Renal Services (UK) Limited

Renal Services (UK) Ltd - Newcastle

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, supported patients to eat, drink, and be comfortable. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to suit patients' needs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- While there were infection control measures in place, disposable privacy curtains had not been changed for two years and the frequency of required changes was not clear in the infection control policy. Disposable suction tubing on the resuscitation trolley had expired but was not part of the regular checks so had not been picked up.
- While there were processes in place to manage medicines actions to address issues was not always clear. Ambient temperatures of medicines storage areas were at times above the required range. Actions were not clearly recorded.
- While there were risk assessments in place with regular review and action taken, including for fire safety, gaps in fire alarm testing had not been recognised.
- While there were service arrangements in place for equipment maintenance, emergency equipment was overdue calibration and three dialysis machines were overdue servicing.
- Patients with a DNACPR (do not attempt cardiopulmonary resuscitation) did not have the decision recorded clearly in their patient record.
- Staff surveys were carried out but actions to improve were not clear.
- Quality assurance audits were not always effectively utilised to identify risks and issues.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis services	Good 	Our rating of this service stayed the same. We rated it as good because: See overall summary for more information.

Summary of findings

Contents

Summary of this inspection

Background to Renal Services (UK) Ltd - Newcastle

Renal Services Ltd (UK) - Newcastle is operated by Renal Services Ltd (UK). The service opened in May 2016. It is a private clinic in North Shields, Newcastle Upon Tyne. The service is contracted by a local NHS trust for the provision of outpatient renal dialysis to their patients in the Newcastle area. They had 10 dialysis stations and had provided 6,500 dialysis sessions in the last 12 months.

The regional manager was the CQC registered manager.

The service is registered with the CQC to provide the following regulated activities: Treatment of disease, disorder or injury.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited the dialysis unit, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four members of staff including the registered manager, unit manager and nurses.
- spoke with three patients who were using the service
- reviewed four client care and treatment records
- observed a shift handover meeting
- looked at three care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that disposable privacy curtains are subject to a programme of disposal and that disposable equipment is regularly checked for expiry. (Regulation 15 (1)
- The service must ensure that equipment is serviced and maintained in line with guidance. (Regulation 15 (1)

Action the service SHOULD take to improve:

- The service should ensure that actions to address ambient temperature fluctuations in medicines storage areas are clearly recorded and that their effectiveness is monitored.
- The service should ensure that fire alarm tests are carried out weekly in line with the fire safety risk assessment.

Summary of this inspection

- The service should ensure that decisions about DNACPR are clearly recorded in the patient record.
- The service should consider action to identify and address staff survey results.
- The service should ensure that quality assurance audits are effectively used to identify issues and that these are addressed.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dialysis services	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Dialysis services

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are Dialysis services safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. The service used on-line training to ensure that their essential knowledge was current. New staff were required to complete training on induction that included modules such as health and safety, information security and use of equipment.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance information was available to allow the registered manager to have oversight and monitor completion.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff were required to complete level 2 safeguarding training. All permanent staff had completed Level 3 Safeguarding training in relation to children and vulnerable adults. Bank staff had completed Level 2 child and vulnerable adult training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that they could access the local authority's safeguarding team if they needed help or support. Telephone numbers for the local team were readily available within the relevant safeguarding policy. The provider followed the recruitment policy when employing new staff which included disclosure and barring service checks and following up on references.

Cleanliness, infection control and hygiene

Good

Dialysis services

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean, however arrangements for changing disposable privacy curtains were unclear.

Ward areas were clean and mostly had suitable furnishings which were clean and well-maintained. We observed staff cleaning equipment before and after dialysis and observed good standards of cleanliness on the unit. However, disposable privacy curtains had not been changed since 2019. Staff told us they believed they should be changed every six months or when visibly dirty, but this was not clearly recorded within the infection control policy. A review of the privacy curtains was not included in the quarterly cleaning and infection control 'bug buster' audit.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service generally performed well for cleanliness. This included regular checks and a monthly cleaning audit. The September 2021 audit showed compliance at 94%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Arrangements were in place to reduce the risk of Covid 19 infection. This included patient, staff and environmental risk assessments. Staff had made changes to the way the service was managed to mitigate the risk. This included changing appointment times to allow for enhanced cleaning in between dialysis sessions and the provision of single occupancy transport arrangements. We observed staff assessing patients for the risk of Covid 19. This included an assessment process to identify any symptoms including elevated temperature, vaccination status or contact with people who had tested positive to the virus prior to commencement of dialysis. There was clear communication with patients about the risk of Covid 19 and they were asked to contact the unit prior to arrival should they feel unwell. Patients and staff were tested for Covid 19 on a weekly basis. There were arrangements in place with the local NHS Trust for dialysis in the event of a patient testing positive.

Staff were observed using PPE appropriately, this included wearing surgical masks at all times on the unit and the use of visors, aprons and gloves when providing treatment and care. Social distancing was in place, with dialysis stations appropriately spaced apart and good ventilation to support the management of Covid 19 risks. Hand hygiene audits were carried out on a monthly basis and we observed staff washing hands and using hand gel appropriately. Results from hand hygiene audits were consistently above 90%.

There were protocols in place for regular screening for infections. Patients were routinely screened for blood borne viruses such as hepatitis or HIV and there were arrangements to dialyse patients who tested positive in isolation using a dedicated dialysis machine. At the time of the inspection we were told that screening for MRSA (Methicillin-resistant Staphylococcus aureus) had been paused on the advice of the commissioning NHS Trust due to a shortage of swabs. We were told that one cycle of screening had been missed as a result and that testing had now recommenced.

Staff had regular competency assessments for the use of aseptic no touch techniques (ANTT) and we observed appropriate practice on the unit.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Dialysis machines were cleaned between each patient and at the end of each day. They followed manufacturer and infection control guidance for routine disinfection and single use lines were used and disposed of after treatment. Staff carried out daily water tests in line with the UK Renal Association Clinical practice guidelines and we saw records that checks were carried out and water quality within recommended standards.

The service had a legionella risk assessment with regular actions to mitigate risk such as water testing, flushing of outlets and temperature monitoring.

All staff were up to date with infection prevention and control training.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, we found that some equipment including dialysis machines were overdue their annual service.

Patients could reach call bells and staff responded quickly when called. Call bells were tested daily and were regularly maintained. Staff were seen to respond promptly to patients requiring assistance.

The design of the environment followed national guidance. There was enough space between dialysis stations to prevent the risk of cross-infection and ensure an appropriate degree of privacy. There was sufficient balance between safety and privacy so that patients were visible to staff at all times. Privacy curtains were available for use when required. An isolation room with a viewing window was available and accessible from the main dialysis area.

There were environmental safety checks in place, including those to minimise the risk associated with fire. Staff had received fire safety training and there was a comprehensive risk assessment which identified the need for weekly checks of the fire alarm system. We viewed records of fire alarm checks and found six gaps in weekly recording over a three-month period between the beginning of July and the end of September.

Staff carried out daily safety checks of specialist equipment. This included daily checks of the dialysis machines and water system, water testing and flushing of the water system. Water testing included a test of the water quality on a daily basis, in addition to monthly laboratory tests for microorganisms, bacteria and endotoxins. Resuscitation and emergency equipment were also checked daily.

The service had enough suitable equipment to help them to safely care for patients. Renal Service UK technicians managed and maintained the dialysis machines, chairs and the water plant. The service had 12 dialysis machines which included two spare machines ready for use. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. Dialysis machines and medical devices were scheduled to be serviced annually. At our inspection in 2019 we found that eight of the 12 dialysis machines were overdue their service date by two months. At this inspection we found that three machines were overdue their service date which was due by the end of September 2021. We were told these were scheduled to be serviced a few days after inspection, however the provider has not provided us with the evidence requested to demonstrate that this was completed. The service had a dialysis replacement plan that was in line with Renal Association guidelines.

Staff reported they received adequate support from the maintenance technicians. For example, a water pump failure had occurred on a weekend and there was effective support from on call technicians to immediately make the system safe to use, minimising the delay to treatment.

There were contracted arrangements for the maintenance of other equipment within the unit. This included annual calibration of medical devices. We saw that medical devices such as a portable blood pressure monitor, suction

machine and scales were overdue calibration by approximately two months. The provider told us these had been booked for a date later in October 2021 and had been impacted by a backlog of visits due to the pandemic. Suction tubing on the emergency trolley had expired at the end of September 2021. This had been identified by staff but was not on the list of items to be checked and had not been replaced.

Dialysis chairs and beds were subject to annual maintenance and we saw evidence of this during inspection.

Staff disposed of clinical waste safely. This was disposed of in yellow clinical waste sacks and contaminated sharps were disposed of in appropriate sharps containers. Clinical waste was safely stored in locked clinical waste bins. There was a contract in place for the bins to be emptied by a specialist clinical waste contractor.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff were trained in the recognition and treatment of sepsis and used the national early warning score (NEWS2) to help them identify deteriorating patients. Records were maintained and we observed staff acting appropriately to escalate a patient who became unwell during treatment. All staff were trained in basic life support, the administration of adrenaline and the use of an automatic external defibrillator. The process for escalation was to call 999 and request an emergency ambulance to transfer patients to the nearest accident and emergency department.

The service had protocols in place for dealing with deteriorating patients including adverse reactions such as hypoglycaemia and anaphylaxis.

Staff completed risk assessments for each patient and reviewed this regularly, including after any incident. Only clinically stable patients were dialysed on the unit and patients acutely ill with renal problems were treated at the local NHS Trust. Suitability for dialysis on the unit was agreed with the local renal consultant. Individual risk assessments were used to identify the risk of falls, pressure sores, manual handling and pain. All patients had a personalised emergency evacuation plan.

Staff assessed patients' vascular access before and during treatment. Photographs were taken of vascular access in line with Renal Association guidelines as a baseline for monitoring. Observations of vital signs such as blood pressure and pulse were recorded before, during and after treatment. This included a lying and standing blood pressure after treatment to reduce the risk of falls as a result of drops in blood pressure. Patients weighed themselves before treatment to establish how much excess fluid needed to be removed during dialysis.

Staff shared key information to keep patients safe when handing over their care to others. Staff told us they could escalate concerns to the renal consultant at the local trust or through the on-call renal registrar.

Shift changes and handovers included all necessary key information to keep patients safe. We observed a shift change and saw that staff communicated effectively about any concerns or ongoing issues.

Good

Dialysis services

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank staff a full induction.

The service had enough nursing and support staff to keep patients safe. Renal Services (UK) Ltd was a nurse led service. Patients remained under the clinical management of the consultant nephrologists at the local NHS trust. At the time of the inspection there were four full time nurses in post, plus the registered clinic manager. There was one full time associate practitioner and one full time healthcare assistant. In addition, there were regular bank staff working on the unit.

The manager told us that the ratio of staff to patients was one to four. We reviewed staff rotas and saw there were regularly three staff on shift, including two registered nurses which was in line with the required ratio. Staff told us there were sometimes four staff on days where there were three dialysis sessions running.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The number of nurses and healthcare assistants on shift matched the planned numbers.

The service had a contract in place with the referring NHS trust and staffing ratios had been calculated based on patient dependency and in line with guidance from the Renal Workforce Strategy group.

Staff told us there were two vacancies for registered nurses on the unit and that shifts were covered by regular bank nurses who were familiar with the service. Sickness and staff absences were covered by staff internally who worked flexibly on the unit. The service worked to recruit additional staff and offered an internal training programme to provide newly qualified or inexperienced staff with the skills required to work on the unit. We were told that sickness rates were below one percent.

Managers made sure all bank staff had a full induction and understood the service. This included access to mandatory and essential training, competency assessments and a period of shadowing other staff.

The service always had access to a named consultant nephrologist who provided medical support to the clinic. They had access to an on-call consultant or renal registrar during evenings and weekends. The consultant nephrologist visited the unit on a monthly basis and aimed to review patients at least every three months. They were available for advice and reviewed patient test results remotely. Staff told us that medical support was easily accessible when required and we saw evidence of medical reviews in patient records.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff used both electronic and paper records. They included up-to-date risk assessments, clinical history and results of previous scans. We reviewed four sets of patient notes and all contained information that was clear and well set out. We reviewed the record of one patient who had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) in place. We were told that the patient carried the

DNACPR form with them, however, it was not clear in the patient record that this was in place. Staff told us they were familiar with all the patients on the unit and that all staff were aware that the DNACPR order was in place, however this knowledge was not documented which was a potential risk. Records were audited on a monthly basis. We viewed an example of a September 2021 audit and saw that five patient records were audited with a 100% compliance rate.

When patients transferred to a new team, there were no delays in staff accessing their records. Electronic records were accessible across the unit and the local NHS[CV1] [HJ2] trust. Medical reviews and decisions were recorded by nurses in the patient record or by the consultant nephrologist when on site. Medical review letters were also sent to the unit and stored in the patient paper record.

Records were stored securely. Electronic records were password protected and paper records were kept with the patient during treatment and stored in locked cabinets when not in use.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely and were administered by appropriately trained staff using individual prescriptions or patient specific directions (a written instruction from a prescriber to administer a specific medicine). Medicines in use on the unit included anti-coagulation treatment and intravenous fluids that were routinely used during dialysis. Staff completed administration and intravenous competency assessments. These were reviewed as part of staff annual appraisals.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were locked securely in medicine cabinets and a medicines fridge within the clean utility room on the unit. The door to the room was locked using a keypad system. All medicines and prescribing documents were stored securely on the unit. There was a log of prescription stationary that was used by the visiting consultant so that prescriptions were able to be tracked.

Temperatures of fridges where medicines required cold storage were monitored daily and were within the expected range. The medicines management policy detailed actions to be taken if medicines fridges were outside of the required range and staff were aware of the action to take. Temperatures of the clean utility and storage rooms where medicine supplies were stored were monitored daily. There were three occasions in July 2021 where the ambient temperature of the clean utility room was marginally above the required range. Staff informed us that when this happened, they opened windows and doors in order to reduce the temperature. However, actions were not recorded on the temperature monitoring sheet and there was no record of repeat temperature checks to ensure the actions were effective.

Staff followed current national practice to check patients had the correct medicines. Staff checked patient identities when administering medicines. This included checks of name and date of birth to ensure administration was to the correct patient.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were shared with staff by email and discussed at meetings. Staff told us that although most alerts

weren't relevant to the medicines stored on the unit, they checked if any patients were prescribed the medicine by their GP. Staff then discussed the implication of the alert with patients and gave them advice and direction as appropriate. We saw guidance around this recorded in staff meeting minutes where potentially relevant alerts were reviewed and discussed.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with provider policy. Permanent staff had access to the electronic reporting system, we saw that incidents had been reported by a range of staff. Bank staff did not have access to the reporting system but were not alone on the unit and reported incidents to the senior nurse on shift who would record the incident on the system.

Variances in prescribed and expected treatment were reported for each shift. This included incidents where treatment times were shortened through patient choice, where patients did not attend for treatment and where patients had symptoms of low blood pressure.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff had a good understanding of the provider's duty of candour policy and were open and transparent with patients. Staff told us they were encouraged to acknowledge when things went wrong and explained this to patients. They offered apologies. For example, at the time of inspection when issues with a water pump failure led to a short delay in treatment, patients were informed, and apologies were given.

Managers investigated incidents thoroughly. Staff received feedback from investigation of incidents, both internal and external to the service. They met to discuss the feedback and look at improvements to patient care. Incidents and treatment variances were investigated and reviewed by senior staff at integrated governance meetings. Issues were discussed with staff both individually and collectively at team meetings. Staff reported that they had the opportunity to discuss when things went wrong and were involved in the identification of learning and improvements.

There was evidence that changes had been made as a result of feedback. For example, as part of a routine review of incidents an increase in reported patient falls was identified. This included falls on site and at home following treatment. As a result of discussions amongst staff, it was identified that patients may have experienced a drop in blood pressure on standing, following dialysis. A new protocol was implemented, where staff would check patients' lying and standing blood pressure immediately following treatment. This helped to identify a drop in blood pressure on standing. When this occurred, they encouraged patients to drink additional fluids.

Learning from variance reports included action to improve staff understanding and action relating to the assessment of patient weight prior to treatment and encouraging patients to complete their full dialysis times. Staff workshops were planned to address these areas.

Are Dialysis services effective?

Good

Dialysis services

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and protocols were based on relevant national guidance including NICE standards and Renal Association Guidelines. Patients were offered dialysis three times a week in line with Renal Association Guidelines and were generally dialysed for four hours. Staff assessed vascular access routinely as part of treatment and used photographs to monitor the condition of access over time. This was in line with NICE Quality Statement 72.

Staff provided advice to patients on dialysis away from base (DAFB) to ensure they could continue their dialysis treatment when away from home. Staff referred patients to the commissioning trust coordinator to organise local DAFB.

Monitoring of compliance with guidance was through dialysis variance reports and audits of patient records. Staff monitored patients' blood results on a monthly basis in line with Renal Association guidelines to measure the effectiveness of treatment.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff were familiar with patients as they were treated on the unit three times a week. We observed staff supporting patients' psychological and emotional needs and information relating to this was shared between staff at handovers.

Nutrition and hydration

Staff gave patients food and drink when needed. Patients could access specialist dietary advice and support.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff encouraged patients to bring their own snacks into the unit during the pandemic. Hot and cold drinks were available and offered to patients during their treatment.

Specialist support from staff such as dietitians was available for patients who needed it. Patients with end stage renal failure requiring dialysis follow a strict diet and fluid restriction plan alongside their treatment. This helps to cut down on the amount of waste in their blood that is not filtered from the body due to their kidney disease. Staff provided ongoing advice and support to patients and when necessary referred them to dietitians for more specialist input. Virtual consultations with dieticians were available along with telephone advice for both staff and patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and supported them to relieve their pain as required. They supported those unable to communicate using suitable assessment tools.

Staff assessed patients' pain using a recognised tool and supported them to administer their own pain relief in line with individual needs and best practice. Patients were assessed on referral to the unit, which included an assessment of pain. There was no provision for the administration of pain relief by staff, therefore, patients were encouraged to bring medicines with them from home to self-administer. A visual pain assessment tool was used as part of the initial and ongoing assessment of patient need to help patients express the degree of pain, they were in.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. The UK Renal Registry collects, analyses and reports data from renal centres. Reports provide renal centre comparisons of the attainment of the Renal Association audit measures. The unit's dialysis patients were part of the commissioning trust's activity therefore their outcome data was entered into the Renal Registry by the trust. This meant that clinic specific data was not available.

Staff monitored the effectiveness of care and treatment in line with clinical standards. Blood results were collated and monitored to establish the effectiveness of treatment in line with Renal Association guidelines. Results were shared with the consultant nephrologist at the commissioning trust and clinical discussions took place regarding patient treatments.

The urea reduction (URR) rate is one measure of the quality of dialysis. August 2021 figures provided by the service showed the proportion of patients meeting the standard of a URR greater than 65% was 80%. October 2021 figures showed improvement, with the proportion of patients meeting the standard at 90%.

The clinic manager monitored clinical variance rates to identify where improvements could be made. Variances were reported in areas such as shortened dialysis times, did not attend (DNA) rates, patients over target weight (indicating excessive fluid) and poor line flow. Variance rates between July and September 2021 ranged between 5% and 8%. Results were discussed at governance and manager meetings and actions to improve were explored. For example, DNA rates were reported on the electronic incident system to identify trends and ensure appropriate follow up. In addition, staff worked with patients to increase their involvement in monitoring their health to improve outcomes. Examples included empowering patients to monitor their own weight and recording pre dialysis observations.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The clinic monitored water quality, blood results and clinical variance. Clinical outcomes were monitored against the Renal Association standards and referring trust requirements.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Senior staff had completed post graduate renal modules. Staff were encouraged to apply to attend university led training in renal care and senior staff supported them throughout.

Managers gave all new staff a full induction tailored to their role before they started work. New nurses on the unit were not required to have previous renal experience and full training and support was provided. Specialist training and competency assessments were part of the induction process. Structured training sessions and practical competency assessments included cannulation, intravenous administration, aseptic no touch technique and dialysis skills.

Managers supported staff to develop through yearly, constructive appraisals of their work. These included a review of competency and identified personalised development aims. Staff were encouraged to develop their competence and complete relevant specialist modules. Associate practitioners and healthcare assistants were supported to develop their skills including access management and dialysis competencies.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us there was good communication between managers and staff. They consistently demonstrated a good understanding of the priorities and areas for development within the service.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they had many opportunities to develop within the service.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The clinic was nurse led where nurses provided prescribed treatments for patients who were under the management of a named consultant nephrologist at the commissioning trust.

Remote monthly multidisciplinary team (MDT) meetings at the trust. These were held to review patient outcomes and discuss changes in treatment. Information from the outcomes of these meetings was shared via the electronic record system. Nurses shared information about changes to treatment with patients at their dialysis sessions.

Staff told us there were effective working relationships with staff at the trust including doctors, specialist nurses and the renal social worker. We saw evidence of patient referrals to other specialist services including for dietetic advice and occupational therapy referrals.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Referrals were made through the commissioning trust.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had relevant information promoting healthy lifestyles and support. This included providing reference materials and signposting to other services. Information about healthy eating was available and self-care was promoted within the philosophy of the unit. The aim of the philosophy was to help patients to achieve and maintain a realistic and recognisable state of wellbeing.

Good

Dialysis services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us that as patients attending the unit had a certain degree of health it was unusual to treat patients with declining mental capacity. However, staff demonstrated a good understanding of consent and the process for assessing capacity.

Staff made sure patients consented to treatment based on all the information available. Staff gained consent from patients for their care and treatment in line with legislation and guidance. All staff had completed consent training. There were signed 'consent to treatment' forms held in patient files. These forms included consent for treatment and the sharing of information such as blood results. Patients also consented to the use of photographs for fistula management. Consent was reviewed on an annual basis.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. They had completed Mental Capacity Act 2005 and Mental Health Act 2007 training.

Are Dialysis services caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw patients being greeted by staff with respect. Staff listened to patients and allowed them time to prepare for treatment. We observed staff responding promptly to call bells and dialysis alarms. The local NHS trust patient reported experience measures (PREMs) included patients treated at the clinic. Renal Services UK managers reviewed the results and reported on them internally. Results for communication and support were marginally higher than the national average.

Patients said staff treated them well and with kindness. We spoke to three patient who were positive about the care they received. They described staff as friendly and kind. Staff had time to listen to them and they were able to ask questions. Patients had a named nurse they could speak to about any questions or concerns.

Staff followed policy to keep patient care and treatment confidential. Staff maintained patients' privacy and dignity using privacy curtain during treatment. PREMs results for privacy and dignity were 6.6 compared with a national score of 6.47.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff had completed equality and diversity training.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff told us they had time to spend with patients and had a good understanding of their psychological and emotional needs. They would refer any concerns to the dialysis hub at the commissioning trust where there were support services available.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. A consultation room was available for private conversations.

Staff undertook training in communication skills and demonstrated empathy when having difficult conversations. We saw staff spending time with patients discussing their needs. We observed staff supporting an unwell patient and saw that they did so with kindness and were focused on emotional as well as physical support.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. They spent time with patients explaining what they were doing and involving them in their treatment and care.

Staff supported patients to make informed decisions about their care. An audit of shared care had been carried out and a project to improved shared care commenced. The audit questionnaire identified patients who were interested in sharing their dialysis care. This included opportunities to measure their own baseline observations, setting up machines, programming machines and putting in an taking out their own needles. Prior to the programme three patients were actively involved in their dialysis care. Those interested in sharing their care had support from the project lead nurse on an ongoing basis, including education, support and supervision. At the end of the initial phase of the programme 25 patients were sharing their care with staff. This included nine patients recording their pre and post dialysis weight, five patients measuring their observations, five patients programming their dialysis treatment and one patient connecting and disconnecting and self-needling. The benefits of the programme included increased control over treatment, greater understanding of treatment, increased confidence and independence.

Patients gave positive feedback about the service. Patient reported experience measures as part of the overall commissioning trust's dialysis figures were positive and above the national average. Patients told us they felt supported by staff and that the atmosphere in the unit was positive.

Good

Dialysis services

Are Dialysis services responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service was commissioned on behalf of patients who attended the local NHS trust. This was in response to the need for additional capacity to deliver renal dialysis in the local area. Patient numbers were agreed as part of a service level agreement. Patient referrals to the service were organised by and agreed with the commissioning trust.

The trust organised transport to and from dialysis sessions. Patients were dropped and collected at the entrance to the building. Those patients driving themselves were able to park within designated parking in the immediate vicinity. The service did not audit waiting times for transport or any delays. Staff reported that delays were minimal. We observed patients being collected and dropped off within a reasonable time of their treatment. During the pandemic patient transport was subject to risk assessments and adjustments made. Single transport was provided as a result, or where a larger vehicle enabled social distancing two patients could travel together.

Facilities and premises were appropriate for the services being delivered. The service was delivered from a purpose-built facility within a business park in North Shields. The location had adequate designated parking spaces for patients choosing to drive themselves to treatment. The building was wheelchair accessible.

The design of the unit enabled patients to access the service through a level entrance and remain two metres apart in line with social distancing guidelines. The waiting area had seating appropriately distanced. Weighing scales were accessible for those patients in wheelchairs. Toilet facilities were available off the waiting area so that patients could use them before and after dialysis.

The nursing station provided good oversight of the unit. Dialysis chairs and beds were adjustable to support patient preference and comfort.

Managers monitored and took action to minimise missed appointments. This included on call arrangements for technician support in the event of system failures within the service. We observed a situation where such support helped minimise the delay in starting dialysis on the day of inspection. Staff adjusted start times for dialysis to ensure that all patients had their treatment despite a delay of approximately 45 minutes. There was a business continuity plan in place in the event of longer delays or interruptions within the service. This included access to emergency support for water, electric and internet services. There were arrangements with other Renal Services (UK) Ltd services, and the local NHS trust should alternative dialysis arrangements be needed in the event of service disruption.

Managers ensured that patients who did not attend appointments were contacted. This included follow up and encouragement to attend for treatment. Staff were flexible and arranged rescheduled treatment sessions promptly

when a session was missed. This included collaboration with the NHS trust to arrange additional dialysis sessions as needed. Missed appointments were recorded as incidents so that they could be monitored for trends and followed up appropriately. Records of missed appointments we viewed were due to individual patient situations and not as a result of issues within the service.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made reasonable adjustments to help patients access services. The service was accessible to people using a wheelchair and could accommodate bariatric patients. They coordinated care with the NHS trust who commissioned their services. As a satellite dialysis unit patients referred were medically stable in line with the agreement with the trust. Patients with more complex needs or those who developed complex needs were dialysed at the trust's hub dialysis unit. Decisions on the appropriateness of patients dialysed by the service sat with the consultant nephrologist. Staff communicated regularly with the consultant and commissioning trust to ensure appropriate care and treatment was given. Weekly virtual meetings were held to discuss ongoing patient needs. Dialysis sessions were usually of four hours duration. Staff discussed patient care with renal clinicians and explored how to provide treatment in collaboration with patients and taking into account patient preferences. This was sometimes to increase or decrease the number or length or dialysis sessions in consultation with the patient and the consultant nephrologist.

Staff recognised that patient's had choice around their treatment and care and had other commitments. They were flexible and supported patients to change scheduled treatment times as needed. Patients had choice in the day and time of their dialysis, with twilight sessions available three days a week.

The service did not provide dialysis away from base routinely, for example, for patients in the area on holiday. This was coordinated by the commissioning trust. However, staff were flexible and had on occasion dialysed patients not normally scheduled with the agreement of the trust.

Patients wishing to participate in their own care were supported to do so. We observed patients monitoring their own weight and observations. Participation was based on patient choice and this was assessed on an ongoing basis. Patients received training and assessment to establish their confidence in participating in their own care.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Because the service was designed to support patients who were medically stable, there were limited times when patients with additional needs were dialysed on the unit. However, staff were trained in understanding dementia, mental health and learning disability needs. Staff knew how to access support from the commissioning trust's specialist services.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had an accessible information standard procedure in place. An assessment form was seen in patient records although this was not always completed. Where information and communication needs were identified, this was recorded in patient records to ensure that appropriate support was given.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There were able to access telephone interpretation services when required, although told us this was rarely needed.

Good

Dialysis services

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service had provided an average of 550 dialysis sessions per month in the last year. The clinic had the capacity to take 60 patients and 44 patients were being treated at the time of the inspection. Patients could access services promptly when needed. Referrals for admission came from the commissioning trust's consultant nephrologist. There were no patients on the waiting list. The service was open Monday to Saturday running either two or three sessions per day.

Managers and staff worked to make sure patients did not stay longer than they needed to. They identified delays and took action to address them. This included providing feedback on transport issues and ensuring prompt maintenance repairs to systems where necessary.

Managers worked to keep the number of cancelled treatments to a minimum and treatments were rearranged as soon as possible within national targets and guidance. Staff told us there had been no unit cancelled treatments since the last inspection. They were flexible and communicated with patients to ensure the continuation of treatment. Staff told us that patients were generally able to be rescheduled at short notice, including at the commissioning trust if this was more appropriate.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service clearly displayed information about how to raise a concern in patient areas. There was a patient information leaflet with details of how to complain and the timeline for response. Patients were encouraged to complain directly to staff in order to have their concerns addressed as quickly as possible. Information provided to patients included the process of escalation to senior staff if they remained dissatisfied. Patients were also given information about contacting the Public Health Service Ombudsman (PHSO), in the instance of complaints not able to be resolved internally.

Staff understood the policy on complaints and knew how to handle them. They were open and friendly and encouraged patients to raise concerns with them so they could be quickly addressed.

Managers investigated complaints and identified themes. Managers treated concerns and complaints seriously. Lessons were shared with all staff. Complaints were recorded on an electronic system. Response timings were identified. There was one written complaint made in the 12 months preceding the inspection. We saw that acknowledgement, action and resolution was prompt and in line with the timeline within the complaints policy. Complainants were informed of investigation outcomes and asked if they were satisfied with the action taken.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. Following a concern from a relative about the

discomfort a patient felt during treatment, a bed rather than a dialysis chair was made available for them. The service installed two beds in the unit as a result of this complaint, providing choice for those wishing to use them. Complaints were reviewed at the integrated governance meetings. Themes and trends were identified to share learning across locations.

Are Dialysis services well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The CQC registered manager was the regional manager, who had responsibility for seven individual units. They were knowledgeable and experienced about the speciality and were clear about their responsibilities and reporting processes. The regional manager reported to the director of clinical operations. At our inspection in 2019 we were concerned that the registered manager did not have enough management time to effectively manage alongside of their responsibilities to other units. They told us they felt they had enough time to support the service and were available to staff on days they weren't on site. In addition, they told us that the unit manager was currently being trained to take over the role of registered manager. The unit manager was an experienced senior nurse with who had worked on the unit for four years.

Staff told us that the regional manager and other senior staff within the company were visible and approachable. A member of the corporate senior nurse team was available for support or advice via telephone or email. Senior staff within the commissioning trust were also available for support with clinical decision making.

Staff told us they were well supported by the regional and unit managers. Staff morale was high and there was clear shift leadership on a day to day basis.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Renal Services (UK) Ltd had were in the process of integrating with Davita International Group. They had a vision to create 'the greatest healthcare community'. Strategic initiatives included the provision of integrated kidney care to help people better manage their kidney disease; and, developing solutions to transform healthcare for patients with kidney disease. There was a focus on caring for each other, including the community, patients and teams. They had a 'we care' behaviour philosophy - welcome, empathise, connect, actively listen, respect, encourage. Staff told us they had been involved in discussions about the vision and strategy.

The vision aligned to local plans within the wider health economy. The corporate provider routinely engaged with local NHS services to assess the needs of local patients who needed dialysis.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were positive about working at the service. There was a clear patient focus. The provider had a zero-tolerance policy in place to manage discriminatory or abusive behaviours. Staff had completed equality and diversity training.

There were opportunities for career development. Senior staff had all completed specialist renal modules at university and there were similar opportunities for other staff. There was internal development programme in place which included training staff with little or no experience and providing opportunity to develop.

Staff felt that they could raise concerns without fear. There was a compliance hotline in place, where staff could report concerns without having to go through the management structure. However, the service did not have a named freedom to speak up guardian. Staff told us they felt confident to use the hotline if necessary and felt able to raise concerns to senior staff and managers.

Governance

Leaders operated governance processes, throughout the service and with partner organisations, although these were not always effectively operated. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Structures, processes and systems of accountability to support the delivery of good quality, services were effective. Staff we spoke with on the unit were clear about their roles and accountabilities.

Quarterly executive board meetings and integrated governance meetings were held. Senior corporate and operational staff attended governance meetings, including the registered manager. There were processes in place to discuss incidents, complaints, performance and business development. Covid-19 was discussed at the meetings, with a review of national guidelines and the impact of staff isolation and positive test results among patients and staff across the organisation. An action log was used to review ongoing governance issues, including actions in response to incidents, policy development and vaccination rates among staff.

Monthly clinic manager meetings were held with the head of nursing. Minutes showed that areas of governance and performance were reviewed. This included incidents, treatment variances, audits, safety alerts, risks, policies, training, health and safety, staff issues and company business. Clinic managers were responsible for sharing information with their teams and we saw evidence of this when we inspected. Staff reported being kept up to date with changes and receiving feedback from managers on areas such as performance, safety issues and learning. Information was shared in meetings on the unit or via email if staff were unable to attend.

Quality assurance audits were carried out on a monthly basis. This included for medicines management, infection control, treatment variances, health and safety and documentation. However, audit processes did not always pick up on issues, for example, in relation to out of date privacy curtains or actions to reduce high ambient room temperatures not being recorded.

Compliance with service protocols were reviewed as part of the audit process and results discussed at relevant meetings and shared with staff.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Corporate and service level risk registers were maintained. Service risks such as electrical failure and loss of water supply were identified, and mitigating actions taken to reduce the level of risk. Business continuity plans were in place to address disruptions in service. The service was on the critical priority list for both water and electricity provision. Risks such as poor weather, staff isolation or Covid-19 outbreaks were recorded on the register and appropriate actions were in place to minimise the risk. Risk registers were reviewed centrally as part of clinic manager meetings.

Clinical patient outcome results were collated, and performance reviewed by the clinic and registered manager. Information about this was shared in the form of reports and discussed at relevant governance meetings.

The commissioning trust reviewed performance against the service contract.

Health and safety measures were in place to monitor and maintain equipment and premises. However, it was noted during the inspection that not all dialysis machines had been serviced by their due date. Other issues were identified around equipment calibration and fire safety checks not being carried out in line with guidance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Patient care needs and outcomes were recorded in the electronic patient record system. Information was shared with the hospital team via the shared record facility. Appropriate patient consent for sharing information was recorded. Paper records were held securely, and these could be couriered to the NHS trust in situations where care was transferred. IT systems were protected by security measures and all staff had their own login.

Data was analysed centrally and reviewed at relevant governance meetings to ensure that staff understood performance and the measures required for improvement. A review of data and evidence of performance discussions was seen in governance meeting minutes. Managers understood requirements for submitting notifications to external bodies.

Engagement

Good

Dialysis services

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We observed staff actively engaging with patients about their treatment, before and during dialysis. Each patient had a named nurse and they encouraged patients to share their care and opinions about the service. There was evidence of changes in response to feedback, for example, the addition of beds for patients' comfort. Patient surveys were ordinarily carried out annually towards the end of the year, although this had been impacted by the pandemic. Patients within the service completed the trust's Patient Reported Experience (PREMs) surveys and results were above the national average. The manager told us they had scheduled an internal survey for the new year, once the 2021 PREMs survey was completed in November. This was to not overwhelm patients with two surveys at once.

Staff told us they felt engaged with the provider and had opportunities to feed back and be involved in improvements. An annual staff survey had been completed in 2021 that included questions about management support for wellbeing, work/life balance, feeling valued and respected. Results showed responses were mostly positive or neutral, however, it was unclear what action was being taken by the provider to improve, this was a continuing issue from a previous inspection.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Staff we spoke with during our inspection demonstrated they were committed to continually learning and making improvements to the service. Staff understood the services performance against key performance indicators and other measures. They could identify where improvements were required were open to challenge poor practice. Meeting minutes showed that learning from incidents and complaints was given priority and there was evidence of appropriate improvements.

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 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met:** • The registered person had failed to ensure that all equipment used by the service was suitable for the purpose for which they are being used. In particular: disposable privacy curtains were not regularly changed and disposed of and suction tubing on the emergency trolley had expired. • The registered person had failed to ensure that all equipment used by the service was properly maintained. In particular: dialysis machines were overdue their annual maintenance, emergency equipment was overdue calibration. This was in breach of Regulation 15 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.