Renal Services (UK) Ltd - Launceston

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

Services we do not rate

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

We found the following areas of good practice:

- There were effective systems in place to keep patients safe. The system supported the safe management and reporting of incidents, effective cleaning schedules and maintenance programmes. All staff were aware of their roles and responsibilities in ensuring patient safety.
- There was a clear incident reporting process where staff received feedback from incidents and organisation wide learning from incidents was also recognised and implemented around patient falls.
- The unit had clear processes to ensure regular servicing and maintenance of equipment, and there were policies and procedures to follow in case of a power failure. Staff were aware of their roles and responsibilities to maintain the service in the event of a major incident.
- Evidence based practice and the renal association guidelines were used to develop how care and treatment was delivered. All policies and procedures were based on national guidance and compliance was monitored through an effective audit programme.
- There was a comprehensive training and induction programme in place to ensure staff competency. Training compliance was 100%.
- There was good multidisciplinary working and strong communication links with the lead consultant and the local NHS trust. Staff had access to local NHS patient records computer systems.
- The unit used several different pain scales, which could be adapted to each patient's needs. Patients' pain and nutrition were assessed regularly and patients were referred to specialists for additional support as necessary.
- There were effective processes for gaining informed consent, which was sought and documented prior treatment.
- Patients were treated with dignity, compassion and respect, and staff took the time to interact with patients whilst maintaining their privacy and dignity in all aspects of care.
- The patients spoke very highly of the unit, the staff and the care they received, and said they 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 their quality of life. The service had seasonal adaptations to support holiday patients.
- There was no waiting list for patients to attend the unit. The service was about to start an evening session to accommodate the increase in demand for holidaymakers wanting to access dialysis treatment over the summer months.
- There was a system to monitor and deal with complaints. There had been no complaints at the unit in the year prior to our inspection.
- Leaders had the skills and experience to lead and staff spoke highly of the senior management team who were visible and accessible.

Summary of findings

- There was an effective governance system to support the delivery of good quality care, supported by a systematic programme of audit. This was presented to the local acute NHS trust on a monthly basis.
- There was a replacement programme for the dialysis machines, in line with the renal association guidelines.

However,

- There was no procedure available to ensure all staff formally identified patients prior to setting patients up for their treatment.
- Patient records were not safely stored during the changeover period at the unit to maintain patient confidentiality.
- Not all patient post dialysis checks were completed on the daily monitoring sheet.
- Clinical and non-clinical waste was not stored separately whilst waiting for collection.
- There was no standard operating procedure or policy to identify early recognition or management of sepsis in line with national guidance (NHS England, 2015).

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Edward Baker

Chief Inspector of Hospitals

Overall summary

Renal Services (UK) Limited - Launceston is operated by Renal Services (UK) Limited. The service has six dialysis stations for patients and can operate 18 sessions daily but can operate 18 sessions per day if required. The service is open three days a week and currently operates 36 sessions weekly, for a current caseload of 10 patients. The service also accepts patients for dialysis who holiday in the region.

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

We inspected the dialysis service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 9 May 2017 and an unannounced visit on 19 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.

Summary of findings

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Background to Renal Services (UK) Ltd - Launceston

Renal Services (UK) Limited - Launceston is operated by Renal Services (UK) Limited. The service opened in 2014. It is an independent healthcare unit in Launceston, Cornwall providing haemodialysis services to the communities of Launceston, on behalf of Plymouth Hospitals NHS Trust. The unit also accepts patient referrals from outside this area.

The unit has had a registered manager in post since 2014 and is registered for the regulated activity: treatment of disease disorder and injury.

We inspected Launceston dialysis unit on 10 May 2017 and carried out an unannounced visit on 19 May 2017. There had been no previous inspections at the unit.

Our inspection team

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

Information about Renal Services (UK) Ltd - Launceston

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

- Treatment of disease, disorder and injury.

During the inspection, we visited Launceston dialysis unit. We spoke with five staff including registered nurses, and senior managers and we spoke with 11 patients. During our inspection, we reviewed six sets of patient records.

There were no special reviews or investigations of the service on going by the CQC at any time during the 12 months before this inspection. The service had not previously been inspected.

The unit has a service level agreement with a local acute NHS trust for the provision of outpatient satellite haemodialysis to patients. The unit is nurse led, with clinical supervision provided by a consultant nephrologist from the local acute trust.

Activity (January 2016 to January 2017)

- In the reporting period January 2016 to January 2017, the unit carried out 1697 haemodialysis sessions. This figure also included haemodialysis sessions for holidaymakers in the area.
- The unit provided haemodialysis for both male and female patients. The unit opened three days weekly and carried out 12 haemodialysis sessions daily, two sessions in the morning and two sessions in the afternoon.

The unit employed two full time registered nurses, as well as having its own bank staff, with a consultant nephrologist providing medical support from a local acute trust.

Track record on safety

- No never events
- Four clinical incidents
- No serious injuries

- Zero incidences of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired methicillin-sensitive Staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero complaints

Services provided at the hospital under service level agreement:

Summary of this inspection

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

Services accredited by a national body:

- The clinic is accredited against ISO 9001 quality management system and the OHSAS18001 health and safety system and are therefore subject to regular audit and review.

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?

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 and organisation wide learning from incidents was also recognised and implemented.
- Staff were fully compliant with mandatory training and safeguarding training and there was a reliable system to monitor this.
- Staff demonstrated good practice with infection, prevention and control processes and policies were in place to ensure the use of ultra-pure water during haemodialysis.
- The unit had clear processes to ensure regular servicing and maintenance of equipment.
- There were policies and procedures to follow in case of a power failure or disturbance with the water supply during a dialysis session.
- A falls assessment had been implemented after an increase in patient falls across Renal Services (UK) Limited registered services.

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

- There was no standard operating procedure or policy to identify early recognition or management of sepsis in line with national guidance (NHS England, 2015).
- There was no standard operating procedure or policy to formalise the process of permanent staff bank staff identifying patients.
- There was a risk to patient confidentiality due to the easy accessibility of patient records on the nurses' station during the changeover period.
- Waste was segregated into clinical and non-clinical but closed bags were stored together in a yellow clinical bin.

Are services effective?

Are services effective?

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

We found the following areas of good practice:

Summary of this inspection

- Evidence based practice and the renal association guidelines were used to develop how services care and treatment was delivered.
- There was a comprehensive training programme to ensure new nurses were competent to carry out their role at the haemodialysis unit.
- There was good multidisciplinary working and strong communication links with the lead consultant and the local NHS trust.
- Staff at the unit had access to information about patients, which enabled effective care and treatment, including access to local NHS patient records via computer systems.
- The unit used several different pain scales, which could be adapted to each patient's needs.
- Informed consent was sought and documented prior to commencing 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.
- Staff took the time to interact with patients and patients found staff to be supportive.
- Privacy and dignity was respected in all aspects of care.
- 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?

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.

Summary of this inspection

- There was no waiting list for patients to attend the unit. The service was about to start an evening session to accommodate the increase in demand from holidaymakers wanting to access dialysis treatment over the summer months.
- There was a system to monitor and deal with complaints. There had been no complaints at the unit in the year prior to our inspection.

Are services well-led?

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.
- There was an effective governance system to support the delivery of good quality care.
- There was an effective systematic programme of audit, which was presented to the local acute NHS trust on a monthly basis.
- The unit valued feedback from patients and carried out a yearly patient survey.
- There was a replacement programme for the dialysis machines, in line with the renal association guidelines.

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 policy and system in place to report incidents, which was available to staff at the unit that outlined the procedure for reporting incidents which was based on recommendations from NHS England and the National Patient Safety Agency. Staff were able to provide us with examples of incidents and near misses they would report.
- An electronic incident report template document was used to report incidents. Staff had access to the incident reporting template on the computer intranet and were aware of how to use this. The completed incident report would be emailed to the head of nursing at corporate level 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 manager at the unit. An incident log was maintained by the head of nursing. Each incident was discussed at the quarterly clinical governance meetings, which took place outside of the unit, to ensure all actions supported learning from incidents. We saw evidence of discussion about incidents, which had taken place at the clinical governance committee. The senior management team had oversight of the incidents. All the incidents following actions being taken were discussed at the quarterly clinical governance meeting. Once the incident was discussed at the clinical governance meeting and all of the team were happy with the actions and had identified no further learning, the incident was closed on the log.
- The dialysis unit had reported four, low harm, clinical incidents between January 2016 and January 2017. All of these incidents were falls at the unit, which had been investigated and actions taken to prevent reoccurrence.
- Staff used learning from incidents to drive improvements at the unit. Following the falls at the haemodialysis unit, changes had been made to reduce the risk of patients falling. Special tape had been stuck around the edge of the weighing scales to help identify the edge of the scales for patients attending the unit. A handrail had been placed on the wall for patients to hold onto when using the scales and a large sign had been put up in front of the scales to remind patients to push the bell for assistance with getting on and off the scales if required.
- There had been no serious incidents reported at the unit between January 2016 and January 2017. 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. There were two nurses working at the unit. Once the incident form had been reviewed by the head of nursing, feedback was provided and returned to the unit. The unit manager would feed back to the second nurse. An overview of all incidents occurring service wide would also be discussed at the monthly manager's teleconference, which was then passed onto the second nurse working at the unit.

- There was evidence of service wide learning from incidents to drive improvements in practice. Following the falls at the Launceston renal unit and a trend of falls occurring at other units managed by the provider, a falls policy and assessment was introduced to ensure the safety of patients. We saw completed assessment forms in all six of the patient records we looked at. The assessment covered physical and social risks such as whether the patient lived alone or used a mobility aid, as well as medical risk for example if the patient had low blood pressure. Staff told us each risk factor scored a point and any actions taken to minimise risks identified had to be recorded in the patient's notes. We saw one set of records for a patient with low blood pressure, and staff had recorded that the patient was to start their dialysis with their legs elevated to help minimise any further drops in blood pressure during the treatment. The staff did have access to one prescribed bag of fluid which they used for priming and which could be used in the event of a drop in blood pressure. This was documented on the medicine chart.
- There had been no never events at the Launceston renal unit between January 2016 and January 2017. Never events are serious patient safety incidents, which have the potential to cause serious patient harm or death and should not happen if healthcare providers follow national guidance on how to prevent them.
- The unit reported on performance measures and clinical variance. The unit monitored risk and performance through their monthly clinical variance report. Clinical variances were not incidents, but aspects of care and treatment, which could be controlled by the nurses at the unit, for example poor line flow, hypotension (low blood pressure) and short sessions. Between February and April 2017, there had been eight episodes of clinical variance managed by the unit during a haemodialysis treatment. Three were due to target weight, three issues with hypotension and two short sessions. After each haemodialysis session, the manager completed the clinical variance form and sent this to the head of nursing. The clinical variance forms contained the clinical issue and the mitigating actions put in place by the nurses of the unit to mitigate the risk to the patient. These were reviewed by the head of nursing to ensure actions had been dealt with appropriately then sent back to the unit with feedback. This ensured the nurses had mitigated all risks and actions taken to ensure patients received the most effective treatment. The unit manager would feed back to the second nurse. Performance and outcomes for the unit and Renal UK wide would also be discussed at the monthly manager's teleconference, which was then passed onto the second nurse working at the unit.
- The unit received and acted upon relevant safety alerts from the Medicines and Healthcare Products Regulatory Agency. Information was sent to the unit via email from the quality manager. If an alert was relevant to the Launceston unit, the manager would email the quality manager to identify their actions and how they had implemented any changes at the unit.
- Staff demonstrated an understanding of their duty of candour responsibilities. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. There was a Renal Services (UK) policy relating to duty of candour, which outlined actions to be taken when something went wrong. All staff had completed training in duty of candour and the steps to follow when something goes wrong. Staff were aware of the thresholds for when the duty of candour process was triggered.

Cleanliness, infection control and hygiene

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

to two handwashing sinks. At each station, both staff and patients had access to antibacterial hand gel. The handwashing audits between January and April 2017 had all achieved 100% compliance.

- The premises were visibly clean, tidy and free from clutter, and there was sufficient space for staff to access patients from both sides of their chair.
- The flooring in the unit was in good condition and visibly clean. It was made of a hardwearing material and extended six inches up the wall, which allowed for effective cleaning and decontamination.
- The reclining chairs in the clinic were of a wipe clean material. They were visibly clean and in good condition at the time of our inspection. We observed the nurses cleaning the chairs with disinfectant wipes before and after the haemodialysis session, and we saw this was recorded on the daily cleaning rotas, which were all completed and up to date.
- The unit had provision in place for the decontamination of equipment and maintained a record to demonstrate compliance. 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 procedures to assess patients as carriers of blood borne viruses such as methicillin-resistant Staphylococcus aureus (MRSA). The unit had protocols available in regard to infection control practice for monitoring MRSA. Swabs for MRSA were taken from each patient using the unit every three months for analysis. The consultant received the results and carried out any actions necessary following the results of the test. This ensured patients attending the unit were free from infection and enabled infection prevention and control process to be adequately maintained.
- There had been no reported cases of Clostridium difficile (C.diff) or MRSA bacteraemia at the unit for the year prior to our inspection.
- There were guidelines to ensure patients attending the unit for holiday haemodialysis were screened for blood borne viruses. The unit's requirement for haemodialysis patients attending the unit whilst on holiday stated patients must be Hepatitis B surface antigen negative. Proof of this was requested four weeks prior to the patient attending the unit. Nurses would review the information provided to ensure suitability of the patient to receive haemodialysis at the unit.
- There were arrangements in place for patients returning from holiday from regions where patients were at high risk of infection. Patients would be isolated in a room and have their own machine for use for three months. Patient's blood would be taken and reviewed at monthly intervals. If nothing was detected in the bloods after the third month, the patient was then able to resume haemodialysis without isolation. This process had never been required at the unit in Launceston.
- Unit staff liaised directly with the infection prevention and control lead at the local acute NHS trust, who was contracted to provide infection prevention and control advice if required for the unit.
- Staff received training in aseptic non-touch technique for the management of haemodialysis vascular access. Staff at the unit had completed competencies in the use of the aseptic non touch technique and the management of vascular access and held their certificates in their staff files to demonstrate compliance.
- Staff used recommended aseptic techniques to attach patients to their dialysis machines. This was completed through either the insertion of large bore needles into an arteriovenous fistula/ graft or central line. Arteriovenous fistulas are an abnormal connection or passageway between an artery and a vein created through vascular surgery specifically for haemodialysis. Grafts are artificial veins inserted for haemodialysis, and central lines are larger cannulas that are inserted for long periods for haemodialysis.
- The unit had a policy to ensure ultra-pure water. The guidelines for water testing and disinfection of the

water plant were available to staff at the unit. The policy identified the daily, monthly and quarterly tests, which had to be carried out, as recommended by the renal association.

- Water used for dialysis was specially treated to reduce the risk of contamination in 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 emergencies.
- 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 the 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. A medical engineering firm carried out monthly checks and maintenance and any actions taken were clearly recorded on the visit sheets. In the event that a daily result showed a large anomaly, staff said they would contact the manufacturer for an urgent review.
- Staff also completed daily tap flushing to ensure water used for handwashing was free from contaminants and bacteria. These checks formed part of the daily cleaning tasks, and records we looked at confirmed this was consistently carried out.

Environment and equipment

- The Department of Health 2013 Health Building Note: Satellite Dialysis Unit had been used to ensure the facilities at the unit were optimised for the treatment being carried out.
- The environment and equipment met patients' needs. The centre provided six dialysis stations, including one isolation room. Dialysis stations were separated into bays of three and two; with a central nurse's station. Each bay had one hand-washing sink.
- Each dialysis station had a reclining chair, dialysis machine, nurse call bell, table, and television with remote control. This provided patients with their own individual environment and direct access to the nurses on duty at the unit.
- The unit had emergency equipment in case of medical emergencies and in accordance with national guidance (Resuscitation Council, 2015). This included automated defibrillators, which staff were trained to use. All staff were trained in basic life support and the medical emergency policy at the unit outlined what to do in the event of and an emergency. The resuscitation trolley was checked daily by staff and was found to be safe to use and records we saw were complete and up to date. The resuscitation trolley was stored in the main treatment area.
- Sharps bins were stored in line with the National Institute of Health and Care Excellence guidelines, Healthcare Associated Infections: Prevention and Control in Primary and Community Care (CG139). Sharps bins were attached to the leg of the table situated at each station. The sharps bins remained temporarily 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 was not always managed correctly and we saw closed clinical and non-clinical waste bags stored in a clinical waste bin. Bins were not overfilled and were emptied regularly. We were told that full waste bags were stored in the secure dirty utility room whilst awaiting collection.
- The stock room appeared clean and tidy with shelving for all equipment. Fluids were stored on pallets meaning they were raised off the floor. Stock was delivered weekly and staff told us there were adequate supplies to ensure that the service could continue if a weekly stock delivery was delayed.
- We saw that the ambient temperature of the treatment room was recorded daily, and there had been no incidents where the temperature had been outside the recommended range.
- All dialysis sets used at the unit were single set use and were CE marked (CE marking defines how the equipment met the health, safety and environmental

requirements of the European Union). The unit maintained a record of the batch number of all the dialysis components used, on the medicine sheet, in accordance with local quality systems. All single use equipment was labelled accordingly, and disposed of after use.

- The unit had a contingency plan to ensure they held enough consumables at the unit to enable continuity of the service for patients, if they were unable to obtain the necessary equipment required for haemodialysis. The unit manager ordered small consumables on a weekly basis and always ensured the unit maintained one or two week's additional supply in case of emergencies, in line with company policy. The unit also had a contingency plan to ensure they held an additional supply of stock over the winter months. Between November and February, the unit would maintain an additional month's supply of equipment, to ensure there would be no disruption to the service in the event of adverse weather conditions.
- All staff were trained to use specific dialysis machines and medical equipment. Either Renal Services (UK) Limited or external providers provided this as necessary. The organisation used the same type of equipment in all clinical areas, so staff transferring between units would be familiar with the equipment. We saw that equipment-training records showed 100% compliance for all staff. The competency booklet also contained a section on training and management of the machines in use at the unit. This ensured all staff were competent and could use the machines and equipment provided at the unit to keep patients safe.
- We saw that there was adequate equipment to enable regular servicing and maintain a full service. All dialysis machines were under manufacturer's warranty and maintained according to guidance. The manufacturers attended the centre at regular intervals to complete routine servicing. All equipment checked was logged with a record sent to the centre 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 dialysis machine alarms were responded to within a few seconds. Alarms would sound for a variety of reasons, including sensitivity to patient's movement, blood flow changes and any leaks in the filters. Nurses attended all alarms promptly and dealt with any problems which arose. No patients attending the unit cancelled their own alarms.
- Staff were aware of the escalation process for the reporting of faulty equipment to ensure patients did not experience delays or sessions were cancelled. The centre had one spare dialysis machine, which was cleaned daily to ensure it would be fit to use in an emergency. The unit had service level agreements with companies to service and maintain the equipment at the unit. If a piece of equipment was not working, the company would replace the equipment immediately so the unit was able to continue to haemodialysis treatment safely, with no disruption to the service.
- Equipment was serviced, maintained and tested for electrical safety. All electrical equipment we saw during our inspection was serviced yearly and service logs demonstrated this was the case. Servicing and maintenance of equipment, other than the dialysis machines, was provided under a service level agreement with a local company.
- The layout of the unit supported staff to maintain the safety and privacy of the patients receiving dialysis. The unit did not have curtains around each station, but had privacy screens that were used when required. There was sufficient space around the dialysis chairs to enable staff to gain rapid access in case of an emergency. This was in proportion to the size of the unit and only two nurses would attend any patient in the event of an emergency.
- The layout of the unit ensure all stations were visible to nurses at all times, as recommended in the Health Building Note: 07-01. Staff were able to see all of the patients throughout their dialysis session. We also observed staff regularly visiting patients at their station to carry out physiological observations, check on the patient and to provide refreshments.
- 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 worked 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.

- 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 40,000 hours of use. The machines at Launceston were three years into their life cycle. An asset register was maintained at head office and the head of contract and governance would be informed well in advance of any machines requiring replacement.

Medicines

- The unit had processes in place for the safe management of medicines. Patients attending would receive prescribed medicines for their dialysis or continuing treatment only. Ongoing oral medicines were taken by the patient at home and not administered by nursing staff.
- Medicines were stored in a clean utility room, away from the main treatment area. This was secured with a keypad access door.
- There were a small number of medicines routinely used during haemodialysis, for example anti-coagulation and intravenous fluids. The centre also had a small stock of regular 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 site.
- Nursing staff completed monthly medicine stock level audits when the amount of and expiry dates of medicines were checked. We saw a nurse checking the weekly delivery, recording numbers of and batches of the medicines delivered and completing stock rotation. Staff told us stock was also rotated during the monthly stock audit.
- The unit had a service level agreement with the local acute NHS trust for the supply of haemodialysis specific medicine for patients attending the unit. Medicine was prescribed by the local consultant nephrologist, in line with individual patient requirements. Original prescriptions were stored in the patient written record. All six patient records we looked at contained up to date, signed original prescriptions.
- Staff ensured the safe administration of intravenous medicine to patients in line with guidance from the Nursing and Midwifery Council (NMC, 2015). We observed 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 prior to administration. Staff also recorded the batch number of medicines used recorded on the patients day sheet. Therefore, if a medicines alert was issued about a particular medicine, staff would know if a patient had taken this particular batch of medicine.
- Safe prescribing and review of medicines was undertaken for patients on haemodialysis by the patients lead consultant at the local NHS trust during the patient's quarterly follow-up appointment. The unit had access to a renal pharmacist as part of the contract with the local NHS trust, but senior staff told us they had regular email contact with the consultant and could raise any medicine queries directly with them. We saw that prescription charts were clearly written, showed no gaps or omissions and were reviewed regularly. In the event of a change to a patient's prescription, staff told us they were informed by email, and the revised signed prescription was sent to the unit.
- Medicines that were temperature sensitive were monitored closely. We saw that the minimum and maximum fridge temperatures were recorded daily, and had been maintained within the recommended parameters. However, the record sheet did not have an escalation process outlined. We spoke with staff who told us that changes in temperature would be escalated to the nurse in charge who would discuss the medicines with the pharmacist to determine if they could still be used.

- The unit did not liaise directly with the patients GP. Any communication with the patients GP regarding medicine or dietary changes were communicated via the lead consultant for the patient at the unit.

Records

- Patient care records were written and managed in a way that kept patients safe. However, the storage of patient records during the changeover period allowed easy access to patient records. This created a risk in which patient confidentiality may not always be maintained. We saw a driver enter the unit at the end of the morning dialysis session. The driver was known to the nurses and sat behind the nurse's station where all of the patient records were kept out on the desk.
- Consultants managing patients who attended the unit were able to access the patient's record and blood results via the local NHS trust computer system. All nurses were also able to access the patient's full NHS record via this system.
- Patients' records were held both electronically and in paper format. Renal Services (UK) staff had access to the local NHS trust electronic records and manually inputted data recorded on day sheets for each patient's dialysis session into their records. This enabled all patient information to be shared with the local NHS trust who submitted the data to the renal registry.
- We saw that the day sheets detailed dialysis sessions by date, time and the number of the machine used during the session. This meant that any changes in treatment, any problems occurring during the session and any treatment changes could be identified.
- The unit kept paper records for each patient, which included the most recent dialysis prescriptions, next of kin and GP contact details, risk assessments, clinic letters, medicine charts and patient consent forms. Paper records were stored in clear files and were kept in a secure drawer overnight and when not in use. All six sets we looked at were completed legibly and accurately.
- Staff at the unit were able to access patient's NHS clinic letters. All clinic letters following patient's appointments with their consultant were electronically stored on the local trust's central renal database, which was accessed by staff from the dialysis unit. Information such as blood results, medicine lists, recent clinic letters, multi-disciplinary planning and all demographic and identity information was also held on this system. This ensured staff had access to the most up to date information about the patient, necessary to provide safe care and treatment.
- Staff completed data protection training as part of their induction and annually. Training compliance was 100% at the time of our inspection.
- There was no formal audit of the day sheet documentation at the unit. The day sheets were inputted electronically after each session where we were told issues could be picked up in a timely manner.

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 a minimum of 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.
- Nursing staff completed a full patient assessment based on the activities of daily living to identify the patient baseline condition on referral to the centre. The assessment included past medical history, falls risk assessment, skin integrity assessment and a visual haemodialysis access assessment. This information was used to plan treatments and attendance at the centre.
- Patients had clinical observations recorded prior to commencing treatment. This included blood pressure, pulse rate and temperature. The nurse reviewed any variances prior to commencing haemodialysis, to ensure the patient was fit for the session. Where necessary the nursing staff consulted with the consultant or on call renal registrar for clarification.
- 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. We saw a patient with low blood pressure prior to their treatment, and nurses explained they altered the machines blood pressure reading interval to 30 minutes instead of 60 minutes to help monitor the patient's blood pressure.

- Nursing staff recorded patients' observations and details of any incidents relating to haemodialysis on the patient's day sheet at the beginning and end of haemodialysis' sessions. This information was later entered into the patient's electronic NHS records.
- Patients were monitored throughout their haemodialysis session and staff recorded an assessment of patients pre and post haemodialysis to ensure patients did not suffer an adverse effect both during and after haemodialysis which may impact upon their safety. However, the service did not use an early warning system to alert staff to a patient who was deteriorating. This however, was not unusual when compared to similar services. Nurses recorded a patient's weight, temperature, blood glucose levels and blood pressure prior to dialysis. Blood pressure was monitored hourly for each patient during the dialysis session and again at the end of the session along with the patient's weight. The patient's day sheet also required the patient's temperature post haemodialysis. However for six patients, out of the 11 individual patient day sheets we observed, the post dialysis temperature had not been recorded.
- Staff told us they used the patient's hourly observations to indicate if a patient was deteriorating. In the event of a medical emergency, staff described how they would administer oxygen, in line with company policy, and call 999 to transfer the patient to an acute NHS facility.
- Staff explained that the biggest risk to patients during their dialysis was dropping blood pressure. We saw staff respond to a patient's alarm by elevating the patients legs and reducing the amount of fluid being taken off to the lowest amount possible for a 10 minute break to help the patient's blood pressure rise. In another case, we saw that the patient's blood pressure was too low prior to the start of the dialysis treatment, so the nurse elevated the patient's legs and re-measured their blood pressure.
- Staff were familiar with the actions they took if they suspected a patient had sepsis. However, there were no policies or standard operating procedures at the unit which made direct reference to the management of sepsis in line with national guidance (NHS England, 2015).The unit did not use the sepsis six pathway (the name given to a bundle of medical therapies designed to reduce the mortality of patients withsepsis). This was due to the nature the haemodialysis unit, its small capacity and not having the ability to carry out of the recommended medical therapies of the sepsis six. However, staff had recently received training around sepsis training relevant to delivering dialysis in a satellite unit and were able to discuss what they would do if they suspected a patient had sepsis.
- Patients with conditions such as Hepatitis B were managed at the centre, and company policy showed they were allocated their own machine for the duration of their treatment. Patients with other blood borne viruses such as HIV were only allocated their own machine if indicated by the referring trust.
- There was no formal assessment of a patient's identity prior to being connected to the haemodialysis machines. Staff told us this did not occur because the unit was very small, the patients had been attending the unit for a long time and there were only two permanent nurses working at the unit. However, new holiday patients attended the unit, particularly over the summer months. All patients were formally identified at their first session and the information was cross-referenced with the information sent to the unit by the referring local NHS acute trust. We were told bank staff would always formally identify patients and they would also have a handover when working at the unit and would always be working with a permanent member of staff. There was no formal written guidance for staff to state they must always formally identify a patient prior to treatment. We recognised that most patients were well known to the clinic team but with the use of bank staff or holiday patients, a system to identify that the right patient was being administered medicines or commencing dialysis treatment and care would provide a better level of assurance to prevent incident or harm.

Safeguarding

- There were systems and processes reflecting relevant safeguarding legislation to safeguard adults and children from abuse. All staff we spoke with understood their responsibility to report safeguarding incidents. The head of nursing for the service 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. At the time of our inspection, staff at the unit had not needed to make a safeguarding referral. The unit did not treat children or come into contact with children. However staff had access to a policy for vulnerable children which provided information about what to do if they had concerns about a child's welfare. Staff at the unit also completed level two safeguarding children training.
- The organisation required staff to attend safeguarding adults training. Both nurses working at the unit had completed level two adult safeguarding and this training was in date. Information about this training was held centrally and staff were sent email reminders when their update was due.

Mandatory training

- Staff completed mandatory training in the safety systems, processes and practices annually. Mandatory training included governance, health and safety, infection control, equality and diversity, intermediate life support, hand hygiene, fire training and consent. All staff at 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, which the staff felt was useful, and of good quality.
- Basic life support training was undertaken each year to give staff the skills and confidence to deal with emergencies at the unit. Staff at the unit were up to date with this training. The unit also had a medical emergency/cardiac arrest policy which staff were familiar with and had access to a paper copy at the unity in case of emergencies.

Nursing staffing

- The unit based it's staffing levels on guidance set out by the Renal Workforce Planning Group 2002 and on the service level agreement with the local trust and on patient dependency. The unit used a ratio of one registered nurse to three patients during each haemodialysis session. At the time of our inspection, there were no vacancies for registered nurses at the unit. One of the nurses at had recently joined the unit in December 2016 and at the time of the inspection was currently working through the competencies set out by the company to ensure full knowledge, understanding and ability to carry out the role of the nurse at the dialysis unit.
- There had been no staff sickness recorded in the last three months at the haemodialysis unit.
- The unit had a plan to cover for sickness and annual leave. In the last three months, eight shifts had been covered by a bank nurse. The unit had two renal trained bank nurses which could work at the unit at manager level. Bank staff completed a comprehensive induction on their first shift. This included orientation to the unit. Bank staff completed their first shift as a supernumerary (present in excess of the normal number of staff required)Assessments to ensure their competence in all aspects of their role at the unit were carried out centrally, using specific checklists, prior to carrying out their first unsupervised shift.
- The manager at the unit had a qualification in advanced renal nursing. All staff working at the unit for over 12 months were encouraged to attended an advanced renal course, provided by 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.
- Medical support and advice was provided by the consultant nephrologist managing patients who attended the unit, who was based at the local acute trust. Nurses were able to contact the consultant directly by telephone, or email with any concerns about patients attending the unit.
- There was a contingency plan in place in the event of absence of the patient's named consultant. The unit were able to contact the on call renal consultant at the

local NHS trust or the renal registrars. The manager told us the named consultant always told the unit when they would be away and provided the name and contact details of alternative contacts in their absence.

Major incident awareness and training

- Emergency equipment was available at the unit and staff had received training to safely use the equipment. The unit had an in date policy for medical emergencies and cardiac arrests that provided information for staff about how to manage these incidents. Staff were also able to tell us what they would do in the event of an emergency situation at the unit.
- There were business continuity plans, policies and procedures available in the event of a power failure or a disturbance to the water supply to enable staff to manage major incidents to ensure patient safety. Due to the essential requirement for the supply of water and electricity in order to treat patients, the unit was in the critical/priority list of the local water authority and electricity board. The unit had an emergency tank of water providing staff with 20 minutes to safely disconnect patients from the haemodialysis machine. There was also a reserve battery pack on the haemodialysis machines which provided staff with time to safely disconnect patients from the machines, in case of a power failure. The policy had a clear section with instructions for staff in the event of an incident specifically at the Launceston unit. The policy also contained information about the account and contact details of services to inform in the event of an emergency.
- The unit had back up equipment to ensure continuity of service, and held a 20% redundancy of 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.

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 Care Excellence standards and guidelines set out by the local acute NHS trust. For example, each month, all patients had their bloods taken. This enabled accurate monitoring of the adequacy and efficiency of haemodialysis treatment as set out by the renal association standards. This enabled any changes to treatment to be made in line with best practice guidelines.
- Patients were assessed using risk assessment tools based on national guidelines and standards. This included falls risk assessments and skin integrity assessments using the Waterlow score. Patients' vascular access was also assessed using a central catheter assessment tool score in line with the local NHS trust policy. This assessment looked for initial signs of infection associated with haemodialysis vascular access lines and contained clear guidance and escalation for each score. All six patient records we looked at contained evidence of this for each dialysis session recorded.
- Patients care needs were assessed and their care planned and delivered in line with evidence based guidance, which was monitored to ensure compliance. The haemodialysis service was commissioned by the local acute NHS trust. The unit collected and provided a performance matrix to the trust, to demonstrate the unit's performance, outcomes and the quality of the service which was provided. Data was collected at the unit on a daily, weekly and monthly basis. A quarterly meeting was held with the local acute NHS trust to monitor the effectiveness, quality of the treatment and any variances within the data collected at the unit.

- Staff at the unit followed National Institute of Health and Care Excellence Quality Statement (QS72) statements 8 (2015):'Haemodialysis access – monitoring and maintaining vascular access.' Staff monitored and recorded patients' vascular access on their individual day sheet. Documentation of concerns following the visual assessment of vascular access was documented in the patient's record and the lead consultant at the local NHS acute trust would be contacted to discuss the concerns further. Nurses at the unit were also aware of the vascular access chart. Vascular access is the term used for access into a vein, for example, 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 the local NHS trust for review and possible intervention. The unit used the document produced by the local NHS acute trust, which could be accesses electronically. The staff could only recall one episode where they had been required to complete the form and discuss directly with the lead consultant.
- Patients were predominantly dialysed through arteriovenous fistulas. We saw that some patients had less established fistulas and were told that more experienced staff were responsible for cannulating these patients. This was in line with the National Institute of Health and Care Excellence Quality Statement (QS72) statement 4 (2015): 'Dialysis access and preparation'.
- The unit did not facilitate peritoneal dialysis (which 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).
- The policies used by the unit were all based on evidence based and best practice guidelines. Each policy available at the unit demonstrated where the information had been taken from to develop the policy and what version of the recommendations or guidelines this had been taken from.

Pain relief

- Patients' pain was assessed and managed effectively. Patients did not routinely receive oral analgesia (painkillers) during their dialysis sessions. However, local analgesia was available for needling the patients' arteriovenous fistula or graft and would be administered as part of their prescription. Needling is the process of inserting wide bore dialysis needles into the arteriovenous fistula or graft, which some patients' found painful when undergoing haemodialysis.
- All patients were assessed using a pain scale of 1-10 or a Wong-Baker smile chart to help them communicate the levels of pain they were experiencing. All six patient records we looked at had completed pain assessment scores. Any issues identified with pain were discussed initially with the nursing staff who escalated concerns to the consultant.

Nutrition and hydration

- Patients' hydration and nutritional needs were assessed and managed effectively.
- Patients in renal failure require a strict diet and fluid restriction to maintain a healthy lifestyle. Patients and staff at the unit had access to specialist dietary support and advice from the local acute NHS trust linked with the unit. The manager raised any concerns with the lead consultant for the patient who then made a referral, if required, to the dietetics team in the acute hospital to ensure the patient received treatment and advice to effectively manage their condition.
- We saw that patients were provided with written information and guidance relating to their diet and fluid management.
- Patients were weighed on arrival to the unit at each visit. This was to identify the additional fluid weight that needed to be removed during the dialysis session. This varied from patient to patient.
- Some patients were observed weighing themselves prior to dialysis, and gave this information to the nurse who recorded it on the day sheet. Nursing staff told us that all patients were encouraged to participate in their treatment to different levels.
- Patients had access to food and drinks whilst undergoing their treatment. The nurses provided

patients with tea and biscuits during their haemodialysis session. Some patients also chose to bring their own food into the unit to eat during their session.

Patient outcomes

- The centre did not directly contribute data to the UK Renal Registry, as the centre's data was uploaded to the national database from the local NHS trust. The Renal Registry is part of the renal association who collected, analysed and reported on data from renal centres in the UK, as mandated by the NHS National Service Specification. The registry also provided access to a clinical database, which could be used in renal research. The registry provided an annual report for the unit detailing the quality of care and treatment provided for patients by the unit. Comparisons could be made with other haemodialysis units to compare performance.
- Patients were monitored in accordance with best practice guidelines and the renal association Haemodialysis Guidelines (2009), for example, guideline 6.2: monthly monitoring of biochemical and haematological parameter (blood tests)'. The unit monitored patient outcomes on a monthly basis. These outcomes consisted of blood results, vital signs, target weights and nutritional status. The unit demonstrated clinical outcomes were above the national average compared to other Renal Services UK units in the UK between January and November 2016.
- The unit monitored key performance indicators centred around patient outcomes and reported these on a monthly basis to the local acute trust. The performance indicators covered infection control, complaints, vascular access problems, infection and clinical variances. The performance matrix identified no problems with the unit's performance indicators between January and April 2017. All audits, for example, hand hygiene and health and safety audits were 100% compliant. There had been no incidences of vascular access infections or infection at the unit.
- There were processes for continuous assessment of a patient's vascular access. Each patient at the unit had a photograph taken of their fistula on starting their treatment at the unit. This provided the nurses with a baseline. Photographs were stored in a file on the computer, which required a log in and password to access the files. Nurses would visually monitor the fistula at each dialysis session and if they were concerned, would refer to the baseline photograph to make a comparison. One nurse told us how they had identified a problem with a patient's fistula and had contacted the patient's consultant at the local acute NHS trust. The original baseline picture and a new picture of the fistula were sent to the doctor to review. Following this, the doctor took action to address the concern raised. Patients went to the local acute trust to have their fistula monitored by a specialist electronic machine, as directed by the lead consultant as required.
- One patient outcome captured looked at the effectiveness of haemodialysis treatment and how much waste product was removed from the patient's body. The urea reduction ratio is one measure of how effectively a dialysis treatment removed waste products from the body and is commonly expressed as a percentage. The renal association standards recommend patients achieve a urea reduction ration of >65%. The national target was 75% of patients and above should be achieving the urea reduction ratio of >65%. The Launceston unit had seen 95% of patients in January, 92% of patients in February and 100% of patients in March and April 2017 achieved a urea reduction ration of >65%. This was better than the national target and demonstrated patients had received an effective haemodialysis treatment. The unit did not measure the patient outcome Kt/V, a further measure to capture the effectiveness of the haemodialysis treatment and how much waste product was removed from the body during treatment. The rate the blood passes through the haemodialyser over time, related to the volume of water in the patient's body is expressed at Kt/V.

Competent staff

- Staff had the knowledge and skills required to carry out their role and were 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 six month framework which saw a newly appointed nurse at the unit taken from being a novice to a competent renal nurse.

Nurses new to the unit undertook a four week supernumerary period at the unit prior to commencing their renal competencies. This supernumerary period introduced new members of staff to the unit and provided an overview of the concepts and practice associated with haemodialysis.

- Nurses working at the unit completed the renal competencies set out by the organisation, to develop the knowledge and skills of the nurse to ensure they were competent in their role at the unit. This took place over five months. The nurse had to demonstrate and be observed by the manager as being competent in a specific area before being signed off. The competencies covered a variety of areas such as 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 manager at the unit after one week, and at one, two and three months of working at the unit. We checked the competency booklet of the nurse currently undertaking these at the Launceston unit. All reviews had been carried out and there was evidence of thorough assessment and sign off of the competencies which had already been achieved. After completing the competencies and working at 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.
- There was no formal reassessment of staff competence in aspects of their role at the unit. However, the nurses were regularly provided with information about best practice advice and new equipment. Staff told us they continued to monitor each other's competencies and this was also followed up a discussed during their yearly performance reviews. However, the two nurses worked at the unit three days weekly covering two sessions. During this time, they completed all aspects of their role covered in the competency booklet. Regular shifts ensure competencies were also being maintained.
- Staff had access to 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 about the principals of medicine used during dialysis treatment. Nurses completed competencies around drug administration, calculations and intravenous therapy, which had to be demonstrated and observed prior to sign off by the manager at the unit.
- Staff received training on the safe administration of intravenous medicines. This was part of the renal competencies booklet, which staff completed on joining the unit. Intravenous therapy competencies started at week five, with an assessment of intravenous therapy on the twelfth week.
- 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 for managers and provided training in aspects of their role as a 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. The next manager away day was in June 2017. The topic for this meeting was yet to be confirmed at the time of our inspection.
- All staff had received a performance appraisal within the year prior to our inspection, where discussions had taken place about performance and career development. Staff set goals to enable career progression and were encouraged to develop in line with the patient and service needs. Appraisals contained learning requirements and actions were clearly documented. Staff felt listened to during their appraisals and supported to achieve their learning objectives.
- Staff were supported with revalidation (a process to renew registration with the Nursing and Midwifery Council (NMC). The 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.

- Disclosure and barring service (a service which helps employers to make safe decisions and prevent unsuitable people working with vulnerable groups of people) checks were carried out at the start of a nurses employment, but 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 required them to be open and honest with employers about any change in their circumstance that might affect their practice, was sufficient mitigation.

Multidisciplinary working

- There was good multidisciplinary working and communication between the unit and the other professional that worked closely with the unit to provide care and treatment to the patients.
- The 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 and these were sent to the local acute trust to be analysed. The patient's link consultant reviewed theblood results and made the necessary changes to an individual patient's treatment to ensure the effectiveness of the treatment. The consultant liaised with the manager at the unit regarding the changes to treatment and this was implemented at the patient's next haemodialysis session.
- Dieticians and physiotherapists from local NHS trusts would be involved with the care and treatment of patients attending the unit for dialysis as necessary. If the nurses at the unit had any concerns about a patient's nutritional status, weight or their falls risk, they would contact the lead consultant with their concerns. If required a referral would then be made by the consultant to the health care professional most suited to manage the patient's needs.
- The consultant nephrologist at the local acute NHS trust, which held the contract for the Launceston haemodialysis unit, had overall responsibility for the patients care. Both nurses, the senior management team at the unit and the consultant felt there was effective communication and multidisciplinary working, which enabled efficient patient centred care.

Access to information

- All of the information needed to deliver effective care and treatment to patients was available to all staff involved in their care in a timely manner. The unit had access to the most recent clinic letters following a patient's appointment with the consultant. This enabled staff at the unit to keep up to date with the patient, their condition and any other concerns or issues arising from their review with the consultant.
- Staff at the unit and the patient's lead consultant had access to the most recent blood results for the patients. Patients were provided with a print out of the analysis of their monthly blood results which were explained to them by the manager of the unit. Following review of the blood results, the consultant made contact with the manager of the unit to discuss any changes required to treatment for patients. This was then explained to the patients and the changes implemented at their next haemodialysis session.
- Patients wore red rubber bracelets on the arm, which contained their fistula to alert other medical staff not to use that arm for blood tests or for checking blood pressure in the event of a medical emergency. The bracelet helped to maintain the patency of the fistula used to cannulate for dialysis treatment.
- All staff had access to the organisations policies via the intranet and were able to show us how they would locate them.

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. We acknowledged the local area had low numbers a of black and minority ethnic population. This meant 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.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the requirements and guidance and received training about the Mental Capacity Act 2005. The unit had systems and processes in place for patients who did not have the capacity to make a particular decision where consent was required. If nurses had concerns about a patient's capacity to make a decision about their care and treatment, they would raise concerns with the patients lead consultant at the local acute NHS trust who took action to address the concern. The lead consultant was responsible for overall care and treatment of the patient.
- The unit currently treated a patient living with dementia and explained how they would escalate any concerns about the patient's capacity directly to the lead consultant.
- Consent was sought from patients at the initial appointment prior to treatment. We observed documented written consent forms for treatment which were completed at the initial appointment with patients.. At the time of obtaining patient consent, the clinic manager would discuss haemodialysis treatment and the risks with the patient. The consent form was kept in each patient record. This was in line with the units consent policy. All six records we looked at contained consent information. Staff did not ask for verbal consent each time prior to receiving care and treatment at the unit. They explained that patients gave implied consent by sitting at their stations and allowing cannulation of their fistulas. Staff also explained that a patient could withdraw consent and gave an example where a patient wished to shorten their treatment session. This was in line with the units consent policy. In this instance, staff had held a conversation with the patient about the risks associated with this and recorded it in the patient's notes.
- Patients were asked for their consent to having photographs taken of their fistula and for those pictures to be stored. Patient records contained completed consent forms specifically about photographs which contained clear guidance about how the photographs would be used and stored.

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 with patients in a respectful and considerate manner. We observed interactions between staff and the patients. Staff remained courteous and polite during all interactions with patients.
- Staff treated patients with kindness, dignity, compassion and respect. Patients we spoke with during the inspection were highly complementary of the care and treatment they received at the unit. Quotes from patients we spoke with included, "the unit is brilliant", "superb" and "welcoming."
- Patient's privacy and dignity was maintained at the unit. Although there were no curtains between the stations, there was access to privacy screens which were used. We were provided with an example of when privacy screens had been used recently for a patient with fistula access in the groin.

- Privacy and dignity had been flagged in the patient survey as an area for improvement, with 30% of patients scoring 4/5. Actions taken included speaking with patients to remind them there was a private room available for confidential discussions.
- Staff demonstrated a supportive attitude to patients at the unit. We observed staff checking regularly to ensure the patient was alright and how attentive staff were when patients needed support to get on the scales at the unit.
- Staff at the unit quickly built up a rapport with patients who attended the unit for treatment and interacted with patients in a respectful manner. Staff put patients at ease and communicated with them like friends. Patients described the atmosphere at the unit "like a family."
- We saw that staff were responsive to all patients' needs, including calls for help, alarms on dialysis machines and any non-verbal signs of distress. All staff were compassionate and attentive.
- Nursing staff maintained patients comfort through the use of additional pillows and pressure relieving aids. We saw that many patients brought their own blankets and comforters.
- All patients we spoke with talked about the exceptional care provided by the unit manager. Patients told us how attentive the manager was, how she was efficient and precise with the care and treatment she provided and how she was helpful and supportive.
- Nursing staff told us that the centre completed annual patient surveys, which covered a range of issues including transport and overall satisfaction. Overall, 100% of patients surveyed had confidence in the nurses treating them. Another question asked if patients were aware of who to contact in an emergency, which showed 10% of patients surveyed were not. An action plan drawn up after the survey results showed action had been taken, which included re-issuing all patients with guides containing out of hours contact information.

Understanding and involvement of patients and those close to them

- Staff communicated with patients to ensure they understood their care and treatment. Patients told us the nurses would always explain what was happening with their care and treatment and would identify any changes set out by the patients lead consultant. Patients told us they felt comfortable to ask questions about their care and treatment to the nurses.
- Staff understood the importance of involving family members and close relatives as partners in patients' care. One patient told us due to having hearing problems the unit staff always involved a family member in their care and treatment discussions, to make sure nothing was missed.
- We saw that staff spoke openly about the treatments provided, the blood results and dialysis treatment plans. Many of the patients were observed speaking to staff about their latest blood results and what these meant.
- Nursing staff told us that as they saw their patients frequently they were familiar with their moods and were able to identify when patients were having a bad day or were feeling unwell. This enabled them to spend additional time with the patients as necessary to support them with their treatment or assist with any concerns they may have.
- On referral to the centre, patients were encouraged to visit for an initial assessment and a look around. On arrival, staff gave patients information packs about the centre, which detailed what to expect from the service and information on haemodialysis. Patients and their relatives were encouraged to spend time with the staff and other patients to ensure that they were satisfied with the unit before agreeing to start treatment..
- Nurses ensured patients understood their kidney condition and how this related to other medical problems they may have, which impacted upon the life choices made by patients.
- Patients had ongoing education provided by the nurses to ensure they and their family were able to make informed choices about the future of their treatment. We observed a patient at the unit who was having problems with the machine alarming. The nurses provided advice and education to the patient about what they needed to do to stop the machine alarming.

- Patients and those close to them were involved in care and treatment. Nurses at the unit took the time to talk to patient's families and relatives during the changeover time. This enabled the patient and their family to ask questions and be kept informed about care and treatment.
- Patients felt informed about their blood results and were given the opportunity to discuss any treatment changes made by the consultant. Patients were provided with a printed sheet of their monthly blood results. The manager discussed the meaning of the results with each individual patient and any changes to their treatment which the consultant had made following the blood results. Patients told us they understood what was happening and felt clear about the status of their condition, following an explanation of their blood results.
- The unit kept patients informed about care and treatment they received. One patient using the unit was relocating. Due to this, the patient was moving units and changing consultants. The unit staff had supported to patient to manage the move to ensure a seamless continuation of haemodialysis treatment. The nurse provided the patient with an update about telephone calls and information they were due to receive from the new unit prior to commencing treatment.

Emotional support

- Staff recognised the broader emotional wellbeing of the patients under their care. One patient had experienced side effects of treatment, which were impacting on theirquality of life. The nurse had recognised this and contacted the lead consultant to request support and advice for the patient.
- Staff understood the impact on a patient's condition, care and treatment and how this affected their family and relatives. The unit had recently held a local event near Launceston, with representation from the National Kidney Foundation. This day was open to the family and relatives of patients attending the unit. The event provided a platform for families and relatives to discuss the challenges they faced; how they coped when their loved one started haemodialysis; and the ongoing impact of the treatment. The National Kidney Foundation was also present to offer support and signpost people to ensure they received the emotional support they required.
- Nurses discussed and sign-posted patients to where they could gain support about their condition. We saw that the centre provided details of support networks for patients and their loved ones. This included organisations such as the Kidney Patients' Association who held social events, and had support networks for patients and their loved ones.

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 people's individual needs

- Services were planned to take into account for the needs of different people, to enable them to access care and treatment. Admission criteria was set out, so all patients irrespective of age, gender, race, religion, belief or sexual orientation could access the services. However, there were patients who would not be able to dialyse at the unit, due to the unit not being able to cater for their individual needs, for example, if they had a high dependency or were unable to dialyse in a chair. Despite the admission criteria, the unit were willing to take patients outside of this, if the lead consultant felt the unit staff would be able to safely manage and treat the patient.
- There were processes in place to ensure a patient new to haemodialysis, was provided with information to ensure their understanding of the nature and purpose of the treatment, the effects, the risks and benefits and any post procedure instructions. Patients were provided with information about haemodialysis treatment and the risks by the lead consultant at the local NHS acute trust, prior to starting their treatment at the unit. Nurses at the unit would also discuss the

treatment and risks again with the patient at their first session at the unit to ensure they were fully informed and had not forgotten or misunderstood any of the previous information provided to them.

- There were arrangements in place to account for patients with complex needs or learning disability. The unit had experience of managing a patient living with mild dementia and told us they would work closely with families and relatives to ensure the needs of the individual were accommodated. The consultant at the local NHS acute trust was aware of the facilities and the set up at the Launceston unit. The consultant would make a decision as to the individual needs of the patient and about the appropriateness of the patient dialysing at the unit.
- The unit had access to translation services via the local acute NHS trust. Although at the time of the inspection, no patients had attended the unit who had required translation services.
- There was a provision for patients to be able to use the toilet prior to commencing treatment at the unit. The toilet facilities also enabled disabled access and were spacious enough to accommodate a wheelchair.
- Patients had access to entertainment or activities during their haemodialysis session. Each station had its own individual television, integrated handsets which included a call bell and individual lights. Patients had access to portable DVD players on request and all patients could access the Wi-Fi at the unit to access the internet via laptops and other personal electronic devices.
- There were provisions to ensure patient comfort during their treatment. Staff offered patients blankets and pillows for their session, ensured patients were comfortable and their privacy respected throughout the session. Patients were also provided with a drink and biscuits during their session. Patients told us the unit was as comfortable as it could be for the treatment it was providing.
- Patients were provided with support once they had booked their treatment at a dialysis centre at their holiday destination. The unit had a specific holiday dialysis co-ordinator who liaised directly with the dialysis unit, patients, consultant nephrologists and other trust holiday co-ordinators to arrange dialysis for patients who were coming on holiday to the area or going on holiday and would require dialysis at a different unit.
- Staff at the unit had access to advice about falls or pressure ulcers via the local acute NHS trust. If staff had any concerns, they would contact the lead consultant for the unit. The consultant would then make the final decision and make a referral to the most team within the acute trust, best equipped to provide the correct care and treatment required by the patient.
- The unit had access to psychological support or counselling for patients who attended the unit for treatment, to ensure their psychological wellbeing. Support for patients was accessed from the local acute trust. If the nurses at the unit had concerns about the psychological wellbeing of a patient, they would make contact with the lead consultant for the patient to discuss their concerns. It was the responsibility of the lead consultant to make a referral.
- Staff at the unit and the senior managers had worked hard to make the unit inviting and welcoming, despite it being located in an industrial estate and having no windows. Prints of sea landscapes were on the two of the walls and there was also painted artwork of a lighthouse and birds to add colour and warmth to the unit.

Service planning and delivery to meet the needs of local people

- Plymouth Hospitals NHS Trust commissioned Renal Services UK to provide haemodialysis treatment to service users in and around the Launceston area at the Launceston dialysis unit.
- Information about the needs of the local population was used to inform the planning and development of the dialysis service. When the service was planned in 2014, there was no local NHS provision of dialysis services in the area. Launceston was chosen as a suitable unit due to it being in central Cornwall and having effective transport links within the area, to enable patients to easily access the unit for treatment. Not having to travel long distances has been shown to help improve a dialysis patient's quality of life.

- 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 three days a week and had the choice of either the morning or afternoon session to receive their treatment. One patient at the unit told us how accommodating the unit had been with altering their appointments times at short notice.
- Stakeholders and other providers were involved in planning the dialysis service provision. The unit met quarterly with representatives from the local NHS trust to discuss the service provision, to ensure the unit met the needs of the local population accessing it. The local trust was keen for the Launceston unit to develop and expand to offer more choice and flexibility to the local population and for patients who attended the unit whilst on holiday.
- Patients who attended the dialysis unit told us they did not have a problem with the transport service. The patient satisfaction survey carried out by the unit, captured information about delays patients experienced. Patients attending the unit made their own way, or were brought to the unit by a local taxi company, commissioned by the local acute trust. Patients and staff told us that they had regular drivers who were punctual and problems only arose if the regular driver was off work. Patients reported they usually waited a short period for transport to arrive. Patients we spoke with did not raise any concerns about the transport service. If a problem arose, this would be feedback to the local NHS trust at the quarterly meetings.
- The unit had designated parking and disabled parking adjacent to the dialysis unit for patients who travelled independently to the unit for treatment. There was convenient and safe access to the dialysis unit for ambulant and disabled patients.

Access and flow

- Patients were assessed for their appropriateness to attend the centre by the local NHS trust. Patients with acute kidney disease were treated at the local NHS trust and only chronic, long-term dialysis patients were referred to the centre for treatment.
- When a patient was identified as being suitable to attend the centre, a referral was completed and an assessment visit arranged. Patients attended the unit to have a look around and meet staff. 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 centre, the local NHS trust arranged transport if necessary and ensured medical notes were available.
- Patients could access dialysis care and treatment at a time to suit them. A convenient time for their haemodialysis was discussed between the patient and their consultant. The unit had, up to the time of our inspection, been able to accommodate patients' needs in this respect. There was a booking map, which outlined the procedure followed for new patients attending the unit. 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 large majority of haemodialysis treatment started as soon as the patient arrived at the unit. Staff collected data for the Renal Registry 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. Patients told us they were impressed with how efficiently the nurses at the unit had them dialysing soon after they arrived at the unit.
- The unit extended its opening hours to provide an evening session for patients over the summer months. The unit was due to commence an evening session three days per week between May and October 2017, to accommodate the increase in demand for the unit over the summer months, particularly with holidaymakers to the area. This provided more choice for people choosing to dialyse in the area and increased the likelihood they would be able to attend the unit at their preferred time due to the increased capacity. One patient currently on holiday told us they were very pleased with the amount of information the nurses had about them before they arrived.

- The service had a process to prioritise care and treatment for people with the most urgent needs. In the event of an emergency where patients were unable to dialyse at the unit, patients' monthly blood results and fluid levels were reviewed and patients would be managed in order of priority, according to their blood results. The unit would liaise with the local NHS trust to secure a station for dialysis for patients. If this was not available, other local providers would be contacted and the organisation would pay for transport and the treatment for patients at another unit. The unit would ensure all patients received their dialysis. This event had not occurred at the Launceston unit.

Learning from complaints and concerns

- People using the service knew how to make a complaint and felt could raise any concerns with the clinical staff. The complaints procedure was made available to all patients at their first session at the unit. However, we did not see any information displayed for patients or their relatives and carers.
- The unit had received no complaints between January 2016 and January 2017 and 12 compliments from patients and their relatives.
- There was a comprehensive complaints procedure to ensure all complaints were handled effectively and confidently. The procedure ensured complainants received a timely response, acknowledgement in two working days and a full response in 20 working days. The Launceston specific complaints policy also outlined the stages the complaint would go through if a complainant was unhappy with their first response. This incidence had not occurred at the Launceston unit.

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 the service

- Leaders had the skill, knowledge, experience and capacity to lead effectively. Three of the senior management team had advanced qualifications in renal nursing and the medical head was a consultant nephrologist and had been working within this area for over 20 years. The head of nursing also had extensive experience of teaching and they had been able to implement a comprehensive set of competencies for the organisation and develop an extensive, good quality training and development programme service wide. Staff told us the training provided was thorough and good quality,
- Leaders understood the challenges to good quality care and were able to identify actions to address them. The senior management team faced challenges as the haemodialysis units covered a large geographical area across the country. Therefore, there were not able to be present at the units every day. In order to ensure they maintained oversight of the unit, a member of the senior management team held daily telephone calls with the units. The Launceston unit had a call from either the regional manager or head of nursing in the morning on each day the unit was open. This was to check on staff wellbeing and make sure there were no problems or concerns they could support with.
- Leaders were visible, approachable and supportive. Nurses at the unit knew the senior management team well and reported their presence at the units from time to time. The head of nursing had visited the Launceston unit four times since commencing her employment with the Organisation in September 2016. Staff told us they would not hesitate to pick up the telephone to contact the team if they had a concern or an issue and felt the team were very approachable and supportive.
- The senior management team and manager of the unit of the unit maintained a strong working relationship with the local NHS 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 local NHS trust quarterly, to discuss the service and its performance. The manager of the unit had regular telephone and email contact with the consultant. They told us the consultant was very helpful. We received feedback from the lead consultant for the unit who described the working relationship with the

unit as "easy to communicate with," "always contactable" and "communication is effective but in a friendly manner which facilitates good working relationship."

- Staff felt respected and valued, and staff we spoke to felt they had a clear path of career progression. Senior staff said the feeling of value came from the organisations willingness to send staff for specialist university based training.
- Staff felt the culture of the unit encouraged candour, openness and honesty. Staff at the unit felt the organisation was developing and morning forwards at a manageable rate. Staff felt they could raise concerns with the senior management team and always felt they were kept informed about developments and changes within the organisation and for the Launceston unit.

Vision and strategy for the service

- There was a clear vision and set of values for the dialysis unit. The values of the unit focused on safety and quality, excellence in patient care, independence for patients and innovation. Staff were aware of the values of the organisation and these were also displayed on the wall at the unit.
- The organisation had a vision and strategy looking towards developing services at the Launceston unit and providing "inspired patient care." The unit currently opened three days a week for two sessions daily. The local NHS trust that held the contract for the Launceston unit was keen for the service to expand in order to open for more than three days a week. Due to the challenges with recruitment of nurses and the limited capacity of the building, the organisation were, at present, unable to move forward with this vision. The strategy had the potential to be achievable and provide good quality of care if the organisation were able to overcome the challenges to its implementation.
- The manager at the unit was aware of the vision and strategy for expansion of the unit. Managers were kept informed personally by the senior management team and also at the monthly managers teleconference meetings.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of good quality care. The governance structure demonstrated how communication flowed up and down from the unit to the senior management team and then onto the Renal Services (UK) Limited board, who had oversight of the whole service. There was a quarterly clinical governance meeting held by the senior management team and monthly unit managers meetings, with the senior management team, via teleconferencing, to discuss topics such as incidents, performance and other aspects of the business. Feedback to the staff was via the unit manager following monthly manager calls and emails sent directly from the senior management team. The chief operating officer sat in on the monthly clinical governance meetings and provided feedback to the board.
- The consultant involved with patients attending the unit attended quarterly contract review meetings and was part of the strategic management of the commissioning arrangements provided by the local acute NHS trust. The contract for the provision of services at the Launceston unit was discussed at these meetings along with the performance of the unit. The senior management team felt they had a good relationship with the trust.
- There were systems and process to identify and manage risks and mitigating actions. The organisation maintained a corporate risk register. The risk register contained specific risks to all the units and to the Launceston unit. These were the challenges to ongoing recruitment and major incidents to the power or water supply and adverse weather conditions. Risks on the corporate risk register were available to staff at the unit via the business continuity policy. Risks had mitigating actions and were monitored by the senior management team. If staff felt an issued needed to be escalated to the risk register, they discussed the issue with the head of nursing, who took this to the clinical governance committee or escalate the issue to the medical director sooner if required.
- 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 results of these audits were captured on a performance matrix, which had started in January 2017. This was also provided to the lead consultant at the local acute NHS trust. The audit programme included daily auditing such as water testing, weekly audits including medicine cupboard audits and monthly audits consisting of bloods audits and cleaning audits. All audits we reviewed, apart from one, demonstrated 100% compliance. In April 2017, the monthly cleaning audit demonstrated 96% compliance. Full compliance had not been achieved due to some minor scratches on the wall. This was escalated to the maintenance team straight away who visited the unit to repair the wall.

- There was a comprehensive assurance system to provide the organisation and the local acute NHS 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. The unit carried out an annual patient satisfaction survey in December 2016. There were three actions at the Launceston clinic following the results of the survey. These were, reminding all patients individually there was a private room for discussion if required, re-issuing all of the emergency contact numbers to patients and improving television reception.
- An all-day event with representation from the National Kidney Foundation was planned and arranged with support from the patients using the Launceston unit. The event was held to provide support, advice and information to all who attended. Patients chose the location for the event, which was also open for their family and friends, established haemodialysis patients, home therapy and pre-dialysis patients. The event was run all day to ensure all patients could attend around their dialysis session. Patients facilitated the day and were able to establish a support network with other patients in a similar situation. The day also provided the opportunity for family and relatives of patients to share their stories and build support networks.
- A pilot staff survey had been completed in 2015. However, on completion of this, the senior management team did not feel they survey was detailed enough to capture the information they wanted to know. It was on the agenda for 2017 to devise a more thorough staff survey and roll this out to staff to get feedback about the organisation.
- Staff understood the value 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.

Innovation, improvement and sustainability

- The unit had an initiative for succession planning, to ensure the future of trained renal nurses at the unit. The unit provided a comprehensive training and development programme for staff. Once staff had completed their competencies and had been working at the unit for over 12 months, they were encouraged to take an advanced renal course at one of the local universities used by the organisation. Mentorship and leadership courses were also available to support staff to develop into more senior roles within the organisation.

Outstanding practice and areas for improvement

Outstanding practice

- All patients we spoke with talked about the exceptional care provided by the unit manager. Patients told us how attentive the manager was, how she was efficient and precise with the care and treatment she provided and how she was helpful and supportive.
- Patients we spoke with during the inspection were highly complementary of the care and treatment they received at the unit. Quotes from patients we spoke with included, “the unit is brilliant,” “superb” and “welcoming.”
- Staff at the unit quickly built up a rapport with patients who attended the unit for treatment and interacted with patients in a respectful manner. Staff put patients at ease and communicated with them like friends. Patients described the atmosphere at the unit “like a family.”
- The unit had a contingency plan to ensure they held enough consumables at the unit to enable continuity of the service for patients, if they were unable to obtain the necessary equipment required for haemodialysis. The unit manager ordered small consumables on a weekly basis and always ensured the unit maintained one or two week’s additional supply in case of emergencies, in line with company policy. The unit also had a contingency plan to ensure they held an additional supply of stock over the winter months. Between November and February, the unit would maintain an additional month’s supply of equipment, to ensure there would be no disruption to the service in the event of adverse weather conditions.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there is an appropriate policy for the early identification of sepsis in line with national guidance (NHS England, 2015).

Action the provider SHOULD take to improve

- The provider should ensure there is a procedure available for bank staff about formally identifying patients prior to setting patients up on dialysis.
- The provider should ensure patient records are safely stored during the changeover period at the unit to maintain patient confidentiality.
- The provider should ensure all patient post dialysis checks are completed on the daily monitoring sheet.
- The provider should ensure clinical and non-clinical waste is stored separately whilst waiting for collection.

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 12 (2)(g) Care and treatment must be provided in a safe way for service users. The registered person must ensure the risks to the health and safety of service users receiving care and treatment are assessed. There was no policy, standard operating procedure available for staff to ensure early identification of sepsis in line with national guidance (NHS England, 2015).