Renal Services (UK) Limited- Wiltshire

Quality Report

Block 10,
Odstock Road
Salisbury
Wiltshire
SP2 8BJ
Tel: 01722 411441
Website: www.renalservices.com

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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) Limited - Wiltshire is operated by Renal Services (UK) Limited. The hospital/service has 11 dialysis stations and operates 22 sessions each day which equals 132 sessions each week for a caseload of 38 patients. The unit also provides services for dialysis patients who holiday in the region. The unit carried out a total of 6550 haemodialysis sessions in the 12 months prior to May 2017.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 23 May 2017 along with an unannounced visit to the unit on 30 May 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

Services we do not rate

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

We found the following areas of good practice:

- There was a clear incident reporting process Staff received feedback from incidents they reported. Organisation wide learning from incidents was recognised and implemented.
- Staff were fully compliant with mandatory training and safeguarding training and there was a reliable system to monitor this.
- There were systems and process in place to safely manage medicines.
- Staff demonstrated good practice with infection, prevention and control processes.
- The unit had clear processes in place to ensure regular servicing and maintenance of equipment.
- There were business continuity policies and procedures to follow in case of a power failure or issues with the water supply.
- A falls assessment had been implemented after an increase in patient falls across Renal Services (UK) Limited services.
- Evidence based practice and the Renal Association guidelines were used to develop service delivery.
- There was a comprehensive training programme to ensure trained nurses were competent to carry out their role at the haemodialysis unit.
- Pain was assessed and manged well.
- Patient's hydration and nutritional needs were monitored and managed well.
- Staff worked well as a team to deliver effective care to patients.
- There was good multidisciplinary working and strong communication links with the nephrology consultants from Portsmouth Hospital NHS trust.
- Staff had access to information about patients which enabled effective care and treatment, including access to NHS patient record computer systems.
- Informed consent was sought and documented prior to commencement of treatment
- Patients were treated with dignity, compassion and respect.
- Privacy and dignity was respected in all aspects of care.
- Staff took the time to interact with patients and had a good rapport with them. Patients found staff to be kind, informative and helpful.

Summary of findings

- The patients spoke very highly of the unit, the staff and the care they received.
- Staff communicated with patients so they understood the care they received and were encouraged to ask questions.
- Staff understood the impact of the treatment on patient's emotional wellbeing and actively supported patients.
- Services were planned and delivered to meet individual patient needs and improve quality of life.
- Patients had access to entertainment during their haemodialysis session.
- Patients were supported to arrange haemodialysis at their holiday destination.
- Patients were supported to achieve home dialysis if it was appropriate for the patient.
- Patients were fully assessed prior to being accepted as patients of the unit.
- There was no waiting list for patients to attend the unit.
- There was a system to monitor and deal with complaints. There had been no complaints at the unit in the last year. There had been 18 compliments.
- Leaders had the skills and experience to lead and staff spoke highly of the senior management team telling us they were visible and approachable.
- There were processes in place for unit managers to meet with other unit managers to ensure they did not work in isolation and shared good practice ideas and information.
- There was an effective governance system to support the delivery of good quality care.
- There was an effective systematic programme of audit which was shared with the consultants and contracting team.
- The unit valued feedback from patients and carried out a yearly staff survey.
- There was a replacement programme for the dialysis machines, in line with the Renal Association guidelines.
- The organisation had a vision and a set of values. They were displayed in the unit and referred to in staff newsletters.

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

- The unit did not have a policy around the management of sepsis and the deteriorating patient policy did not make direct reference to the management of suspected sepsis in a patient. However staff had received training on how to recognise signs of sepsis.
- There were no formal identify checks carried out prior to patients being connected to haemodialysis machines for treatment.
- There was no detail about what action staff should take if the drugs fridge temperature was out of range.

Following this inspection, we told the provider that it should make improvements, to help the service improve.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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Background to Renal Services (UK) Limited- Wiltshire

Renal Services (UK) Limited - Wiltshire is operated by Renal Services (UK) Limited. The service opened in 2008. It is an independent healthcare service in Salisbury, Wiltshire. The unit is situated within the grounds of Salisbury General Hospital. The service primarily serves the communities of Salisbury and surrounding areas. It also accepts patient referrals from outside this area from people holidaying in the area. The unit has been operational since May 2008.

The service has had a registered manager in post since January 2016 and is registered for the regulated activity: treatment of disease disorder and injury.

We inspected Renal Services (UK) Limited – Wiltshire on 23 May 2017 and carried out an unannounced visit on 30 May 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,Mandy Norton and other CQC inspectors. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

Information about Renal Services (UK) Limited- Wiltshire

The haemodialysis unit is registered to provide the following regulated activities:

- Treatment of disease, disorder and injury.

During the inspection, we visited Renal services (UK) Limited – Wiltshire dialysis unit. We spoke with four staff including registered nurses, and senior managers and we spoke with seven patients. We also received four 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection we reviewed six 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 prior to this inspection. The service had previously been inspected in August 2013 which found that the service was meeting all standards of quality and safety it was inspected against.

The unit has a service level agreement with Portsmouth Hospitals NHS trust for the provision of outpatient satellite haemodialysis to patients based within a local NHS trust. The unit is nurse led, with clinical supervision being provided by a consultant nephrologist from Portsmouth. There are 12 dialysis stations, including one in a side room.

Activity (January 2016 to January 2017)

- In the reporting period January 2016 to January 2017. The unit carried out 6,550 haemodialysis sessions. This figure included haemodialysis sessions for holidaymakers in the area. All of the sessions are NHS funded.
- The unit provided haemodialysis for both male and female patients. The unit opened six days a week and carried out 22 sessions per day, one session in the morning and one in the afternoon.

The unit employed 5.6 whole time equivalent registered nurses and two health care assistants, as well as having its own bank staff.

Track record on safety over the 12 months prior to the inspection:

- No never events
- No serious incidents

Summary of this inspection

- No serious injuries

Zero incidences of healthcare acquired methicillin-resistant Staphylococcus aureus (MRSA),

Zero incidences of healthcare acquired methicillin-sensitive Staphylococcus aureus (MSSA)

Zero incidences of healthcare acquired Clostridium difficile (c.diff)

Zero incidences of healthcare acquired E-Coli

No complaints

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Maintenance and servicing of medical equipment
- Maintenance of the building

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We found the following areas of good practice:

- There was a clear incident reporting process. Staff received feedback from incidents they reported. Organisation wide learning from incidents was recognised and implemented.
- Staff were fully compliant with mandatory training and safeguarding training and there was a reliable system to monitor this.
- There were systems and process in place to safely manage medicines.
- Staff demonstrated good practice with infection, prevention and control processes.
- The unit had clear processes in place to ensure regular servicing and maintenance of equipment.
- There were business continuity policies and procedures to follow in case of a power failure or issues with the water supply.
- A falls assessment had been implemented after an increase in patient falls across Renal Services (UK) Limited services.

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

- The unit did not have a policy around the management of sepsis and the deteriorating patient policy did not make direct reference to the management of suspected sepsis in a patient. However staff had received training how to recognise signs of sepsis.
- There were no formal identify checks carried out prior to patients being connected to haemodialysis machines for treatment.
- There was no detail about what action staff should take if the drugs fridge temperature was out of range.

Are services effective?

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

We found the following areas of good practice:

- Evidence based practice and the Renal Association guidelines were used to develop service delivery.
- There was a comprehensive training programme to ensure trained nurses were competent to carry out their role at the haemodialysis unit.

Summary of this inspection

- Pain was assessed and manged well.
- Patient's hydration and nutritional needs were monitored and managed well.
- Staff worked well as a team to deliver effective care to patients.
- There was good multidisciplinary working and strong communication links with the nephrology consultants from Portsmouth Hospital NHS trust.
- Staff had access to information about patients which enabled effective care and treatment, including access to NHS patient record computer systems.
- Informed consent was sought and documented prior to commencement of treatment

Are services caring?

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

We found the following areas of good practice:

- Patients were treated with dignity, compassion and respect.
- Privacy and dignity was respected in all aspects of care.
- Staff took the time to interact with patients and had a good rapport with them. Patients found staff to be kind, informative and helpful.
- The patients spoke very highly of the unit, the staff and the care they received.
- Staff communicated with patients so they understood the care they received and were encouraged to ask questions.
- Staff understood the impact of the treatment on patient's emotional wellbeing and actively supported patients.

Are services responsive?

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

We found the following areas of good practice:

- Services were planned and delivered to meet individual patient needs and improve quality of life.
- Patients had access to entertainment during their haemodialysis session.
- Patients were supported to arrange haemodialysis at their holiday destination.
- Patients were supported to achieve home dialysis if it was appropriate for the patient.
- Patients were fully assessed prior to being accepted as patients of the unit.
- There was no waiting list for patients to attend the unit.

Summary of this inspection

- There was a system to monitor and deal with complaints. There had been no complaints at the unit in the last year. There had been 18 compliments.

Are services well-led?

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

We found the following areas of good practice:

- Leaders had the skills and experience to lead and staff spoke highly of the senior management team telling us they were visible and approachable.
- There were processes in place for unit managers to meet with other unit managers to ensure they did not work in isolation and shared good practice ideas and information.
- There was an effective governance system to support the delivery of good quality care.
- There was an effective systematic programme of audit which was shared with the consultants and contracting team.
- The unit valued feedback from patients and carried out a yearly staff survey.
- There was a replacement programme for the dialysis machines, in line with the Renal Association guidelines.
- The organisation had a vision and a set of values. They were displayed in the unit and referred to in staff newsletters.

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

- Staff were aware of their responsibilities to raise concerns, record safety incidents and near misses and report them internally. There was a system in place to report incidents. The policy was available to all staff at the unit. It detailed the procedure for reporting incidents which was based on recommendations from NHS England and the National Patient Safety Agency.
- An incident report document was used to report incidents. Staff had access to the incident reporting template on the organisations intranet. Staff said they knew how to complete the form but added they had not had to use them very often. The completed incident report was emailed to the head of nursing and the immediate actions, mitigating actions and how the incident was graded was reviewed. The head of nursing completed an evaluation, following the review of the incident, within 48 hours and returned the form to the registered manager at the unit.
- An incident log was maintained by the head of nursing. Each incident was discussed at the monthly clinical governance meetings and at monthly clinical conference calls to ensure all actions were appropriate. We saw evidence of discussion around incidents which had taken place at the clinical governance committee. Once the incident had been discussed at the clinical governance meeting it was closed on the log.
- There had been no serious incidents reported at the unit in the 12 months prior to our inspection. Serious incidents are incidents where one or more patients or staff members experience serious injury or harm alleged abuse, or the service provision is threatened.
- Staff received feedback on incidents they had reported, once the incident form had been reviewed by the head of nursing. An overview of all incidents occurring across the organisation was discussed at the monthly manager's teleconference; this was then passed onto the other staff working at the unit via local team meetings and/or email.
- The organisation and individual units showed learning from incidents had occurred. For example, after a number of falls at the haemodialysis unit the weighing scales had been identified as risk areas. Grab rails and call bells had been installed by the scales to reduce the risk of falling and to encourage a patient to call for help if they felt unwell.
- There had been no never events at the unit in the 12 months prior to our 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.
- There had been no duty of candour notifications in the 12 months prior to our 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. In data provided to us prior to the inspection Renal services (UK) Limited stated "In order to promote and uphold the professional Duty of Candour Renal Services employ a Being Open policy, this ensures information is shared with patients in an honest fashion, ensure the

implications or consequences of any untoward incident are explained to the patient and that apologies are given and that remedy or support is offered to make matters right". Staff had an understanding of what duty of candour was and how it was applied.

Mandatory Training

- Staff completed mandatory training annually. Mandatory training included governance, health and safety, infection control, equality and diversity, intermediate life support, hand hygiene, fire safety training and consent. All staff working on the unit were up to date with their mandatory training. A log of mandatory training was maintained centrally for the unit. Staff received an email one month before their training was due to expire, which also contained dates for staff to register for their mandatory training update. Mandatory training was carried out in face to face sessions.
- The unit did not have a policy for the management of sepsis management and but all staff had received training in sepsis recognition and management.

Safeguarding

- There were systems and processes in place to safeguard adults and children from abuse. All staff we spoke with understood their responsibility to report safeguarding incidents and who to report them to. The head of nursing for the organisation was the safeguarding lead and staff were aware of this. The head of nursing was qualified to carry out this role and had completed safeguarding adults level three training.
- Staff told us what they would do if they needed to make a safeguarding referral. They were not able to give any examples of when a safeguarding referral had been made. The unit did not treat children or come into contact with children; however, staff completed safeguarding vulnerable children level one and two. Staff also had access to a policy for vulnerable children which provided information about what to do if they had concerns about a child's welfare.
- Staff were required to attend level two safeguarding adults training. All staff were up to date with their training. Information about this training was held centrally and staff were sent email reminders when their update was due.

Cleanliness, infection control and hygiene

- Staff adhered to infection, prevention and control policies and procedures. There was access to personal protective equipment (gloves and aprons) and handwashing sinks. At each station, both staff and patients had access to antibacterial hand gel. We saw staff using good hand hygiene techniques during our visit. The handwashing audits between January and March 2017 had achieved 100% compliance. However, this dropped to 91.5% in April 2017 as some nurses were observed not to have decontaminated their hands prior to patient contact. Feedback was given to all staff on the unit. The audits were carried out on a monthly basis. The audit for May 2017 was not yet available at the time of the inspection.
- The whole unit appeared clean and was clutter free. External cleaning staff came into the unit on a daily basis and followed a daily cleaning schedule.
- We saw staff wearing personal protective equipment (PPE) when disconnecting patients from their dialysis, this included aprons, gloves and a full face visor. Staff cleaned the visors before and after use with each patient.
- Staff cleaned the dialysis chairs, pillows and dressing trolleys after each use.
- We saw staff using aseptic no touch techniques (ANTT – a standardised approach to aseptic practice that has been shown to support the reduction of healthcare acquired infection) when connecting a disconnecting patients from the haemodialysis machines. This was completed through either the insertion of large bore needles into an arteriovenous fistula/ graft or central line. Arteriovenous fistulas are an abnormal connection or passageway between an artery and a vein created through vascular surgery specifically for haemodialysis. Grafts are artificial veins inserted for haemodialysis, and central lines are larger cannulas that are inserted for long periods for haemodialysis. Aseptic no touch techniques had been reassessed on the unit in the week prior to our inspection.
- Sharps were disposed of correctly and waste was disposed of into the correct bags. They were sealed and labelled when full and awaiting collection.
- We saw staff wearing blue aprons when serving food and drinks. This reduced the risk of cross contamination and was distinct from the aprons worn whilst providing patient clinical care.

- There had been no reported cases of Clostridium difficile (C. diff) or methicillin-resistant Staphylococcus aureus(MRSA) bacteraemia at the unit in the 12 months prior to the inspection.
- MRSA screening was carried out routinely every three months. The patient's consultant received the results and carried out any necessary actions. This ensured patients attending the unit were free from infection and enabled infection prevention and control processes to be safely maintained.
- The unit maintained a decontamination of equipment record to demonstrate compliance with the decontamination policy and procedure.
- The unit had a policy for the disinfection of haemodialysis machines, which outlined specific instructions for the safe decontamination of the equipment used for haemodialysis. The policy outlined a specific cleaning regime for the machines both in use and not in use, in line with the manufacturer's guidelines and recommendations from the Renal Association.
- There were guidelines to ensure holiday makers attending the unit for haemodialysis were screened for blood borne viruses. The requirement for holiday makers attending the unit was that they must be Hepatitis B surface antigen negative. Proof of this was requested four weeks prior to the patient attending the unit. Nurses reviewed the information provided to assess the suitability of the patient for haemodialysis at the unit.
- There were arrangements in place for patients returning from holiday from regions where they were at high risk of infection. Patients were isolated in a single room and had their own machine for use for three months. Patient's blood was taken and reviewed at monthly intervals. If nothing was detected in the bloods after the third month, the patient resumed haemodialysis without isolation.
- Taps had filters on them to help prevent waterborne bacteria getting into the water supply. They were changed once a month and dated to show when the next change was due.
- Each tap was run for five minutes each day to ensure there was no stagnant water in the system that could encourage waterborne bacteria. We saw records that showed the daily water testing had taken place.
- The unit could ask the infection control team, based at the local NHS trust, for advice on infection control including water testing. Staff could not recall an occasion when they had had to do this.

Environment and equipment.

- The environment and equipment met patients' needs. The unit had 12 dialysis stations, including one isolation room with an en-suite toilet. There were toilets available for patient use; they were accessible to wheelchair users. There was a large waiting room.
- Each dialysis station had a reclining chair, dialysis machine, nurse call bell, table, and a television with remote control.
- Resuscitation equipment was available and checked daily, we saw records that confirmed this. All equipment on the trolley was in date.
- Sharps bins were attached to the leg of the trolleys used at each dialysis station. They remained closed throughout the session and were only opened when the nurses were connecting and disconnecting patients. The sharps bins were in good condition and not overfilled.
- Waste bins were not overfilled and were emptied regularly. Full waste bags were stored in the secure dirty utility room whilst awaiting collection.
- There was sufficient space around the dialysis stations to allow for equipment and for staff to be able to manage the patient from either side of the chair. The space did not allow for much privacy; however mobile screens were used to increase privacy if a patient was not well for example. We saw mobile screens in use during our visit.
- The stock room was clean and tidy with shelving to store equipment. Fluids were stored on pallets meaning they were raised off the floor. Staff told us there were adequate supplies to ensure that the service could continue if a weekly stock delivery was delayed.
- All dialysis sets used at the unit were single use and were CE marked (CE marking defines how the equipment met the health, safety and environmental requirements of the European Union). The unit maintained a record of the batch number of all the dialysis components used. Stickers from the haemodialysis sets used for a patient were kept on the patients records to enable them to be traced if necessary.

- The unit staff ordered small consumables, for example disposable gloves and aprons, on a weekly basis and always ensured the unit maintained one or two week's additional supply in case of emergencies, in line with the organisations policy. The unit also had a contingency plan to ensure they held an additional supply of stock over the winter months to ensure there would be no disruption to the service in the event of adverse weather conditions.
- All staff were trained on the equipment in use. Either Renal Services (UK) Limited or external providers provided the training as necessary. The organisation used the same type of equipment in all clinical areas, meaning any staff transferring between units were familiar with the equipment. We saw that equipment training records showed 100% compliance for all staff.
- We saw that there was enough equipment to enable regular servicing and still maintain a full service. All dialysis machines were under manufacturer's warranty and maintained according to guidance. The manufacturers attended the unit at regular intervals to complete routine servicing. All equipment checked was logged with a record sent to the unit manager and head office detailing works completed. Senior managers told us planned preventative maintenance was co-ordinated centrally at the company head office.
- During the inspection, we saw that staff responded to haemodialysis machine alarms within 30 seconds of them sounding. Alarms sounded for a variety of reasons, including sensitivity to patient's movement, blood flow changes and leaks in the filters. Nurses promptly dealt with any problems which arose.
- Staff were aware of the escalation process for the reporting of faulty equipment. The centre had one spare dialysis machine, which was cleaned daily to ensure it would be ready to use in an emergency.
- Equipment was serviced, maintained and tested for electrical safety. Service logs we saw demonstrated this was the case. Servicing and maintenance of equipment, other than the dialysis machines, was provided under a service level agreement with an external company.
- Ultrapure water (water that has been purified to very strict specifications) was used for dialysis to reduce risks to patients. There was a large water treatment room, which was monitored remotely by the manufacturer. This enabled them to identify any issues with supply, effectiveness of treatment or leaks. In addition to the remote monitoring, staff had telephone access to the manufacturers for emergency situations. Medical engineers carried out monthly checks and maintenance of the water plant. Any actions taken were clearly recorded on the visit sheets.
- Nursing staff monitored the water supply and water testing was completed daily and weekly to ensure that water used during dialysis was free from contaminants. This was in line with guidance on monitoring the quality of treated water and dialysis fluid. We saw the record log that recorded the testing and the results. Staff were aware of the processes for obtaining samples, and actions to take if results showed some contaminants. There had been no reported incidents of contamination. We saw that weekly checks covered chlorine levels and hardness of the water as well as any actions taken to rectify any anomalies, such as adding sodium chloride to the water.

Medicine Management

- The unit had systems in place for the safe management of medicines. Patients attending the unit received prescribed medicines required for their haemodialysis treatment only. Ongoing prescribed medicines for other conditions were taken by the patient at home and not administered by nursing staff.
- Medication for the haemodialysis was prescribed by the patient's consultant nephrologist in line with individual patient requirements. Prescriptions were stored in the patient's written record. All six patient records we looked at contained up to date, signed prescriptions
- Medicines were stored in a treatment room, away from the main treatment area. The door was locked and accessed by nursing staff only.
- There were some medicines routinely used during haemodialysis, for example anti-coagulation injections and intravenous fluids. The unit always had ample stock of these items. The unit also had a small stock of regularly used medicines such as erythropoietin – a subcutaneous injection required by renal patients to help with red blood cell production. Controlled drugs (requiring extra security of storage and administration) were not used or available on the unit.
- Nursing staff completed monthly medicine stock level audits when the amount of and expiry dates of medicines were checked. Staff told us stock was also rotated during the monthly stock audit.

- Staff received training on the safe administration of intravenous medications. This was part of the renal competencies booklet which staff completed on joining the unit. Intravenous therapy assessment was commenced around week five, with an assessment of intravenous therapy on week 12.
- Staff ensured the safe administration of medication to patients. We saw two nurses checking the anticoagulant provided was in date and correct for the patient. We also observed the nurses formally identify the patient's date of birth against the anticoagulant prescription prior to administration.
- In the event of a change to a patient's prescription, staff were informed and a new prescription was issued. This usually happened during a patients' clinic appointment with their consultant, held at the unit. This meant staff were able to act on the changes quickly. The consultants let the patients GP know of any changes to their prescription.
- The fridge used to store medicines had daily temperature checks recorded. Whilst there was some detail about the acceptable temperature ranges on the checklist there was no detail about what action staff were to take if the temperature was out of range. When asked staff told us they would call the contractor to request the fridge to be calibrated. Staff were not clear that they would remove the drugs stored in the fridge when the temperature was out of range in case they were no longer effective.

Records

- Patient care records were written and managed in a way which kept patients safe. Patient records were kept on the top of the nurse's station during their session. Although no members of the public had access to the unit, ambulance personnel and an anticoagulation nurse entered the unit and could have had access to patient records. The same could apply to patients coming on and off dialysis. However, when we were on the unit it was rare for a nurse to not be at the desk or in line of sight of it at all times. At the time of our unannounced inspection the patient's records were not seen at the nurse's station.
- Unit staff kept paper records for each patient, which included the most recent dialysis prescriptions, next of kin, GP contact details, clinic letters, medication charts and consent forms. Paper records were kept in a secure drawer overnight and when not in use. All records we reviewed were complete, accurate and legible. The six sets of patient records we reviewed also included a monthly Malnutrition Universal Screening Tool (MUST) assessment, fistula reviews, monthly pressure ulcer assessment (unless indicated more often) for predicting the risk of pressure ulcers, blood results and a monthly review and a list of medications each patient took, that was signed as reviewed monthly by a consultant.
- We saw completed assessment forms in all of the patient records we looked at. The assessment covered physical and social risks, for example, whether the patient lived alone or used a mobility aid. Medical risks were documented for example if the patient had low blood pressure or diabetes.
- Consultants managing patients who attended the unit were able to access the patient's record and blood results via their trust computer system. All nurses were also able to access the patient's full NHS record via this system. A consultant we spoke to told us the computer system at the unit was quite slow to retrieve information from the lead trust's system which meant it was sometimes quicker to ring the laboratory or X-ray to get the most up to date results. When we discussed this with the unit manager they said that the week prior to the inspection the computer had been upgraded and the speed of retrieval of information should now be quicker.
- Patients' records were held both electronically and in paper form. Renal Services (UK) Limited staff had access to the lead trust's electronic records and manually inputted data recorded on each patient's day sheets into the electronic records. This enabled all patient information to be shared with the patients NHS trust who submitted the data to the renal registry.
- We saw that the patient's day sheets detailed dialysis sessions by date and time. This meant that any changes in treatment and any problems that occurred during the session could be identified.
- There was a record of patient details in the 'contact number' folder this ensured staff had quick access to patient's information if a consultant or other health care professional called the unit about a patient. This was available at the nurse's station and was locked away with the rest of the patient's records when the unit closed each evening.
- Staff completed data protection training as part of their induction and annually. Training compliance was 100%.

Assessing and responding to patient risk

- Effective systems were in place to assess and manage patient risks. Nursing staff used comprehensive risk assessments to review patients on a regular basis. We saw that patient records showed weekly risk assessments, which were repeated up to three times a week depending on the findings and the patient's condition. This enabled staff to identify any deterioration or changes in patients' physical condition.
- We saw completed assessment forms in all of the patient records we looked at. The assessment covered physical and social risks, for example, whether the patient lived alone or used a mobility aid. Medical risks were documented for example if the patient had low blood pressure or diabetes.
- Nursing staff completed a full patient assessment to identify their baseline condition on referral to the unit. The assessment included past medical history, falls risk assessment, skin integrity assessment and a visual haemodialysis access assessment. This information was used to plan treatments and any special requirements the patient had when attending the unit.
- Patients were assessed using risk assessment tools based on national guidance and standards. This included falls risk assessments and skin integrity assessments. Patients vascular access was also assessed using a central catheter assessment tool (CCAT) score in line with the lead trust's policy. This assessment looked for initial signs of infection associated with haemodialysis vascular access lines, contained clear guidance and the escalation process for each score. Patient records we looked at contained evidence the assessment had been carried out at each dialysis session.
- Patients had clinical observations recorded prior to commencing their treatment. This included blood pressure, pulse rate, temperature and weight. The nurse reviewed any variances prior to commencing haemodialysis, to ensure the patient was fit for the session. Where necessary the nursing staff consulted with the consultant or a member of their team for clarification. The patient's weight and blood pressure were also measured at the end of each session to ensure they were fit to leave the unit. We saw one patient whose blood pressure dropped at the end of their haemodialysis session. Staff allowed the patient time to feel better and continued to record their observations, including lying and standing blood pressure, until they felt better and their blood pressure had risen.
- Patients' blood pressures were recorded at regular intervals during their haemodialysis. Alarm settings on the haemodialysis machine were adapted to each patient, allowing any variance to the patients' normal readings to be highlighted to nursing staff.
- There was a patient who wanted to finish their dialysis sessions earlier than recommended. Details of their decision were signed and dated and kept in the patient records. Their consultant was aware.
- The organisation provided training on sepsis and its management. Staff were able to describe how they would manage suspected sepsis. The patient's consultant would be contacted and given details of the patient's condition. If sepsis was still suspected the patient would be seen by their consultant at the lead trust or if immediate treatment was required the patient could be admitted to host trust for assessment.
- Patients with conditions such as Hepatitis B were able to be managed on the unit, and the organisations policy said patients were allocated their own machine for the duration of their treatment. Patients with other blood borne viruses were only allocated their own machine if indicated by the referring trust.
- There was no formal assessment of patient's identify prior to being connected to the haemodialysis machines. Staff told us this did not occur because the patients had been attending the unit for a long time and they knew the patients very well. There was no formal guidance on checking the patient's identity prior to setting a patient up on a haemodialysis machine. However, there would be a risk to patient safety, particularly in the summer months when new patients attended the unit for dialysis whilst on holiday or if new bank staff were working on the unit, that a patient could be incorrectly set up on a dialysis machine.
- Following a number of falls in Renal Services (UK) Limited units the head nurse had developed a falls assessment. We saw completed assessments in a number of patient records and although the policy did not describe actions to take if a score was high, meaning a patient was at higher risk of falls, staff were confident about the actions they would take to reduce the risks.

The falls in the units had mostly been attributed to the use of the stand on/wheel on scales. As a result grab rails and call bells had been placed next to the scales to increase patient safety.

- There was an escalation policy for patients who required an immediate review. As the unit was nurse led the default was always to contact the patient's consultant or a member of their team as they had overall responsibility for the patient.
- In an emergency the staff were able to have a patient admitted to the emergency department or medical assessment unit at the host trust in whose grounds the unit was situated. If the patient was fit to travel to the lead trust transport would be arranged to transfer them. There had been no patients transferred from the unit to another health care provider in the 12 months prior to the inspection.

Staffing

- Staffing levels on the unit were based on guidance set out by the Renal Workforce Planning Group 2002 and on the service level agreement with the local trust and commissioning team alongside patient dependency. The unit used a ratio of one registered nurse to three patients during each haemodialysis session.
- The unit employed 5.6 whole time equivalent registered nurses and two health care assistants, as well as having its own bank staff, who were familiar with the unit. The registered manager had been working at the unit for six years and became the registered manager in 2016.
- There were vacancies for 0.4 whole time equivalent trained nurses and 0.2 whole time equivalent health care assistants. Bank renal nurses had been used for 64 shifts in the three months prior to the inspection and no agency staff had been used. Staff told us the bank staff were very familiar with the unit and knew the patients well.
- There was a 2.5% sickness rate for trained nurses and 0.7% for health care assistants. Episodes of sickness were covered by other team members or bank staff.
- The unit ensured ongoing assessment of staff competence in aspects of their role at the dialysis unit.
- Medical support and advice was provided by the two consultant nephrologists managing patients who attended the unit. They were based at the lead trust and held regular clinics at the Renal Services (UK) - Wiltshire dialysis unit. Nurses were able to contact the consultant or a member of their team directly by telephone, or email with any concerns about patients attending the unit.
- If a patient's named consultant was on leave. The unit were able to contact the on call renal consultant at the lead trust or a member of their team. Staff said the consultants were good at informing them when they were on leave and that they then may need to speak to another consultant if there were any issues.

Major incident awareness and training

- There were business continuity plans, policies and procedures available in the event of a power failure or a disruption to the water supply. The policies contained information about the account and contact details of services to inform in the event of an emergency.
- The organisation told us "due to the essential requirement for the supply of water and electricity in order to treat patients, all Renal Services units are on the Critical/Priority List of the local water authority and electricity board. If the supply of water is interrupted, the plant alerts staff. The break tank continues to provide water for dialysis for a further 20 minutes this enables staff to safely discontinue patients' treatment. In the event of power failure, our dialysis machines and chairs have reserve battery packs, which enable us to discontinue patient treatment safely." Staff confirmed they understood the process to follow in the event of water system or power failure.
- The unit had back up equipment to ensure continuity of service, this included having spare machines at the unit in case of equipment failure or breakdown. This ensured patients were able to receive their haemodialysis and treatment would continue as normal in the event of equipment breakdown.
- There was appropriate emergency equipment available on the unit. Staff had received training to safely use the equipment. There was an up to date policy for medical emergencies and cardiac arrest. In the event of a cardiac arrest on the unit the staff called the internal emergency number and the cardiac arrest team from within the host NHS trust responded.

Dialysis Services

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

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

Evidence-based care and treatment

- Current evidence based guidance, best practice and legislation was used to develop how services, care and treatment were delivered. The unit used the Renal Association standards, National Institute for Health and Clinical Excellence (NICE) standards and guidelines set out by the lead trust. For example, each month, patients had their bloods taken. This enabled accurate monitoring of the adequacy and efficiency of haemodialysis treatment as recommended by the Renal Association standards. This enabled any changes to treatment to be made in line with best practice guidelines.
- Most patients weighed themselves before and after their treatment and told their nurse the results. Staff were available to help patients who needed some assistance. We saw that if a nurse had any concern about the accuracy of the patient's weight they would re-weigh the patient to ensure that the correct weight was recorded and used. Nurses took the patients temperature, pulse and blood pressure before and after each treatment. We saw the recordings were documented on the patient records.
- Staff monitored and recorded patients' vascular access using a vascular access chart. Vascular access is the term used for access into a vein, for example, via a dialysis catheter. Recordings detailed the type of access, appearance and details of any concerns. Each category was given a score of zero for no issues and one per issue identified. Any patient scoring one or more were referred immediately to their consultant for review and possible intervention. This was in line with the NICE Quality Statement (QS72) statement 8 (2015): 'Haemodialysis access-monitoring and maintaining vascular access'.
- The policies used by the unit were all based on evidence based and best practice guidelines. Each policy showed where the information had been taken from to develop the policy and what version of the recommendations or guidelines this had been taken from.
- Water testing, disinfection of the water plant and dialysis machines were all carried out in line with best practice guidelines. The unit followed recommendations from the Renal Association and the European Pharmacopoeia Standards for the maintenance of water quality for haemodialysis. The organisation had a service level agreement with a company which tested the water. This company was chosen due to it working in line with the European Pharmacopoeia Standards. The unit's policy for water testing and disinfection of the water plant and machines was in date and also based on evidence based practice.

Pain relief

- Patients' pain was assessed and managed appropriately. Patients did not routinely receive oral analgesia (pain killers) during their dialysis sessions; however, local analgesia was available for cannulating (inserting a needle) the patients' arteriovenous fistula or graft. Needling is the process of inserting wide bore dialysis needles into the fistula or graft, which some patients find painful.
- We saw a patient given medication as they were feeling sick during their dialysis. The nurse kept a close eye on the patient's blood pressure, checked their pain levels and gave them a small amount of water until they felt better.
- We saw the Wong- Baker pain rating scale in use in patient records. This used faces to help patients communicate their level of pain. Episodes of pain were discussed with the patient's consultant to determine ongoing management.
- If patients were using pain medication for other non-related conditions they bought their own medication and took it when required. Staff were aware and documented all medication the patient took. This was also reviewed regularly by their renal consultant to make sure none of the medication was contraindicated for use in patients in renal failure.

Nutrition and hydration

- Patients' hydration and nutritional needs were assessed and managed appropriately by nursing and dietetic staff.
- Patients in renal failure require a strict diet and fluid restriction to maintain a healthy lifestyle. There was access to specialist dietary support and advice during clinic sessions at the unit. Staff could access the dieticians in between clinic appointments for advice and guidance as necessary. Staff reported a good working relationship with the dietetic service based at the lead trust.
- We saw that patients were provided with written information and guidance relating to their diet and fluid management.
- Patients weighed themselves on arrival at each visit. This was to identify the additional fluid weight that needed to be removed during the dialysis session. This varied from patient to patient.
- We saw that patients were offered drinks, toast and biscuits during their haemodialysis sessions. Some patients also bought their own snacks with them.

Patient Outcomes

- The unit collected data, which was submitted, to the UK Renal Registry by the local NHS Trust. This allowed the service to compare treatment outcomes to similar outcomes from other services in England. The service collected data about frequency of treatments, treatment time, blood pressure recordings and blood test results including haemoglobin, phosphate and calcium levels. The service's performance indicators were similar to the country average for all key indicators. For example between January and March 2017 the percentage of patients achieving renal association standards in calcium, phosphate, haemoglobin and urea levels was between 62% and 96%. This was similar to other dialysis units we held information for.
- The unit set key performance indicators based on Renal Association and Renal Services (UK) guidelines and the referring trusts requirements. Each month, all patients had pre and post dialysis bloods taken to monitor dialysis adequacy and efficiency. If the consultant prescribed changes to treatment as a result of the blood tests nursing staff ensured these were implemented where necessary. The Unit Manager collated this data and a variance report was generated which was used to assess the effectiveness and quality of the treatment.
- The unit compiled performance reports that were sent to the organisational chief operating officer and head of nursing for review. The senior management team held information about key performance indicators which was reviewed against set targets, as agreed with the lead NHS trust and included infection control, water testing, mandatory staff training and information about staffing levels. This was shared with commissioners and the lead consultants during governance and quality meetings.
- The unit was benchmarked against other units within the organisation as part of performance monitoring.
- Staff followed evidence-based guidance when carrying out checks before the dialysis treatment. Patients weighed themselves before their treatment commenced. Staff checked patient's vital signs including blood pressure, pulse and temperature before they commenced their dialysis treatment. During treatment, staff checked patients vital signs hourly or more often if there were concerns or identified trends of any abnormality. At the end of the dialysis treatment, patients weighed themselves again and reported their weight to the nurse. This helped staff assess the effectiveness of the dialysis session.
- The majority of haemodialysis treatment started as soon as the patient arrived at the unit. The unit collected data for the UK Renal Registry (clinical database that collects analyses and compiles reports from 71 adult and 13 paediatric renal centres regarding patient arrival at the unit and their treatment start times). Data collected between January and April 2017 demonstrated 100% of patients attending the unit commenced their treatment within 30 minutes of their appointment time.
- The unit had an internal audit schedule which covered hand hygiene, documentation, housekeeping and patient satisfaction for example. As part of the 2016 patient survey 87% of patients rated the helpfulness of staff and being treated with respect and dignity as 'excellent' and 85% of patients rated the environment as 'excellent'.

Competent staff

- Staff had the knowledge and skills required to carry out their role. Staff were enthusiastic and proactive about learning and developing their skills.
- Staff were competent to carry out their role at the haemodialysis unit. The head of nursing had developed

a comprehensive framework, in the form of a booklet, which saw newly appointed nurses taken from being a novice to a competent renal nurse in six months. Some staff needed longer to achieve competence and that was monitored closely to ensure they were developing their skills appropriately. The nurse had to demonstrate and be observed by the registered manager as being competent in a specific area before being 'signed off' as competent. The competencies covered a variety of areas for example drug administration, vascular access, intravenous therapy and water treatment. The booklet set out a clear programme of work. The nurse undertaking the competencies was reviewed by the registered manager of the unit after one week, and after one, two and three months of working at the unit.

- After completing the competencies and working on the unit for 12 months staff were encouraged to undertake an advanced course in Renal Nursing, in conjunction with local universities the organisation had arrangements with. This enabled staff to develop a more detailed insight into renal nursing, developing their knowledge, skills and ability to competently carry out their role at the unit.
- Nurses new to the unit undertook a four week supernumerary induction period prior to commencing their renal competencies. This supernumerary period introduced new members of staff to unit and provided an overview of the concepts and practice associated with haemodialysis.
- Staff had access to appropriate training to meet their needs. The organisation had recently purchased licences to access online E-learning modules in vascular access, fluid balance and aseptic non-touch technique. We saw evidence that staff at the unit had undertaken these courses and had kept copies of the tests which followed the training. The head of nursing also had access to the modules to review the test results of the nurses. This enabled the head of nursing to understand if there were any concerns with the knowledge and ability of the staff to competently carry out their role, and to provide the support required to address any concerns.
- Staff were competent in the use of medication used during dialysis treatment. Nurses completed competencies in drug administration, calculations and intravenous therapy which had to be demonstrated and observed prior to sign off by the registered manager of the unit.
- All staff had training in basic life support. The unit was very close to the cardiac arrest team manager. The manager said they were able to ask them for advice if required.
- Unit managers were supported to ensure they were competent and able to effectively carry out their role as manager. Quarterly manager away days were held for all the managers within the organisation. The days provided an overview of the business and provided training in aspects of their role as manager. For example, October's 2016 meeting provided training about incident reporting and reviewing, whilst February's 2017 training was around clinical and corporate governance.
- All staff had received a performance appraisal within the last year, during which discussions had taken place about performance and career development. Staff were encouraged to set goals to enable career progression and were encouraged to develop in line with the patient and service needs. Appraisals contained learning requirements and actions to achieve these were clearly documented. In addition regular meetings took place to discuss staff personal development plans that supported ongoing training and education.
- Staff were supported with revalidation (a process to renew registration with the Nursing and Midwifery Council (NMC)). The organisations head of nursing supported the nurses with their revalidation and staff were able to send documents for review prior to submission for revalidation. The organisation also reviewed each of the nurses NMC registration and provided a reminder to nurses individually about when they were required to re-register and revalidate.
- The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. DBS checks were carried out at the start of a nurse's employment. There was no set time frame to review these checks. Senior staff said they felt the revalidation process and NMC registration held by each nurse, which required nurses to be open and honest with their employer about any change in their circumstance which might affect their practice, was sufficient mitigation. .

Multidisciplinary working

- The registered manager also described good working relationships with staff and departments within host trust. There was an agreement that patients suspected of sepsis could be admitted to the host trust if it was deemed too far to send them to the lead trust for effective treatment.
- Unit staff described good working relationships with the renal consultants and their teams and the dietetic staff despite them being based at the lead trust. The consultants and dieticians held clinics at the Wiltshire unit and told us they had excellent working relationships with the staff.
- The patients lead consultant was closely involved with patients and was kept up to date with the patient's conditions including their blood results. The staff took blood samples from the patients, that were analysed at the host trust under a service level agreement with the lead trust. The patient's consultant reviewed the patient's blood results and made the necessary changes to an individual patient's treatment to ensure the effectiveness of the treatment. The consultant liaised with the registered manager of the unit about the changes to treatment and this was implemented at the patient's next haemodialysis session.
- Communication with patients GPs was via their consultants who would tell the GP of any changes to the patient's condition or medication.
- Staff described effective working with local community nursing teams when necessary for example if they were concerned about a patient's mobility at home.

Access to information

- All of the information needed to deliver effective care and treatment to patients was available to all staff involved in their care, in a timely manner. The unit staff had access to the most recent clinic letters following a patient's appointment with the consultant. This enabled staff at the unit to keep up to date with the patient, their condition and any other concerns or issues arising from their review with the consultant.
- Patients, who wanted to, had access to their blood results securely on line via the internet. Staff explained blood results to the patients as required.
- Information following patient's three monthly reviews was shared with the unit as the clinics were held in the unit and a nurse from the unit helped in the clinic. If a patient attended a clinic appointment at the lead hospital staff said any changes to a patient's treatment was communicated to them quickly so they could implement the changes at the patients next session.

Equality and human rights

- The service had an Equal Opportunities policy to ensure there was no discrimination towards job applicants or employees, either directly or indirectly on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation. The policy was integrated into the employee handbook and demonstrated how the organisation was committed to ensuring equal opportunities for all and including private contractors working for the organisation.
- The Workforce Race Equality Standard is a requirement for organisations which provide care to NHS patients. This was to ensure employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Workforce Race Equality Standard had 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 Workforce Race Equality Standard 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. Although these reports may be written at corporate level, there should be data about workforce race equality collected and reported at local level. Staff at the unit were not aware of a report relating to the Wiltshire unit.
- The staffing reflected the ethnicity of the patient group and the local population.

Consent, Mental Capacity Act and Deprivation of Liberty

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

raise concerns with the patient's consultant who would take action to address the concern. The lead consultant retained responsibility for overall care and treatment of the patient at all times.

- Patients were not asked for verbal consent to their treatment at each session. Formal signed consent had been gained when the patient first started their treatment at the unit in line with the organisations consent policy. The fact the patients went to their station and started setting it up to suit them implied consent to the process.
- The consent policy, issued in 2008 and reviewed in 2016, did not direct staff to check a patient's identity prior to gaining consent.
- Patients could withdraw consent at any time and this would be escalated to the patient's consultant for discussion. We saw documentation for one patient who chose to end their dialysis sessions early. Potential risks of this were discussed with the patient. It was signed and dated by the patient.
- We observed a nurse asking a patient for consent prior to taking a swab for MRSA testing.
- The registered manager said that patients who lacked capacity or were unpredictable would probably be looked after at the lead trust.

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

- Staff interacted well with patients, they were respectful and discreet.
- Staff protected patient's privacy. Despite the fact that the dialysis stations were quite close together and patients could not leave the station during their session staff maintained patient privacy by using quiet conversation and/or portable screens. We saw screens in use when a patient was not feeling well and needed some personal care.
- All staff were attentive to the patient's needs. They answered call bells promptly.
- We heard staff speaking to patients in a caring way, ensuring they were comfortable and had everything they needed to hand. This was important as a dialysis session usually lasted for four hours.
- Staff had a good rapport with patients who attended the unit. They saw the patients regularly over a long period of time and got to know them really well. This meant there was a relaxed atmosphere between the staff and patients.
- Patients told us staff were caring and supportive. They said there was good communication between the unit staff and consultants and access to the consultants at the clinics held at the unit. They said staff responded quickly to alarms on the haemodialysis machines.
- Comment cards left at the unit prior to the inspection included the following comments: "staff are very pleasant and hardworking", "[staff] are experienced, caring, very friendly and always willing to listen and advise when necessary" and "always found staff friendly and professional. New staff fit in nicely and I never mind coming here. I always feel safe".
- Staff maintained patients comfort with the use of additional pillows, pressure relieving cushions or other aids as required. Some patients bought in their own blankets or comfort items.
- During the inspection we witnessed one patient being given a foot massage by a nurse as the patient was experiencing cramps.
- One patient had a relative who was an inpatient at the host trust. The patient usually dialysed at the lead trust but was enabled to dialyse at the Wiltshire unit, at short notice, so they could spend longer vising their relative.
- The patient satisfaction survey for the unit, conducted in December 2016, showed that 87% of patients felt they were spoken to in a courteous and pleasant manner, the same number rated the staff as 'helpful', 'caring' and as having confidence and trust in the nurses treating them.

Understanding and involvement of patients and those close to them

- Staff ensured patients understood their treatment. They explained what was happening with their treatment and any changes required. Consultant clinics were held at the unit and the nurses also provided staff to support the clinic. The registered manager said this helped staff

to keep up to date with any changes to patient treatment and instigate them quickly. She said it was often an opportunity to meet family members and understand their concerns also.
- Patients and their loved ones were able to look around the unit prior to starting haemodialysis to ensure it would meet their needs. This gave them a chance to meet other patients and ask any questions or discuss concerns.
- Nurses provided ongoing information and advice to ensure patients and their family were able to make informed choices about their ongoing treatment.
- Patients were involved in developing their treatment plans.
- Patients, who wanted to, had access to their own blood results via an online system. This meant they could discuss them with the staff team and the impact the results may have on their treatment.
- One patient, on the unit, was 'self-needling' with a view to starting home dialysis in the near future. Staff supported the patient whilst they learnt about the process and built up their confidence.

Emotional support

- Staff were able to signpost patients and their relatives to support services, for example bereavement support and counselling services, if necessary.
- The registered manager said that if a patient was perceived as needing some extra support such as counselling this would be provided by the host trust via a referral from the patient's consultant.
- Patients told us staff recognised when they needed extra support, for example if they were feeling unwell or needed to talk through experiences.
- There was information about and staff were knowledgeable about the National Kidney Foundation and the Kidney Patients Association who held social events and had support networks that patients and their loved ones could access.
- Staff recognised the impact regular dialysis had on a person and their normal family life. They were able to offer support to patients of all ages and request additional support via their consultant if necessary.

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

- The dialysis service reflected the needs of the population served and provided flexibility and choice for patient care. Patients were able to access the unit six days a week and had the choice of either a morning or afternoon session to receive their treatment. Patients told us how accommodating the unit had been with altering their appointment times at short notice due to other commitments or appointments.
- The annual patient satisfaction survey carried out in December 2016, showed that 27% of patients rated the transport service they received as 'poor', with 7% rating it as excellent. In answer to the question 'on average how many minutes are you collected after your ready time' 40% indicated it was 30 minutes or more. The unit manager said they had spoken with the range of providers of transport for their patients to highlight the issues. Patients had also been encouraged to contact the transport providers themselves or form a transport user group, but at the time of the inspection this had not happened.
- There were four designated, free, parking spaces for those patients able to drive themselves or be driven to sessions.
- Stakeholders and other providers, for example the clinical commissioning group and the host trust, were involved in planning the dialysis service provision, which opened in 2008. They continued to have regular meetings to review and assess the service.
- The Department of Health 2013 Health Building Note: Satellite Dialysis Units had been used to ensure the facilities at the unit were appropriate for the treatment being carried out.

Access and flow

- Patients were assessed for their suitability to attend the unit by their consultant based at the lead trust. Patients with acute kidney disease were treated at the lead trust and chronic, long-term dialysis patients were referred to the unit for treatment.

- When a patient was identified as being suitable to attend the unit, a referral was completed and an assessment visit arranged. Patients attended the unit to have a look around and meet staff and other patients. This gave staff the opportunity to complete the initial risk assessments and collect patient details and consent. Once the patient had agreed to attend the unit the lead trust arranged transport if necessary and ensured medical notes were available.
- Patients could access dialysis care and treatment at a session time to suit them. The patient and their consultant discussed an appropriate time for them. The unit had, up to the time of our inspection been able to accommodate patients' needs in this respect. At the time of our inspection, there was no waiting list for patients requiring haemodialysis at the unit and there was a surplus of capacity at the unit to accommodate any new patients.
- There had been no appointments cancelled or treatments delayed between January 2016 and January 2017.
- The majority of haemodialysis treatment started as soon as the patient arrived at the unit. The unit collected data for the UK Renal Registry (clinical database that collects analyses and compiles reports from 71 adult and 13 paediatric renal centres regarding patient arrival at the unit and their treatment start times. Data collected between January and April 2017 demonstrated 100% of patients attending the unit commenced their treatment within 30 minutes of their appointment time.

Service planning and delivery to meet the needs of individual people

- The unit had a number of toilets that patients could use prior to their dialysis session. They were wheelchair accessible. The side room had an en-suite toilet facility.
- There was access to translation and interpretation services as required. Leaflets and other printed information could be produced in different languages and formats, for example large print, as required.
- Patients who had some cognitive difficulties or a learning disability could be looked after on the unit and could be accompanied by a carer.
- One patient using the unit was hoping to start home dialysis. In preparation for this they had begun to 'self-needle' (insert their own needles prior to being hooked up to the dialysis machine) under supervision of the staff. They said staff had been very encouraging and supportive as in the beginning the patient did not even like needles. Staff told us there would be community support mechanisms put in place to ensure equipment and ongoing supplies were provided to the patient's home. Support from renal nurses would be ongoing and the patient would continue to see their consultant every three months.
- We spoke with a holidaymaker who used the unit twice a year. They said they contacted the unit with the dates they needed haemodialysis and the arrangements were put in place. They had never been refused their preferred dates. The patient bought all their up to date treatment information with them, although he unit had also had this in advance in order to plan for the treatment required. They knew the unit had details of their own consultant and could contact them for advice if necessary.
- One patient using the unit was visiting from abroad and visited the unit each year. They were very happy with the arrangements the unit made with them
- In information provided to us prior to the inspection the organisation stated "we have a dedicated holiday dialysis co-ordinator who liaises with NHS trust holiday coordinators, the patients, consultant nephrologists and the units for treatment bookings. The co-ordinator ensures that all necessary administration arrangements are in place and follow up on any outstanding information prior to the unit being given the go-ahead to treat the patient. The information is requested four weeks prior to the holiday dates and all information is checked by the nursing staff prior to accepting the patients".
- We saw non-verbal communication between staff on a number of occasions during our observation on the unit. For example a patient needed to be weighed and was having some difficulty walking with one nurse. Another nurse noticed this and without being asked got a wheelchair and helped the staff member help the patient to the chair. This maintained the dignity of the patient and was an efficient way of working within the staff group

Learning from complaints and concerns

- People using the service knew how to make a complaint and felt they could raise any concerns with the unit staff. The complaints procedure was made available to all

patients at their first session at the unit inside the patient information pack. There was no information about how to make a complaint displayed within the unit or waiting room.

- The unit had received no complaints in the 12 months prior to our inspection. The unit had received 18 compliments.
- There was a comprehensive complaints procedure that ensured all complaints were handled effectively and confidently. The procedure ensured complainants received an acknowledgement within two working days of receiving a complaint and a full response within 20 working days. The policy also outlined the stages the complaint would go through if a complainant was unhappy with their first response.
- We spoke to one of the two renal consultants who worked with the unit. They said they saw the patients every three months and had not had one concern raised with them about the unit or any of the staff.

Are dialysis services well-led?

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

Leadership and culture of service

- Leaders had the skill, knowledge, experience and capacity to lead effectively. The lead nurse for the unit was a registered nurse with teaching and assessment in clinical practice qualifications and over 10 years' experience in renal nursing. The lead nurse was supported by the regional clinical manager, head of nursing, and quality and regulatory manager. All staff had mentors who provided supervision, management and clinical leadership.
- Managers were responsible for ensuring relevant induction checklists, competency workbooks, targets and objectives were monitored, documented and achieved. We saw evidence of this on our inspection.
- The unit manager attended unit manager/sister 'away days' with the executive team every three months. These were used for sharing, learning and updates on wider organisation issues including governance and recruitment. These meetings were held on Sundays so that all managers could attend. The manager told us these meetings were valuable for information sharing and senior manager support.
- Unit managers, from all units, had a monthly management call. Issues discussed included admissions, infection control, rotas, good news and incidents. We saw that minutes were shared within 24 hours of the meeting. The unit manager had a phone call every day with the head of nursing to discuss any concerns or issues and information from all units was shared during this meeting to ensure that learning was shared quickly.
- Unit managers had a dedicated email address and junior staff had access to a unit email address that they could all access to read latest updates. However there was no audit trail to show that all staff had read each email.
- Leaders were visible, approachable and supportive. Nurses told us that their manager was very supportive, approachable and encouraged a culture where they could raise a concern or issues.
- The senior management team and manager of the unit maintained a strong working relationship with the host trust, to ensure the safety and well-being of the patients attending haemodialysis at the unit. The head of governance and contracts met with the lead consultants and the lead trust quarterly to discuss the service and its performance. The manager of the unit had regular telephone and email contact with the consultants. They told us the consultants were very responsive and that there was an open and honest dialogue. We spoke with one of the two consultants for the unit who told us they had a very good working relationship with the staff on the unit. They said the staff were "good at sorting problems out", "they got in touch when necessary" and "I trust their judgement". They added there had been no complaints about the unit made to them during their consultations with patients.

Vision and strategy for this core service

- There was a clear vision and set of values for the dialysis 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. We saw the vision and values displayed in the clinical area and referred to in staff newsletters.
- Although the staff could not recite the organisational vision they could describe aspects of it. During our inspection nurses spoke of and demonstrated high quality patient care.
- We saw that organisational vision and values were reflected in comprehensive staff appraisals, with comprehensive inductions and ongoing training to keep patients safe.

Governance, risk management and quality measurement (medical care level only)

- There was an effective governance framework to support the delivery of good quality care. The clinical governance lead for the unit was the registered manager supported by the regional clinical manager, head of nursing and the corporate quality and regulatory manager. We saw that there was a regular flow of information from the unit to the senior management team and then onto the Renal Services (UK) Limited board, who had oversight of the whole service. The unit manager provided feedback to staff following monthly manager calls. The chief operating office sat in on the quarterly clinical governance meetings and provided feedback to the board.
- A risk register was held at provider level and maintained by the regulatory and quality manager. We viewed the risk register electronically and saw identified risks which were applicable to all of the renal dialysis units under the management of Renal Services (UK) Ltd. These included recruitment, loss of water supply and other risks, which would prevent business from taking place such as fire or pandemic illness. We saw that mitigating actions to be taken were specific to the Wiltshire unit. The risk register was reviewed by the chief operating officer, the regulatory and quality manager and chief executive each month. The risk register was a standing agenda item on the quarterly senior manager meetings.
- A hard copy of the policy was available on the unit and we saw that staff had signed it to show that they had read it. Staff we spoke to could describe what to do in the event of an incident. Staff told us that the risks on the register aligned with what was on their 'worry list'.
- There was a systematic programme of clinical and internal audit used to monitor quality and identify where actions needed to be taken. The unit had a programme of daily, weekly and monthly audits which were carried out. The audit schedule included daily auditing such as water testing, drugs fridge temperature check and daily cleaning; weekly audits included fire alarms, medication cupboard, and cleaning audits; and monthly audits included water checks, infection control, waste management and staff file audits. We reviewed the results of audits and saw that targets were being achieved; with the exception of April 2017 where hand hygiene fell to 91.5% and cleaning to 96% (both had a target of 100%). We saw that in this case reasons had been identified, including identifying nurses who had not washed their hands prior to patient contact, and that blood was seen on the side of a clinical waste bin. Actions were put in place to reduce the risk of this occurring again.
- There was a comprehensive assurance system to provide the organisation and the lead trust with information regarding patient outcomes and performance at the unit. The unit monitored key performance indicators around patient outcomes and reported these on a monthly basis to the trust. The performance indicators covered infection control, complaints, venous access problems, infection and clinical variances. The performance matrix identified no problems with the unit's performance indicators between January and April 2017.

Public and staff engagement

- Patient's views and experiences were gathered and acted on to shape and improve services. Patients we spoke with told us that they could feedback at any time to staff working on the unit. The main issue for patients was transport to and from the unit, and managers told us that they worked with providers of transport services to improve patients' experiences.
- Patients could also use the comment boxes provided in the reception area to provide feedback on the unit. However, patients we spoke to told us that they would speak to nurses directly if they had any comments or complaints.
- Patients were encouraged to test any new equipment prior to purchase and chose the artwork displayed in the unit.
- Staff understood the importance of raising concerns. Staff told us the senior management team were approachable and supportive and would always

provide feedback about concerns or issues raised with them. Nurses told us that managers were open to new ideas and that they were encouraged to feedback any ideas. For example, nurses raised a risk of patients bleeding or haemorrhaging on the unit, and the company provided staff with advice from the British Renal Society, and provided further training for staff. Staff also raised concerns following a patient fall. A dialysis falls risk assessment for each patient was introduced and rolled out to all other Renal Services (UK) units.

Innovation, improvement and sustainability

- There was a system to ensure the phased replacement of older haemodialysis machines. The organisation had a replacement programme for their haemodialysis machines in line with the Renal Association guidelines. The recommendation for machine replacement was either every 7 years, or after 45,000 hours of use, below the recommended replacement hours of 50,000. An asset register was maintained at head office and the head of contract and governance was informed well in advance of any machines requiring replacement.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must implement a standard operating procedure or policy for staff to access about the management of suspected sepsis

Action the provider SHOULD take to improve

- The provider should ensure there is a procedure available for staff to formally identify patients prior to setting them up on haemodialysis.
- The provider should ensure there is a clear policy about what action staff should take if the drugs fridge temperature was out of range.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not met: {cke_protected_1}· The service did not have a sepsis policy or pathway to ensure patients with potential sepsis were identified and treated in a timely manner. Treating sepsis in patients receiving dialysis may differ from usual management intervention. Regulation 12(2)(a)