes and standard operating procedures in infection prevention and control, medicines management, equipment and patient care records to ensure patients were protected from avoidable harm.
- Staff identified and responded appropriately to changing risks to deteriorating patients including those patients with suspected sepsis.
- Safeguarding vulnerable adults, children and young people was given sufficient priority. All staff were trained to an appropriate level and demonstrated an understanding of how to protect patients from abuse. Staff could describe what safeguarding was and the process to refer concerns.
- Staffing levels were of an appropriate number for the unit and staff were suitably skilled. Staff were up to date in mandatory training.
- There were arrangements in place to respond to emergencies. Business continuity plans were in place to advise staff of actions to be taken in the event of a utilities failure.

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

- Staff did not fully follow the provider medicine management policy for the positive identification of patients when they were administering medicines.

Are services effective?

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

We found the following areas of good practice:

- Patient's care and treatment was planned and delivered and clinical outcomes monitored in line with evidence-based guidance, standards, best practice and legislation.

Summary of this inspection

- Patient's had an assessment of their needs which included pain, nutrition and hydration and consideration of individual physical health needs. In addition, care and treatment was appropriately monitored and updated.
- Information about patient's care and treatment, and their outcomes, was routinely collected and monitored. Outcomes for patients were consistently positive.
- There was effective multidisciplinary working with the unit and the referring trust working together to deliver effective care and treatment.
- Staff were qualified and had the skills they needed to carry out their roles effectively and were supported to develop through timely performance reviews.
- Staff had good access to all the information they needed to assess, plan and deliver treatment and there was appropriate sharing of information between the unit and the referring trust.
- Consent to care and treatment was carried out in line with legislation and guidance and appropriately monitored.

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

- On-going competency-based assessments to ensure staff were up to date with using, for example, dialysis machines was undertaken informally but not documented.

Are services caring?

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

We found the following areas of good practice:

- Feedback from patients was consistently positive about the way staff treated them.
- Patients were treated with dignity, respect and kindness during all interactions with staff.
- Patients understood their care and treatment; staff spent time talking to patients, communicating information in a way that patients could understand.
- Staff were sensitive to the individual needs of patients including those patients living with a disability, sight impairment or living with dementia.
- Staff responded in a compassionate, timely and appropriate way to calls for help, alarms on dialysis machines and any non-verbal signs of distress.

Are services responsive?

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

We found the following areas of good practice:

Summary of this inspection

- The unit was commissioned with the needs of the local population in mind and offered flexibility and choice to its group of patients.
- The facilities and premises were appropriate for dialysis treatment.
- The needs of different patients were taken into account when delivering treatment. For example, patients who did not speak or understand English.
- A wide range of patient information leaflets were available in the unit including information on how to raise a concern or complaint.
- The unit had received no complaints in the past year. However, patients were aware of how to raise a complaint and there were processes in place to ensure that patients could offer feedback.
- Patients could access dialysis treatment at the right time. The unit did not have a waiting list and there had been no delays or cancellations to treatment in the last year.

Are services well-led?

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

We found the following areas of good practice:

- There was a governance framework in place to address performance, safety and risk and staff were aware of their responsibilities.
- Local leadership at this unit was effective with senior staff having the appropriate skills and qualifications to undertake their roles.
- Staff were committed to 'doing the best' for their patients and passionate about delivering high quality care, a culture of putting the patient first was evident throughout the unit.
- There was an organisational vision in place for the unit, to deliver "inspired patient care". This was supported by seven organisational values: safety, service excellence, responsibility, quality, communication, innovation and people.
- There were supportive relationships amongst staff and we observed high morale and staff satisfaction.

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

- A Workforce Race Equality Standard (WRES) report was not produced for this service.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

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

Incidents

- The service had a paper-based incident reporting system. An incident reporting flowchart detailed the process to be followed for reporting of all incidents. All staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally.
  - During the period February 2016 to January 2017, 14 clinical incidents had been reported through the incident reporting system.
  - Incidents were categorised on a severity scale of one to five with 'severity level one' being 'insignificant' (no harm) and 'severity level five' being 'catastrophic'. Of the clinical incidents reported by this service 100% were severity level two (low harm).
  - During the period February 2016 to January 2017 there had been no serious incidents requiring investigation, as defined by the NHS Commission Board Serious Incident Framework 2013. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
  - There had been no incidence of a 'never event' in the last 12 months prior to this inspection. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- All incidents were logged on to a central database. This was reviewed for themes and actions every six weeks by the clinic sister in addition to a review by the head of nursing for the organisation. A final review of all incidents was undertaken by the provider clinical governance committee. Lessons learned were cascaded to the dialysis clinic staff at their monthly meetings. The sister was responsible for ensuring required actions were implemented and embedded into the dialysis clinic culture and practice.
- Lessons learned, and action taken as a result of an incident were discussed at monthly unit staff meetings. Minutes of these meetings confirmed where discussions had taken place. Minutes also showed where incidents that had taken place in other dialysis units within this organisation had been discussed for example as a result of a 'fall with harm' at another unit there was a 'phone a fall' initiative in place that also included patient call bells sited next to the weigh scales for patient's to summon assistance should they feel unwell.
- There were no notifiable safety incidents that met the requirements of the duty of candour regulation in the 12 months preceding this inspection. 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.
- Duty of candour training was provided to all new starters during their induction period. All the staff were

aware of and demonstrated to us an understanding of duty of candour. Within the incident report form there was a section to be completed regarding duty of candour if it was applicable to the incident.

Mandatory training

- Renal Services (UK) Limited held annual classroom based mandatory training days. The service maintained a core of mandatory training requirements that all staff were required to undertake on an annual basis, such as basic life support (BLS) including the use of an automated external defibrillator, health and safety, manual handling, fire training, infection control, food hygiene, hand hygiene, protection of vulnerable adults (POVA), information governance, equality and diversity and dignity and respect.
- At the time of this inspection all staff had completed this training.
- All staff had received training in identifying and managing patients with sepsis. Sepsis is a severe infection which spreads in the bloodstream. Training included screening for sepsis and actions to be taken by the nursing staff where sepsis was suspected.

Safeguarding

- All staff had been trained to recognise adults at risk and were supported with effective safeguarding policies for vulnerable adults and children. All staff could give us examples of raising safeguarding concerns with the local authority. Safeguarding contact numbers and a flow chart were visible on the unit.
- The head of nursing was the safeguarding lead for the organisation, supported by the registered manager at individual locations and had been trained to safeguarding 'level three'.
- Safeguarding level four support was provided at this location by the referring trust. Safeguarding level four trains managers within the health and social care sector to a higher capability level of knowledge with adult safeguarding procedures.
- The service did not treat patients who were under the age of 18. However, children and young people were permitted to visit relatives on the unit. All staff had received safeguarding children training (level two).

Cleanliness, infection control and hygiene

- Renal Services (UK) Limited had an infection prevention and control (IPC) policy in place which provided staff with structured arrangements for the monitoring, prevention and control of infection and followed the recommendations of the Renal Association (RA) in the treatment of hepatitis B, hepatitis C and HIV positive patients.
- There were two members of staff who were the IPC leads for the unit. Their responsibilities included for example, the completion of IPC audits, including hand hygiene, ensuring actions had been taken for any areas of non-compliance following the referring trust's annual IPC audit, attendance at three-monthly IPC training and attendance at monthly IPC meetings with the referring trust.
- Local IPC audits included for example, hand sanitiser availability, cleaning of dialysis machines, staff uniform and central venous catheter (CVC). For the reporting period January to April 2017. Overall compliance rates were between 95 and 100%.
- An annual IPC audit was carried out at the unit by the referring trust. Results for the 2016 audit were largely positive with three 'fails' identified and a score of 92% awarded. Where the unit had failed to meet trust IPC standards we saw an action plan had been created and actions had been addressed. At the time of this inspection the 2017 IPC audit had not yet been undertaken.
- During this inspection we observed all areas of the unit to be visibly clean. External contractors visited the unit, six days a week, at the end of the day to perform cleaning duties. Staff performed disinfection of medical devices, including dialysis machines between each patient and at the end of each day. These followed manufactures and IPC guidance for routine disinfection. We observed staff cleaning equipment and machines during this inspection. We reviewed six dialysis machines during this inspection and saw where appropriate disinfection of the machines had taken place on all machines.
- All the patients we spoke with were consistently positive about the cleanliness of the unit and the actions of the nursing staff with regards to infection prevention and control. Patients told us, "they {the

staff} are always washing their hands", "they {the staff} are always cleaning under the bed" and "they {the staff} wash machines in-between patients with chlorine".

- The provider monitored infection prevention and control as part of their annual patient satisfaction survey. Results from the 2016 patient satisfaction survey showed 100% of patients, at this unit, felt the cleanliness of the unit, their chair space and the toilet facilities were either "good" or "excellent".
- Guidelines for water testing and the disinfection of water plant and dialysis machines were readily available to all staff. These guidelines had been reviewed by Renal Services (UK) Limited's water treatment specialist, medical director and an independent technician.
- All water testing for the unit was carried out in line with the recommendations by the UK Renal Association and European standards for the maintenance of water quality for haemodialysis and haemodiafiltration.
- The unit had a large water treatment room. On a daily basis, nursing staff monitored the water supply in accordance with local guidelines and the requirements of the referring trust. Records we reviewed indicated where this had taken place. In the event that a result showed an anomaly, staff told us they would contact the manufacturer for an urgent review and we saw details displayed in the water treatment room advising staff of the contact details for the 'water treatment helpline'. The unit had not had any abnormal water testing results in the 12 months preceding this inspection.
- During the period May 2016 to April 2017 there had been no incidences of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA). MRSA is a bacterium responsible for several difficult-to-treat infections.
- During the period May 2016 to April 2017 there had been no incidences of healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA). MSSA differs from MRSA due to antibiotic resistance.
- During the period May 2016 to April 2017 there had been no incidences of healthcare acquired Clostridium difficile (c.difficile). C. difficile is an infective bacterium that causes diarrhoea, and can make patients very ill.
- Procedures were in place to assess patients as carriers of MRSA and/or blood born viruses (BBV) such as Hepatitis B and C. This included routine testing of susceptible patients in line with best practice guidelines. Patients were screened three-monthly for BBV. All seven patient care records we reviewed confirmed this had taken place.
- MRSA positive patients were dialysed in the side room, with appropriate isolation precautions in place to prevent the spread of infection to other patient's. Hepatitis B virus (HBV) positive patients were dialysed in isolation on a designated dialysis machine. Hepatitis C virus (HCV) and human immunodeficiency virus (HIV) positive patients were dialysed in isolation but not on a designated dialysis machine unless specified by the referring trust. This practice was in line with company guidance.
- Patients who had been dialysed in the European Union (EU) would have a hepatitis screen on their first treatment in the unit and the machine would be isolated until the results were available; all patients who had been on holiday to a non EU destination would be dialysed in isolation on a designated machine for a period of three months; new patients to the unit would have a hepatitis screen before treatment as part of the admission criteria.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Results for the reporting period February to April 2017 showed an average compliance rate of 99%. Hand hygiene results were communicated to staff through their staff meetings. Minutes we reviewed from these meetings confirmed this had taken place.
- Throughout the unit all staff were observed to be compliant with best practice regarding hand hygiene,

and the use of an aseptic non touch technique (ANTT) where necessary, and staff were noted to be bare below the elbow. An ANTT is a method designed to prevent contamination by applying strict rules and practices. There was access to hand washing facilities and a supply of personal protective equipment (PPE), which included gloves, aprons and face shields. During this inspection we observed all staff to be using PPE appropriately. This included, but was not limited to, the use of face shields during the initiation and termination of haemodialysis.

- All staff were trained and competent in aseptic non touch technique (ANTT). ANTT is the standard intravenous technique used for the accessing and attaching of all venous access devices (VADs) regardless of whether they are peripherally or centrally inserted and is considered best practice in line with the National Institute for Health and Care Excellence (NICE).

Environment and equipment

- The lay out of the unit was compatible with health and building notification (HBN07-01) guidance. Access was good, parking plentiful with a secure entry point. A nurse's station allowed visibility of all patients during dialysis and privacy curtains were available when required. Patients could, if they wished, speak with each other during dialysis in line with HBN recommendations. During dialysis all patient chairs permitted access to call bells.
- Dialysis sets were single use and CE marked (this demonstrates legal conformity to European standards). A record of the batch number of all the dialysis set components used was recorded in the patient care records. This was visible in all seven patient care records we reviewed.
- There was a system in place to ensure that repairs to equipment were carried out if machines and other equipment broke down, and that repairs were completed quickly so that patients did not experience delays to treatment. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme and we saw the service had an active equipment and maintenance schedule. Dialysis equipment and other medical devices were serviced annually and water treatment was carried out six monthly. There were also daily, weekly and monthly checks carried out on the premises and equipment. All equipment checked during this inspection was service tested and in date.
- In the event there were a failure of a dialysis machine whilst a patient was receiving treatment a 'back up' dialysis machine was available. We reviewed the replacement machine and saw it had been appropriately safety tested and was visibly clean and ready to use.
- The unit had a seven-year replacement programme for dialysis machines. This was in line with Renal Association Guidelines.
- Patient weigh scales were available on the unit and we saw where they had been appropriately service tested. Staff told us, in the event the weigh scales developed a fault or were unfit for use, a replacement set was available on the unit and the fault would be reported to an external company for repair.
- We checked the resuscitation equipment on the unit. The resuscitation equipment appeared visibly clean. Single-use items were sealed and in date, and emergency equipment had been serviced. Records indicated resuscitation equipment had been checked daily by staff and was safe and ready for use in an emergency.
- Servicing and maintenance of medical devices was carried out by an external company. Equipment records we reviewed indicated all equipment had been checked for safety (including recalibration where applicable) in June 2016. All staff were able to explain the process they would follow for any equipment faults and/or issues. Non-urgent equipment faults requiring technical support were raised through email and urgent issues were raised through a 24-hour telephone contact number.
- We observed all staff to have regard for alarm guards on the dialysis machines. Alarms were addressed appropriately and not overridden inappropriately by staff or patients. This meant significant risks such as the detection of dislodged needles could be identified at the earliest opportunity thus avoiding the risk of significant blood loss or cardiac arrest.

Medicine Management

- The medication procedure was checked against the prescription chart at the end of completion of dialysis treatment and documented on the patient's 'daily dialysis record sheet'. We reviewed nine daily dialysis record sheets and saw where the medication procedure had been consistently documented.
- Pharmacy support for this unit was provided by the referring trust. All non-dialysis related medication was prescribed and dispensed by the patient's general practitioner (GP). Dialysis specific medication was prescribed by the consultant nephrologist or the unit's non-medical prescriber and delivered directly to the unit in line with patient prescriptions.
- The registered manager was a non-medical prescriber and was supported by the consultant nephrologist overseeing the clinical care of the patients. Their role as a non-medical prescriber was for the prescribing of dialysis specific medication. Non-medical prescribing is undertaken by a health professional who is not a doctor. It concerns any medicine prescribed for health conditions within the health professional's field of expertise.
- The non-medical prescriber completed an annual reassessment of their competencies which was submitted to the referring trust's lead for non-medical prescribing.
- Dialysis prescriptions were faxed to the unit from the referring trust. The referring consultant would review prescriptions during their monthly visit to the unit. On a daily basis the non-medical prescriber would review all prescriptions.
- Staff were trained on the safe administration of intravenous medicines. We reviewed staff competency files and saw all staff had received this training.
- We observed staff administering medications in line with Nursing and Midwifery Council (NMC) standards for medicines management. This included patient identification, not leaving medications unattended and confirming all prescriptions were administered during dialysis.
- Medicines, including intravenous fluids were stored securely. No controlled drugs were stored within Renal Services (UK) Ltd - Grantham. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs.
- Patient group directions (PGDs) were not used at this unit. PGD allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predetermined group of patients without them seeing a doctor.
- Medicines requiring refrigerated storage were stored at the correct temperatures to ensure they would be fit for use. We reviewed the fridge and room temperature records for February to April 2017 and saw where staff had signed daily to indicate temperatures had been checked and were within the required range. We spoke with staff who told us that where temperatures were not within the required range this would be escalated to the nurse in charge.
- Medication audits were undertaken as part of other audits undertaken at this location For example, documentation and environment. Following this inspection the provider was in the process of rolling out a medication audit for all locations within the organisation. The draft audit template was provided to us following our inspection.

Records

- Individual patient care records were written and managed in a way that protected patient's from avoidable harm. We reviewed seven patient care records during this inspection and saw records were accurate, complete, legible, up to date and stored securely.
- Patient care records were updated both pre and post their dialysis treatment. Care records included for example, a comprehensive patient referral/admission document, a consent form, patient specific risk assessments, a copy of the monthly blood results, multidisciplinary review notes, evidence of a dietetic review and any NHS clinic letters.
- Machine and water specifications, and patient prescriptions determining frequency and length of

dialysis, were written by the consultant nephrologist from the referring NHS trust and documented on the patient's 'daily dialysis record sheet', stored within the patient's care record.

- Patient care records were paper-based. Where the consultant nephrologist needed to access the patient record and/or blood results these were shared electronically through the referring trust's renal database.
- Dialysis staff accessed the patient's NHS clinic letters through the referring trust's renal database. Clinic letters were printed off and a copy stored in the patient care record. Our review of seven records confirmed this.
- The service was registered with the Information Commissioner's Office (ICO). The ICO is responsible for the promotion and enforcement of the Data Protection Act 1998.

Assessing and responding to patient risk

- The unit did not use a nationally recognised early warning scoring system to monitor deterioration in the patient's condition. Observations, including temperature, blood pressure and heart rate were recorded on the patient's daily dialysis record sheet at the start, during and at the end of dialysis.
- An electronic monitoring system within the dialysis machine alerted staff to any deterioration in the patient's blood pressure or heart rate. In event of deterioration in condition, staff would monitor the patient's observations more frequently to determine whether dialysis should be discontinued and/or the patient required transfer to an acute hospital. On the day of our unannounced inspection we saw where staff responded appropriately to a 'drop' in a patient's blood pressure; this included increasing the frequency of monitoring of the patient's blood pressure and discussing the patient with the referring consultant nephrologist.
- Comprehensive risk assessments were carried out for patient's and risk management plans developed in line with national guidance. For example, in the seven patient care records we reviewed we saw evidence of risk assessments in all records for falls and pressure ulcers and patient specific risk assessments in records where patient's had specific health needs. Where one patient had reduced mobility a risk assessment was in place advising staff of the actions to take were there a need to evacuate the unit.
- There were no 'vulnerable adults' currently receiving treatment at this unit. One nurse gave us an example of where they had previously provided treatment for a patient living with dementia. On this occasion they had encouraged a carer to attend with the patient. Patients who required additional support, for example, if they had challenging behaviours and/or worsening dementia received their treatment at the referring NHS trust.
- All seven patient care records we reviewed included a three monthly assessment of the screening status of all patients for potentially infectious blood born viruses.
- Staff recorded an assessment of the patient pre and post dialysis on a 'daily dialysis record sheet'. This included the start and finish time of treatment, a summary of the patient during treatment and a final evaluation of the patient following treatment.
- There was not a policy in the unit for the positive identification of patients. We discussed this with staff who told us the organisation did not have a policy. Staff told us they ensured the correct identification of a patient by asking the patient to confirm their name and date of birth, we observed this taking place during this inspection. Staff on the unit felt, because of the size of the unit and the small number of patients, they were familiar with each patient and felt therefore the risk of incorrectly identifying the patient was low. A process was also in place whereby a second member of staff checked the patient, the dialysis machine and dialysis prescription before the patient commenced their treatment. A nurse handover at the start of the shift also gave staff the opportunity to confirm an individual patient's identity; this included those patients who were new or receiving 'holiday dialysis'.
- Where patients were to receive medicines staff were to check the patient's name, date of birth and postcode in accordance with the provider's 'medicine management policy'. With the exception of not checking the patient's postcode all staff followed this policy.

- Patients did not receive blood transfusions at this unit. Where a blood transfusion was required this would be carried out at the referring trust.
- Staff followed the referring trust's sepsis policy and screening toolkit which they accessed through the trust electronic renal database. All the staff demonstrated a good understanding of sepsis and the actions they would take were a patient to present with or develop sepsis.
- There was a process in place for the emergency transfer of a patient to an NHS acute trust. Guidance was provided through the provider's 'medical emergency / cardiac arrest policy'. There were no patients requiring an 'unplanned transfer' from the service to another health care provider in the 12 months preceding this inspection.

Staffing

- The nurse staffing ratio was determined by the service level agreement (SLA) the unit had in place with their referring NHS trust and patient dependency. The ratio was currently one nurse to four patients. We reviewed staffing rota's for the period 1 January 2017 to the date of this inspection. There was no time where the nurse: patient ratio was less (worse) than one nurse to four patients.
- The nursing establishment for this unit was three registered nurses. The unit did not employ unregistered nurses.
- The unit had no vacancies for nursing staff at the time of this inspection.
- The rate of staff sickness for the reporting period 1 April 2016 to 31 March 2017 was low at three days.
- There were appropriate arrangements in place for using bank and agency staff in order to keep patient's safe at all times. An induction was provided for all bank and agency staff during their first shift. Competency assessments were also carried out using service specific checklists. Nurse bank/agency use for the reporting period 1 April 2016 to 31 March 2017 was low with 21 agency days and 71 bank days recorded.
- There was appropriate provision in place for medical cover of the dialysis patients. This was provided by the consultant nephrologist based at the referring trust in addition to a consultant nephrologist from a local NHS trust. The unit staff were able to access the referring consultant nephrologist by telephone, bleep and email. In the event the consultant was not available the staff were able to discuss patient concerns with the on-call renal consultant.

Major incident awareness and training

- There were arrangements in place to respond to emergencies. Business continuity plans were in place detailing actions to be taken by the unit staff in the event of a utilities failure.
- Due to the essential requirement for the supply of water and electricity in order to treat patients, the unit was on the 'critical/priority' list of the local water authority and electricity board. If the supply of water was interrupted, the water plant would alert staff. The break tank would continue to provide water for dialysis for a further 20 minutes; this would enable staff to safely discontinue patients' treatment. In the event of power failure, the dialysis machines and chairs had reserve battery packs, which would enable staff to discontinue patient treatment safely.

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

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

Evidence-based care and treatment

- Services, care and treatment were delivered and clinical outcomes monitored in line with and against the Renal Association Standards, National Institute for Health and Care Excellence (NICE) and the referring trust's requirements. The Renal Association is the professional body for United Kingdom (UK) nephrologists (renal physicians, or kidney doctors) and renal scientists in the UK.
- Renal Association guidelines were followed for the management of 'life-threatening' haemorrhage from arteriovenous fistula (AV) and AV grafts. An AV fistula is an abnormal connection or passageway between an artery and a vein. An AV graft consists of synthetic tube

implanted under the skin, connecting between the artery and the vein, and providing needle placement access for dialysis. Patient care records demonstrated where regular discussions had taken place with the patient regarding this risk.

- All staff monitored patients vascular access as part of their pre-dialysis assessment and following treatment. We saw an assessment of the patient's vascular access included in all seven patient care records we reviewed. This followed NICE Quality standard [QS72]: Renal replacement therapy services for adults. Where there were concerns identified regarding the patient's vascular access, a photograph was taken and shared with the referring consultant nephrologist for advice. During our unannounced inspection of the unit we saw where concerns had been appropriately raised and the patient had been referred to their referring NHS trust for a review of their vascular access.
- At the time of this inspection, 85% of patients (17 patients) had an arteriovenous fistula. This was in line with Renal Association guidance.
- Staff at the unit were able to access all patient records, including blood and test results through the referring NHS trust's electronic database.
- The unit did not provide assistance or support to those patient's who were dialysing in their own home. The unit did offer support to those patient's who were dialysing 'away from base' for example, those patients requiring dialysis whilst on holiday. At the time of our inspection two patients were receiving dialysis away from base.
- The unit did not offer peritoneal dialysis. Peritoneal dialysis (PD) is a type of dialysis that uses the peritoneum in a person's abdomen as the membrane through which fluid and dissolved substances are exchanged with the blood. It is used to remove excess fluid, correct electrolyte problems, and remove toxins in those with kidney failure.
- Each patient's weight, temperature, pulse and blood pressure was checked at the beginning and end of dialysis. In addition to continual monitoring during the haemodialysis session. This was documented on the patient's daily dialysis record sheet.

Patient outcomes

- The unit participated in the UK Renal Registry through the referring Trust. The UK Renal Registry is a resource for the development of patient care in renal disease. It provides a focus for the collection and analysis of standardised data relating to the incidence, clinical management and outcome of renal disease. Due to the inclusion with other units, the unit was not able to benchmark the effectiveness of the service against other providers.
- For the reporting period May 2016 to April 2017 100% of patients were treated within 30 minutes of their appointment times for treatment.
- Clinical patient outcomes were monitored by the service, in order to benchmark services provided across the organisation, and included for example, target weights, hypotension (low blood pressure) and prolonged bleeds. For the period 1 May 2016 to 30 April 2017 there were 189 variances from the expected outcome recorded at this unit.
- Monthly blood sampling was carried out and results were checked by the nursing staff. Urea reduction ratio's (URR's) were calculated and checked against the Renal Association (RA) guidelines. The URR is one measure of how effectively a dialysis treatment removed waste products from the body. For May 2016 to April 2017, an average of 95% of patients achieved a URR of greater than 65% as indicated by RA guidelines.
- For the reporting period February 2016 to January 2017, 100% of patients received three dialysis sessions per week, each for a minimum of four hours duration.
- The referring trust monitored the unit's performance against a number of quality indicators including for example, infection prevention and control, sepsis, dialysis water and dialysis fluid quality and the environment. With the exception of the environment (95%) results for February to April 2017 were all 100%.
- Clinical metrics including patient observations, falls assessment, pressure area care, nutritional assessment, medicine prescribing and administration, resuscitation equipment, patient dignity and infection prevention and control were monitored monthly by the referring trust with results RAG rated (red, amber, green). Results for December 2016 showed this unit as achieving 100% (green) in all areas.

Pain relief

- An assessment of pain was documented in all seven patient care records we reviewed. The pain assessment tool used provided a pictorial as well as numerical scale to assess a patient's level of pain. A pictorial scale is useful for patients who cannot verbalise and/or may have a cognitive disorder.
- Simple analgesia (pain relief) such as paracetamol was prescribed for all patient's. Where a patient required a stronger form of pain relief a discussion would take place with the referring trust and a prescription would be written and faxed to the unit or prescribed by the unit non-medical prescriber.

Nutrition and hydration

- Patients had access to food and hydration while undergoing treatment.
- A service level agreement (SLA) was in place for dietetic support which was provided by a nearby NHS trust. Following a review of a patient's blood results, the dietician provided support remotely through telephone advice and during regular visits. Where indicated a referral would be made to outpatient dietetic services.
- We reviewed seven patient care records and saw evidence of a nutritional assessment and appropriate care plans. Care records also demonstrated patients were seen monthly, as a minimum, by a dietician.

Competent staff

- Basic life support training was a mandatory training requirement that all staff were required to undertake on an annual basis. All staff had completed this training and were competent to use all items of emergency equipment. For example, the automated external defibrillator (AED).
- Training and supervision in for example, catheter dressing, vascular accessing techniques, taking blood samples, safe injection practices, management of intravenous cannula and arteriovenous fistula was included as part of a comprehensive renal competency programme. A review of all three staff's personal competency files indicated staff had been trained and assessed as competent in these procedures.
- Staff training was supported by annual performance reviews (appraisals). In addition to these, regular meetings took place to review targets and professional development. To support on-going training and education, personal development plans (PDP) and targets were set around the performance review, taking into account career progression and patient/service needs. In the 12 months preceding our inspection all eligible staff had received an annual performance review.
- Arrangements for supporting staff through revalidation and checking nursing and midwifery (NMC) pin numbers was carried out by the provider's human resource (HR) department.
- Within the organisational structure all staff had a direct line manager who worked with mentors to provide supervision, management and clinical leadership. They ensured that all relevant induction checklists, competencies, workbooks, targets and objectives were achieved. The mentors were supported by other senior nurses provider wide. Reflective practise was on-going both formally and informally. A clinical nurse specialist was actively involved in implementing reflective practice and action learning.
- The provider seconded its registered nurses to an accredited advanced renal course and had arrangements with three universities. At this location two out of three nursing staff had a qualification in renal nursing. The third member of staff was currently in their first year of working at this unit and was expected to complete a formal qualification in renal nursing following successful completion of their local renal competencies.
- A local induction checklist was in place for all new starters to the service and was completed within two weeks of commencement of their employment date. Content included introduction to the workplace, introduction to the job and department, health and safety , arrangements, policies and procedures, learning and development needs and quality and regulatory. One nurse at this unit had been required to complete an induction. A review of their personal competency file indicated this had taken place.

- A four week introductory supernumerary programme was in place for new starters. This programme introduced and provided an overview of the concepts and practice associated with haemodialysis. Associated competencies provided the opportunity to learn them in more detail and to work towards becoming a competent renal practitioner.
- A 'novice to competent dialysis nurse practitioner' framework was in place for all staff working on the unit. As part of the framework a package had been designed to enable staff to maximise the learning opportunities available in the dialysis unit, as well as being a tool that would allow staff to map their progress as they moved from a novice to a competent staff nurse. It also enabled a means by which statutory revalidation requirements for continued registration could be met.
- The package allowed staff to reflect on the learning and development they had undertaken, identify what they had learnt, how this learning could be applied to their role and future development and how this learning could contribute to the improvement of care for the renal patient. To complete the package, staff worked through each section with their allocated mentors, ensuring that each objective was signed off on completion.
- All staff had received training on the use of dialysis equipment and staff competency files we reviewed confirmed this. However, on-going competency-based assessments to ensure staff were up to date with using, for example, dialysis machines was undertaken informally but not documented. Senior staff told us they would observe staff 'ad-hoc' but not document when this had taken place unless concerns had been identified.
- All staff had received up-to-date training on manual handling and fire safety.
- All staff had received training on the recognition and management of sepsis.
- All staff demonstrated to us they had an understanding of the principles of the drugs used, such as erythropoietin (an essential hormone for red blood cell production) and anticoagulants (commonly referred to as blood thinners). We did not see evidence of on-going competency-based assessments to ensure staff were kept up to date.
- This was a small service with only three staff and as such the unit did not have identified link nurses for falls, pressure ulcers or nutrition.

Multidisciplinary working

- Communication with a patient's general practitioner (GP) was undertaken by the consultant nephrologist from the referring trust.
- The unit had an escalation policy for a patient with sepsis who required immediate review. This included close monitoring of the patient's observations and oxygen levels, requesting a '999' ambulance for immediate transfer to the nearest NHS trust emergency department and discussing the patient with the referring trust renal unit.
- Patients were assessed for suitability for treatment at Renal Services (UK) Ltd - Grantham by their referring consultant nephrologist prior to transfer. The patients were seen by their consultant nephrologist employed by the referring trust at least every three months. Our review of seven patient care records indicated patient's had been seen three-monthly as a minimum.
- The unit had close contacts with the referring trust's multi-disciplinary team (MDT). Where indicated, patients would be referred to a social worker, counsellor, dietician and other members of the MDT.
- MDT meetings, between this unit and the referring trust, were held monthly with the Consultant Nephrologist and three-monthly with a pharmacist and dietician.
- Renal Services (UK) Ltd - Grantham was a 'nurse-led' dialysis unit. Overall responsibility for the patients care lay with the patient's consultant nephrologist at the referring trust.
- On a day-to-day basis, where advice or support was required, staff told us they had good access to the referring renal consultant or a renal specialist at a nearby NHS trust. We observed staff accessing a consultant by telephone on a number of occasions during this inspection.

Access to information

- Renal Services (UK) Limited policies and procedures were accessible, in paper format, in the unit. Policies and procedures for the referring trust were accessible electronically through the trust's renal database. We saw where local policies included a signature sheet confirming staff had read updated policies.
- Following treatment patient information was documented directly on to the referring trust's electronic patient information management system. Patient information was communicated to the GP by the referring consultant nephrologist in the form of letters.
- Dialysis staff accessed the patient's NHS clinic letters, blood results and dialysis prescriptions through the referring trust's renal database. We observed this taking place during this inspection.

Equality and human rights

- Equality and diversity training was a mandatory training requirement that all staff were required to undertake on an annual basis. All staff had completed this training.
- Our review of seven patient care records demonstrated to us where staff had considered individual patient needs for example, age, disability, race and religion or belief. This meant discrimination was avoided when making care and treatment decisions.
- The Accessible Information Standard (NHS England) aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read and understand and with support so they can communicate effectively with health and social care services.
- Following inspections of other units within this organisation the provider had developed an 'accessible information policy' and assessment form. Information received following our inspection told us both documents had since been approved and were currently being rolled out across all units within the organisation.
- At this location patient communication needs were assessed on admission and on an on-going basis throughout their treatment. Any changes were documented in nursing notes and discussed with the nurse in charge and the rest of team. The nursing team liaised closely with the patient's GPs and carers as indicated. Support was also given by the multi-disciplinary team from the referring trust. All new patients received a 'patient guide' on their first dialysis treatment at the unit providing them with information on the service, including opening times and who to contact out of hours. If a need was identified that the patient required information in another format and language this would be accommodated. Information leaflets on treatment, kidney disease, nutrition, access and various other subjects were provided by the referring trust and a renal charity and were displayed in the unit's waiting room. Copies of leaflets were given to all patients when they first dialysed on the unit.

Consent, Mental Capacity Act and Deprivation of Liberty

- A consent policy written in line with the Mental Capacity Act 2005, Mental Health Act 1983 and Department of Health guidance documents on consent was available to all staff. We reviewed seven patient care records and saw all patient records included a consent to treatment record. We observed staff obtaining verbal consent from the patients during the course of their treatment.
- During the time of this inspection there were no patients who lacked capacity to make decisions in relation to consenting to treatment.
- Where a patient lacked the mental capacity to give or withhold consent for themselves staff told us they would encourage a patient to be accompanied by a family member or carer for support and would follow the provider policy on consent for guidance.
- At the time of our inspection staff told us there were no patient's receiving treatment at this location that were subject to the Mental Health Act 1983 (MHA). However, staff were knowledgeable about protecting the rights of patients and staff demonstrated to us their regard to the MHA Code of Practice.

- If required the unit had access to an external interpreting and/or translation service for those patient's whose understanding was limited due to a language barrier.
- At the time of this inspection the unit had no patients who had an active 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place.
- Medical advance planning and end of life care decisions were made jointly with the patient and the referring consultant nephrologist. Staff told us where advance decisions were in place this would be communicated to the unit.

Are dialysis services caring?

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

Compassionate care

- Patient satisfaction was formally measured through an annual patient satisfaction survey. Responses were based on a scale of one to five where one was 'no, never' and five was 'yes, always'. Results from the 2016 patient satisfaction survey showed 95% of patients felt, overall, they had been treated with respect and dignity.
- Patient privacy and dignity was maintained at all times. Patients received treatment in an open clinical area. Privacy screens were available in the event of an emergency to maintain the patient's dignity during any emergency treatment or when required to maintain privacy at any other time. We observed the use of privacy screens during this inspection.
- During this inspection we observed all staff treating patients with dignity, kindness, compassion, courtesy and respect. Staff interacted with patient's and were inclusive of patient's during general conversation.
- During this inspection we spoke with all seven patients present on the unit. We also conducted nine telephone interviews with patients currently receiving treatment at this unit. Without exception feedback was consistently positive about all aspects of care received at this unit.
- All staff were observed to be sensitive to the individual needs of patients including those patients living with a disability, sight impairment or living with dementia. One patient told us staff always helped them to their chair, to the toilet or to the weigh scales because of their {the patient} restricted mobility. Another patient preferred to dialyse away from other patients, where possible staff ensured this patient received their treatment in the side room.
- Staff monitored patient's throughout their dialysis session. This meant staff were able to respond in a compassionate, timely and appropriate way when patient's experienced physical pain, discomfort or emotional distress. We saw staff responded promptly to calls for help, alarms on dialysis machines and any non-verbal signs of distress.
- Individual televisions and portable DVD players were available during a patient's dialysis session and patients were encouraged to bring in items of equipment or pillows or blankets to aid their comfort.

Understanding and involvement of patients and those close to them

- Staff communicated with patients' so that they understood their care, treatment and condition. In order to prepare and familiarise patients with what they could expect whilst receiving treatment at the unit, staff discussed this with them as part of their consent to treatment.
- Patients were reviewed a minimum of three-monthly by the consultant nephrologist and monthly by a dietician. This allowed the opportunity for the patient to discuss any concerns they may have. Additional visits by either health care professional could be arranged as required. One patient saw the consultant every six weeks.
- The unit was Wi-Fi capable and patients could access the internet or 'Patient View' through the use of a laptop. Patient View allows renal patients to view their latest test results online, along with clinic letters and information about diagnosis and treatment. Most patient's we spoke with told us they chose not to access 'patient view' because the nursing staff always discussed and explained their blood results to them.

- To enhance the patient experience, patient days were hosted for friends and family of existing patients and potential patients. The staff had previously organised social events involving patients and family during Christmas and competitions (such as an Easter bonnet competition) for both patients and staff.
- At the time of this inspection the unit did not have any patients' requiring additional support to help them understand and be involved in their care and treatment. Staff told us were this the case they were aware of how to access additional resources such as for example, language interpreters, sign language interpreters, specialist advice or advocates.
- Patients and their relatives were encouraged to participate in their treatment. Staff encouraged patients to take responsibility for parts of their treatment, such as weighing themselves prior to dialysis.
- A consultation room was available for patients to discuss issues with members of the team in privacy.
- Patient's had a dedicated 'named nurse'. However patient's told us they knew all the staff and could approach any one of them regarding their care and treatment. During this inspection a patient was receiving 'care away from base', we observed the nurse taking extra time to introduce themselves.
- A number of information leaflets were available for patients offering information and support around renal disease and dialysis. Most of the patient's we spoke with told us of these leaflets and how staff had gone through the leaflets with them to ensure they understood the information.

Emotional support

- Patients did not have access to a renal social worker or renal psychologist. However, most of the patient's we spoke with did not see this as a negative. They {the patients} felt they received all the emotional and practical support they needed from the nursing staff. One patient told us, "they {the nurses} treat me like a friend" another said, "they {the nurses} are always asking me what I've been up to, they always chat with me".
- We spoke with the nursing staff about access to emotional support for patients. Staff recognised this was a challenge due to limited resources available but felt they were able to signpost patients appropriately if necessary. All of the staff we spoke with saw recognising and providing support to patient's as an important part of their job.
- In all seven patient care records we reviewed we saw evidence of regular discussions with patients.

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

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

Meeting the needs of local people

- Renal Services (UK) Ltd – Grantham was previously at a different location. It was a six station unit, with no side room or consultation room. Due to the increase in patient numbers, a new unit was commissioned in October 2015 with a side room and consultation room.
- Patients local to the Grantham area were previously travelling to Lincoln and Peterborough for their dialysis treatment. The dialysis unit at Grantham made it possible for patients to be treated locally rather than make, on average, a two hour journey to Lincoln or Peterborough three times per week. Not having to travel long distances can significantly enhance a patient's quality of life.
- The unit did not have a transport user group. However, the provider monitored transport services as part of their annual patient satisfaction survey. Results from the 2016 patient satisfaction survey showed 100% of patient's at this unit, using transport services to attend for dialysis, were collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis.
- The unit met the recommended practice for haemodialysis facilities: Health Building Note 07-01: Satellite dialysis unit. For example, the unit was

located on the ground floor and had its own dedicated entrance, the entrance was easily accessible to patient's using wheelchairs or walking aids and dedicated parking spaces were available.

- From October 2016 to January 2017 the unit provided treatment to an extra eight patient's whilst an additional dialysis satellite unit in Peterborough was being commissioned.
- Dialysis sessions were available from 7am to 6pm for patients, taking into consideration the working, cultural and family responsibility needs of the patients currently receiving treatment at the unit. Staff and patient's told us of times when session's would be changed to accommodate a patient's individual circumstances.

Service planning and delivery to meet the needs of individual people

- There was provision for patients attending for haemodialysis to be able to visit the toilet before dialysis commenced. We observed nursing staff providing assistance and a number of patient's told us staff were always helping them.
- Dialysis patients may be susceptible to cold as such the unit performed on-going monitoring of the temperature of the unit. During this inspection the unit temperature felt comfortable. None of the patients we spoke with, who were receiving treatment at the time of this inspection, expressed concerns regarding the temperature of the unit.
- The provider had a dedicated holiday dialysis co-ordinator who liaised with trust holiday coordinators, the patients, consultant nephrologists and other dialysis units, including overseas, for treatment bookings. The co-ordinator ensured that all necessary administration arrangements were in place and would follow up on any outstanding information prior to the unit being given the go-ahead to treat the patient. The information was requested four weeks prior to the holiday dates and all information was checked by the nursing staff prior to accepting the patient. All the staff were aware of the holiday co-ordinator and the process for arranging holiday dialysis.
- There were no dedicated beds allocated solely for holiday dialysis. Holiday dialysis was offered around the availability of extra capacity.
- Staff could access interpreting services for patients who did not speak or understand English. The service was provided externally and included the provision of British Sign Language.
- A wide range of patient information leaflets were available in the unit including information on how to raise a concern or complaint. Leaflets were provided in English only but we saw information on the back of the leaflets providing details of how they could be translated into other languages if required.
- Patients were encouraged to participate in their treatment. Staff encouraged patients to take responsibility for parts of their treatment, such as weighing themselves prior to dialysis.

Access and flow

- Staff told us session times and appointments for example, for medical review were arranged as far as possible to suit the individual patient. During this inspection we saw where session times were swapped between patients's to accommodate individual preferences. One patient present on the day of this inspection had been able to change their day of dialysis to accommodate an NHS trust appointment.
- The unit was open Monday, Wednesday and Friday 7am to 6pm and Tuesday, Thursday Saturday 7am to 1pm.
- The average level of utilisation of capacity in the unit for December 2016 to April 2017 was 48%. This meant the unit had a surplus of available capacity. At the time of our inspection there were no patient's on their waiting list for dialysis treatment, all referred admissions were accepted.
- There were no planned dialysis sessions cancelled or delayed for a non-clinical reason in the 12 months preceding this inspection.
- None of the patient's we spoke with raised concerns regarding delays in treatment start and finish times. Most were complimentary of how efficient the unit was.

- The unit provided outpatient haemodialysis therapies for patients in end stage renal disease (ESRD) who were either already established on renal replacement therapy (RRT) or new patients who had been assessed by the referring doctor to be fit to commence treatment in a satellite setting. Referrals were made as part of the contract with the referring acute NHS trust.

Learning from complaints and concerns

- A complaints procedure was in place and made available to all patients at their first treatment session. The complaints procedure had a staged approach to complaints and outlined the timescales appropriate to raise them, and also the timescales for a response from the service. Complaints were handled in a staged approach that provided an escalation procedure in order to progress complaints that were not resolved in the initial stages.
- The service monitored compliments and verbal and written complaints. For the reporting period February 2016 to January 2017 the service received eight written compliments. There had been no complaints received during the 12 months preceding this inspection. However the unit sister was aware of the actions they should take should a complaint be raised.
- Complaints posters and leaflets were visible in the unit and all the patient's we spoke with were aware of how to make a complaint.
- The unit did not have an active 'patient user group'. A patient user group consists of a number of patient representatives who meet to share their views to positively influence change. One of the patient's we spoke with told us there had previously been a group but that this was no longer in place. The same patient told us they would be keen to lead such a group.

Are dialysis services well-led?

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

Leadership and culture of service

- Renal Services (UK) Ltd – Grantham was led by a clinic manager, supported by a regional clinical manager and head of nursing.
- The registered manager of the unit was a registered nurse with over 25 years experience in renal nursing with formal qualifications. The clinic sister responsible for the day to day management of the service was a registered nurse with formal specialist renal and mentorship qualifications with 10 years experience in the renal speciality.
- Local leadership at this unit was effective and staff felt supported by their leader. We received many positive comments about senior leaders at provider level and staff we spoke with were all encouraged by the attitudes of the executive team.
- Throughout this inspection we observed staff who were committed to 'doing the best' for their patients and passionate about delivering high quality care, a culture of putting the patient first was evident throughout the unit. Staff described to us supportive relationships amongst staff and we observed high morale and staff satisfaction. Staff told us executive leaders consistently provided a high level of support and visibility and that the provider chief executive (CEO) visited the unit at least three times a year.
- Staff demonstrated a good understanding of the challenges they faced in order to deliver good quality care and were constantly striving to identify actions needed to address them.
- The unit sister and registered manager were visible and approachable during this inspection. Staff described this as always being the case. The unit sister did not have 'dedicated' management time and as such often worked alongside colleagues within the clinical area.

Vision and strategy for this core service

- There was an organisational vision in place for the unit, to deliver "inspired patient care". This was supported by seven organisational values: safety, service excellence, responsibility, quality, communication, innovation and people. We saw the vision and values displayed in the clinical area.
- Whilst staff were unable to 'recite' the exact wording of the vision and values they all demonstrated to us what

the organisation wanted to achieve and all consistently demonstrated the values of the organisation. For example, at this unit staff were keen to increase the level of utilisation within the unit and to work collaboratively with the referring trust to promote dialysis in the patient's own home.

Governance, risk management and quality measurement

- The clinical governance lead for the unit was the registered manager. They were supported by the regional clinical manager, head of nursing and the corporate quality and regulatory manager.
- We saw there was an effective governance framework in place ensuring information was shared from the unit to the board and vice versa. The unit dialysis staff met every four weeks, information from these meetings was shared at the monthly head of nursing, regional managers and dialysis clinic managers and sisters meetings. Information from these meetings was shared through the three-monthly clinical governance committee and senior management team meetings, attended by the chief operating officer, medical director, head of nursing and regional managers. Renal Services (UK) Limited executive board met every three months where the chief operating officer and medical director would be in attendance.
- Unit staff reported incidents to both Renal Services UK Limited and the referring trust (through the trust electronic incident reporting system). Feedback for local incidents was cascaded through the provider governance framework, which included the unit staff meeting. Actions from local incidents included for example, changing the process for setting up dialysis which now included a 'second checker' to ensure machines were programmed correctly. Where incidents had been raised at other dialysis unit we saw evidence of shared learning. For example, the introduction of the 'phone a fall' initiative and the sharing of information regarding implantable cardioverter defibrillators (ICD). An ICD is a small device which can treat people with dangerously abnormal heart rhythms.
- Clinical metrics including patient observations, falls assessment, pressure area care, nutritional assessment, medicine prescribing and administration, resuscitation equipment, patient dignity and infection prevention and control were monitored monthly by the referring trust with results RAG rated (red, amber, green). The unit manager received feedback on metrics results through a six-monthly quality assurance meeting with the referring trust. In addition staff were familiar with their performance in relation to other dialysis units and as such able to benchmark their performance.
- There was a comprehensive assurance system and service performance measures, which were reported and monitored, and action taken to improve performance. We reviewed the results of nine audits that were completed monthly by the unit manager. Examples of audit's included: Documentation, environment, health and safety, central venous catheter (CVC) and infection prevention and control. Results for the months between January and April 2017 showed results to be consistently above 95% with most audits achieving results of 100%.
- The clinical governance framework included processes that ensured patient outcomes and experience were monitored and supported by appropriately qualified staff. The service's medical director who was a consultant nephrologist was a member of the organisation's clinical governance committee.
- A risk register was held at provider level and maintained by the regulatory and quality manager. The risk register was reviewed by the chief operating officer, the regulatory and quality manager and chief executive monthly. A local [Renal Services (UK) Ltd – Grantham] risk register was in place, the unit sister was aware of the risks and risks aligned to the provider risk register. Risks identified at location level were discussed six-weekly with the clinic sister, chief operating officer, clinical governance manager and regional manager. Risks identified were; recruitment, electrical failure/loss of water supply, premises unavailable due to fire, flood or any other incident, inclement weather, pandemic illness of staff and failure of the air-conditioning system.
- Training associated with risk management and incident reporting was provided externally. The training included health and safety, hazard reporting,

accident and incident reporting, risk assessment and management. Training was carried out for every new member of staff as part of their induction and renewed on a 12-monthly basis.

- Clinic managers and unit sisters meetings were held monthly with the head of nursing. This was an opportunity to share information across locations, discuss 'local' performance and receive any organisational updates. Minutes we reviewed demonstrated where governance, risk management and quality measurement were important agenda items for these meetings. For example we saw discussions around; unit activity, including new admissions, health and safety, incidents, clinical variance, infection control, recruitment and retention and staff rotas.

Equality and Diversity

- All independent healthcare organisations with NHS contracts worth £200,000 or more are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. A WRES report was not produced at this location.

Public and staff engagement

- The unit engaged with the British Kidney Patient Association (BKPA) advocacy service. Information received before our inspection described a well led service, patients were receiving safe care, all patients were happy with their care and staff were observed to be caring.
- The unit did not have an active 'patient user group'. A patient user group consists of a number of patient representatives who meet to share their views to positively influence change. One of the patient's we spoke with told us there had previously been a group but that this was no longer in place. The same patient told us they would be keen to lead such a group.
- The unit had hosted open days for healthcare professionals, especially those working in care homes and GP surgeries. This supported staff to get an overview of dialysis and how to care for renal patients. They provided patient information days with the local community nursing teams for existing and pre-dialysis patients in order to increase awareness on renal disease within the care home staff. Patient information days had resulted in some patient's choosing home haemodialysis with the support of community nursing teams.
- The unit had a number of different methods in which to collect feedback. There was a confidential suggestions box in the unit in which patients could post feedback/complaints/comments. This is in addition to patients being able to provide feedback/ raise concerns verbally with staff members in the unit, by telephone or in writing. All feedback was recorded, reviewed and responded to.
- The patients also had the ability to provide feedback of the service directly to the referring trust's renal team. In order to formally measure patient satisfaction an annual patient satisfaction survey was carried out in the month of December.
- A pilot staff survey was undertaken by the provider in 2015. The pilot survey did not include staff from Renal Services (UK) Ltd - Grantham. During this inspection we were not made aware of whether future survey's had been planned to include this location.
- Unit manager/sister 'away days' were held quarterly with the provider executive team. These allowed individual managers to share experiences with other unit managers, provided 'scenario-based' training on performance management and gave an update on the organisation, governance and the current situation on recruitment. Staff told us they enjoyed these days and felt privileged that the organisation was willing to invest time and resources when organising them.
- The organisation produced a six-monthly newsletter for staff. We reviewed the latest newsletter and saw reference to, new staff, a message of thanks from the executive team, information on the organisations new company logo and birthday messages from a number of dialysis clinics within the organisation.
- All the staff we spoke with understood the value of raising concerns and all told us they would feel comfortable doing so. None of the staff we spoke with

had ever had to raise a concern but said they had confidence in the unit manager and the organisation that were a concern to be raised appropriate action would be taken as a result.

Innovation, improvement and sustainability

- The organisation encouraged improvement and innovation. Close links with three universities had enabled two out of three nurses to complete an accredited renal course, there were plans for the third member of staff to complete this course once they had achieved their local renal competencies. The unit manager had attended a British Renal Society (BRS) conference and the unit sister told us they had been given the opportunity to attend.
- Senior staff attended conferences to promote good practice; at this location both the registered manager and unit sister had attended.
- The unit demonstrated commitment to the future of environmental protection. This unit addressed energy conservation through the use of 'motion-sensor' lighting throughout the unit. This meant lights were only activated when necessary.
- Recycling of suitable goods was in operation from the unit through an external contract.
- The unit had a seven-year replacement programme for dialysis machines. This was in line with Renal Association Guidelines.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all staff follow the provider medicine administration policy when administering medicines.
- The provider should consider formal, documented on-going competency-based assessments to ensure staff remain up to date with using, for example, dialysis machines.
- The provider should consider collecting, reporting, monitoring and publishing their WRES data and take action where needed to improve their workforce race equality.