

Renal Services (UK) Limited

Renal Services (UK) Ltd - Holsworthy

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

Requires Improvement



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?

Requires Improvement



Summary of findings

Overall summary

We have not previously inspected this service. We rated it as requires improvement because:

- The service had not always recognised key risks to patients and staff and taken action to mitigate these.
- While the provider held evidence of quality assurance, governance, and safety compliance centrally, this was not easily accessible locally. Staff were not always aware of provider-level work, which meant there was a gap in assurance.
- Documentation and monitoring of equipment servicing, and maintenance was inconsistent and did not provide assurance of a safe working system.
- The service did not engage well with patients and staff and there was a clear focus on corporate-level drives that did not always reflect local work at this unit.

However:

- The service operated with a staffing level agreed in advance with the referring NHS trust.
- Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- 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.
- 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.
- 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.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Summary of findings

Our judgements about each of the main services

Service		Rating	Summary of each main service
Dialysis services	Requires Improvement		We rated this service as requires improvement. See the overall summary for more information.



Summary of findings

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Summary of this inspection

Background to Renal Services (UK) Ltd - Holsworthy

Renal Services Ltd (UK) – Holsworthy is operated by Renal Services (UK) Limited. It offers planned dialysis services to patients under the long-term care of a nearby NHS trust as well as occasional patients from other areas visiting on holiday. This was the first inspection of the service since its registration.

The location has three dialysis chairs in one bay and a private side room equipped with dialysis equipment. The unit operates six days a week and is registered to provide the regulated activity of treatment of disease, disorder and injury.

Care is nurse-led and medical oversight is sought from the local NHS trust when needed.

How we carried out this inspection

We carried out an unannounced inspection of the service on 30 March 2022. Our inspection team consisted of a lead inspector and a specialist advisor with clinical experience of renal services. An inspection manager provided remote support.

After our inspection we carried out a series of remote interviews with the senior leadership team and registered manager. We also asked the provider to send us additional evidence of working standards, practices, and outcomes.

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>.

Outstanding practice

We found the following outstanding practice:

- The provider promoted the national shared haemodialysis care guidance from Kidney Care UK and The Renal Association. The programme empowered patients to take as much responsibility with which they felt comfortable in leading their care alongside the service. For example, nurses trained patients to take their own blood pressure and to assess changes in symptoms that might indicate a change in condition.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **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 should ensure that governance systems and frameworks reflect local, specific risks, issues, and performance. (Regulation 17)
- The service must ensure the senior leadership team engage with staff consistently. (Regulation 17)

Summary of this inspection

- The service must ensure staff have equitable access to corporate drives and strategies. (Regulation 17)

Action the service SHOULD take to improve:

- The service should ensure that governance systems and frameworks reflect local, specific risks, issues, and performance.
- The service should ensure local documentation of equipment maintenance and servicing is up to date.
- The service should ensure consistent use of the equipment cleanliness labelling system.






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	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Dialysis services

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

Are Dialysis services safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills to permanent staff and made sure they completed it. There were gaps in assurance in training for temporary or flexible staff.

Staff received and kept up-to-date with their mandatory training. At the time of our inspection the mandatory training completion rate was 96%. This included permanent members of staff. The service kept separate training records for bank and agency staff.

Mandatory training was comprehensive and met the needs of patients and staff. It included 29 modules relevant to the service and the provider supplemented this with ad-hoc specialised training.

The clinic manager monitored mandatory training and alerted staff when they needed to update their training.

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. The associate director of clinical services was the named safeguarding lead and was trained to level four. The head of nursing was in the process of completing level four training to provide staff with an additional point of contact for safeguarding concerns.

Staff completed safeguarding training for adults and children to level 3 as well as national 'PREVENT' training, which aimed to identify people at risk of radicalisation.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Consultants from each patients' NHS trust provided details in advance of any safeguarding concerns. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding processes were fully embedded in the service and reflected the nature of care. All local patients were under the substantive care of an NHS trust. Staff maintained up to date contact details for the trust safeguarding team.

Dialysis services

The clinic provided short-term dialysis for patients on holiday in the region. The referrals team ensured the patient's home trust provided contact details for their duty safeguarding service, which local dialysis staff could use in the event of a concern. NHS safeguarding contacts were supplementary to the provider's own safeguarding process, which enabled staff to access rapid support at any time.

The provider was in the process of implementing a new safeguarding policy and had an established safeguarding champion system. However, there was no safeguarding contact information on display in the clinic during our inspection. Afterwards, the provider told us this information should be readily available.

Cleanliness, infection control and hygiene

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.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The service performed well for cleanliness. The clinical services team audited monthly standards in five areas, including hand hygiene and environmental cleaning. In the previous 12 months the service reported 100% compliance with provider standards of practice.

Staff used a series of nine monthly audits to monitor standards of infection prevention and control. This was a flexible system based on risk and the senior team increased audit frequency when results were lower than the target. Audits included a benchmark against the World Health Organisation five moments to hand hygiene, environment cleaning, and uniform standards.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact although did not use a labelling system to show when each item was last cleaned.

Staff monitored access site infections. In the previous 17 months there were none reported.

Environment and equipment

The design of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. Equipment maintenance documentation and tracking was inconsistent.

Patients could reach call bells and staff responded quickly when called. The design and size of the unit meant staff could see all patients most of the time. All areas were equipped with emergency call equipment.

The design of the environment followed national guidance. The service was compliant with the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09 in relation to clinical environment design and HBN 00/10 in relation to infection control in the clinical environment.

Staff said they carried out daily safety checks of specialist equipment. However, there was a lack of local assurance that equipment was serviced and safe to use. For example, on the day of our inspection one patient was attached to an infusion pump that had no documentation of servicing or electrical safety. Local documentation indicated two dialysis

Dialysis services

machines were overdue for servicing. Another machine was marked as out of use awaiting maintenance and staff said the provider had arranged for collection imminently. However, this had not taken place over one week later. The provider held more up to date records that indicated equipment had been serviced. This meant maintenance and servicing arrangements were inconsistent.

The provider told us they used a programme of planned preventative maintenance to ensure dialysis machines were serviced in line with manufacturer guidelines. After our inspection the provider sent us evidence of equipment maintenance that was better than manufacturer guidance. This provided us with assurance of equipment safety and a need for improved local access to records.

The service had enough suitable equipment to help them to safely care for patients. The service offered pre-planned treatment and staff allocated equipment in advance. Equipment manufacturers provided training and updates to staff to ensure they maintained up to date practice.

Staff disposed of clinical waste safely and in line with DHSC Health Technical Memorandum (HTM) 07/01 (2013) in relation to the safe management and disposal of healthcare waste.

At the time of our inspection there was no controlled access to the clinical area, which exited directly into a car park. This presented a safety, security, and infection control risk and we raised it as a concern with the senior team. After our inspection the provider implemented a new entry system that addressed these concerns.

The manager carried out a simulated fire evacuation in January 2022 and changed local policies and practices as a result. For example, the simulation highlighted a need to keep patient's wheelchairs next to their dialysis chair to facilitate a fast exit if needed. Learning led to more comprehensive guidance for the nurse in charge and improved safety for the management of oxygen bottles.

The service was compliant with DHSC HTM 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste

Spill kits were stored in key locations and included equipment to help staff contain bodily fluid spills and other similar risks.

Staff carried out weekly water flushing of all outlets in the service as a strategy to reduce the risk of Legionella build-up. This approach reflected good practice and meant the service was compliant with DHSC HTM 04/01 in relation to the management of safe water in healthcare premises.

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 responded promptly to any sudden deterioration in a patient's health. Incident reports indicated staff acted quickly when patients' needs changed. Patients received care on a long-term basis and staff maintained an up to date understanding of their health needs.

Dialysis services

The provider had established patient eligibility criteria and the NHS trust triaged patients using this before making a referral. Staff knew about and dealt with any specific risk issues. Staff carried out a monthly falls risk assessment, and a manual handling risk assessment for patients every six months, or more often if their health condition changed. The assessments ensured staff provided appropriate support to patients when moving between transport, wheelchairs, and dialysis chairs

Staff completed risk assessments for each patient on arrival, using the national early warning scores (NEWS2) tool, and reviewed this regularly, including after any incident. This was a standard procedure regardless of whether the patient felt well, and staff started a new monitoring chart for each patient on arrival.

Staff completed an individual risk assessment with each patient on arrival. This included a general check of how they were feeling, a check for swollen ankles, feet, and legs, and a check for breathlessness. This reflected good practice and meant staff could modify treatment based on each patient's needs.

Routine treatment did not require planned handovers and staff knew how to carry out ad-hoc handovers to other health professionals in specific scenarios.

The service learned from instances in which patients deteriorated at other clinics and improved processes. For example, the service required more information from the referring trusts on the acuity of each patient and implemented a new assessment process to identify the specific phase of treatment during which deterioration started.

Staff undertook practical training in fluid assessment, anaphylaxis and vascular access and were trained in basic life support.

The unit was equipped with emergency equipment including an automatic external defibrillator (AED), oxygen, and breathing support equipment. Incident reports indicated staff used oxygen therapy and AEDs appropriately.

An on-call registrar and consultant nephrologist were available for urgent clinical discussions and referrals at all times the service was in session.

Staff audited safety processes and acted on the results to improve practices. For example, the service recently implemented a new key performance indicator for the management of venous needle dislodgements and the outcome monitoring of central venous catheter (CVC) outcomes and fistulas.

Staffing

Staff had 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, agency and locum staff a full induction.

Two registered nurses and one nursing associate dialysis assistant worked permanently in the clinic with support from a team of six bank staff. The usual staffing level was one registered nurse and one dialysis assistant.

Staff worked shifts of up to 15 hours and there was no relief cover in the event of an incident or staff member becoming unwell. After our inspection the provider told us the shift pattern was a result of staff preference.

Dialysis services

The service maintained a nurse to patient ratio of 1:4, which was the ratio agreed with the referring NHS trust. Up to 12 patients per day received dialysis and staff were responsible for all aspects of their care journey. On the day of our inspection, one registered nurse and one dialysis assistant were delivering care. This team dialysed 12 patients over a 14.5 hour shift. They were responsible for all clinical, operational, and logistical aspects of the service, including cleaning before and after patient lists.

The number of nurses and healthcare assistants matched the planned numbers. There was one vacancy in the unit.

The service had low turnover rates, with one staff departure in the previous 12 months.

Managers made sure all bank and agency staff had a full induction and understood the service.

The service did not employ doctors and the referring NHS trust always had a consultant and renal registrar on call.

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. The service kept records as part of the referral process. These included each patient's latest haemodialysis prescription, blood borne virus test results, and COVID-19 status.

When patients transferred between teams, there were no delays in staff accessing their records, such as when patients received dialysis temporarily while on holiday.

Records were stored securely and encrypted by the provider. The service archived records in hard copy and digitally and used service level access agreements with the referring trust about storage and access.

Staff audited standards of documentation monthly using a comprehensive tool that included clinical, demographic, and other care details. In the previous six months the service achieved over 99% compliance with provider standards.

Staff recorded blood results and uploaded them to the NHS trust's renal database. It was the trust's responsibility to submit the results to the renal registry.

Medicines

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

Staff followed systems and processes to store, manage, and administer medicines safely. Each patient's renal consultant prescribed anti-clotting medicines and staff administered these locally. They maintained a good standard of documentation, including tracking of stock and batch numbers.

Staff completed medicines records accurately and kept them up-to-date. Staff stored and managed all medicines and prescribing documents safely.

Staff carried out monthly medicines audits to benchmark standards against expectations in relation to preparation, documentation, and storage.

Dialysis services

Incidents

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them, including near misses and incidents involving other services. Between January 2022 and March 2022, staff reported 23 clinical variances, which included incidents. Of these, 61% related to intradialytic hypotension and 39% to the early termination of treatment.

Staff reported access problems such as fistula clots or poor blood flow to inform training, risk assessments, and local practices. In the previous 17 months staff reported 37 such instances, 90% of which related to poor blood flow.

Details of the four most recent incidents indicated staff took appropriate action to reduce harm. For example, the most recent incident involved a patient who experienced a side effect during holiday dialysis. The team contacted their home doctor and next of kin, stabilised their condition, and organised a transfer to hospital when they were concerned about the patient.

Managers shared learning with their staff about incidents that happened elsewhere and included the severity of harm to help staff learn from colleagues nationally.

Staff understood the duty of candour. The head of nursing was the named responsible person for the duty of candour and assessed each incident in line with the provider's framework to identify if the policy had been triggered. They were open and transparent and gave patients and families a full explanation if, and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff said they received feedback from the provider about improvements to patient care mostly by e-mail newsletters. However, incident records did not always include consistent standards of learning. For example, one incident reflected a patient who was injured when they fell in the waiting area. Staff implemented new standards of practice in relation to patients who used a wheelchair but there was no information as part of the investigation to identify if the local team had taken account of the patient's mobility during routine risk assessments.

The service identified areas for improvement relating to incident management. These included improved consideration of harm for patients who did not attend a scheduled appointment, a need for root cause analysis training for staff, and general incident management processes.

The provider maintained a record of patient safety alerts and communicated these using a register with local managers and staff.

Are Dialysis services effective?

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.

Dialysis services

All patients were under the long-term care of an NHS trust, whose consultants planned and monitored their dialysis regime. Staff followed policies and protocols based on guidance from the National Institute of Health and Care Excellence (NICE) and the Renal Association. Staff worked to NHS trust policy in relation to the ultrafiltration rates of haemodialysis patients.

Staff assessed vascular access and used medical photography to monitor access conditions over time, in line with NICE quality guidance.

Most policies and operating procedures were standardised across the provider. Managers tailored individual policies to each clinic, such as the local business continuity plan.

Nutrition and hydration

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

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Staff provided patients with guidance on healthy eating issued by The Association of UK Dieticians and the Renal Nutrition Specialist Group. This was an element of the service's overall approach to health promotion and used visual aids and individual diet plans to help patients prolong the useful life of their kidneys.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and supported them to relieve pain.

Staff assessed patients' pain using a recognised tool on arrival in the unit. They used a visual pain assessment tool throughout treatment to help patients express their degree of pain.

Staff did not administer pain relief and patients knew to bring their own medicines with them to self-administer. The provider communicated this with patients in advance of starting treatment.

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 the national renal patient reported experience measures (PREMS) audit with the referring NHS trust. This was part of a reciprocal agreement in which the trust and this provider collaborated to identify patient outcome measures for patients who received care from both organisations. This was a new initiative and results were not yet available at the time of our inspection.

Staff used a rolling programme of non-clinical audits to monitor the service and check improvements. The programme was flexible, and staff increased frequency where they identified risks. Staff shared the results of audits with referring trust and consultants. This included water sampling results and blood monitoring results to establish the effectiveness of dialysis by monitoring urea reduction ration (URR). URR is a measure of how effectively dialysis is working.

Dialysis services

Outcomes for patients were positive, consistent and met expectations, such as national standards. The referring NHS trust benchmarked standards of care against the UK Renal Registry and Renal Association standards and worked with the provider to ensure the results were as expected. Alongside this process, the provider's integrated governance committee benchmarked each dialysis clinic against specific service requirements.

The trust's consultant nephrologist reviewed patient outcomes monthly and the provider's nursing team prepared data and adapted care based on feedback.

Staff reported treatment variances to the on-call consultant and reported these using the provider's electronic records system.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Dialysis assistants undertook competencies specific to their role and were qualified as associate practitioners.

Nursing staff undertook a novice to competent dialysis practitioner framework programme that enabled them to provide specialist care to patients with established renal failure (ERF). The framework was comprehensive and incorporated a four week introductory supernumerary programme that supported skills development.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. The process incorporated three performance reviews at key stages of the year to measure personal objectives and ensure staff had the support they needed.

The provider's nurse specialist supported the learning and development needs of staff. They worked with staff remotely and during site visits to deliver training and continuing professional development.

Managers did not routinely include all staff in team or other meetings. The senior leadership team said they convened team meetings on an ad-hoc basis only. They distributed the minutes from other meetings by e-mail.

The registered manager was a registered nurse and worked in the service clinically. Senior managers rarely visited the unit and said someone had visited only twice in the previous three months. We were not assured senior managers had enough oversight to identify training needs their staff had and provide time and opportunity to develop skills and knowledge. After our inspection the provider told us they felt oversight from the head of nursing and the nurse specialist was sufficient.

The provider worked with one agency to supply nurses on a long-term consistent basis. The agency ensured nurses retained core competencies that supplemented the provider's mandatory training. The agency provided regular assurance of up to date training.

Multidisciplinary working

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

Dialysis services

Staff worked within service level agreements and contracts with the referring NHS trust. The senior team joined monthly contract meetings with the referring NHS trust and said these were multidisciplinary in nature. However, the provider did not schedule or join a structured multidisciplinary programme.

Staff delivered care prescribed and monitored by NHS trusts who retained overall responsibility for care planning and pathways. Renal staff had telephone access to an on-call renal registrar and consultant nephrologist at all times the service was open in the event they needed a clinical discussion.

The service held details of each patient's GP and nurses were equipped to make community referrals if additional care or assessment was needed.

Staff liaised with GPs, hospices, and community teams to ensure patients with palliative or end of life care needs received coordinated, individualised care. Staff used a treatment escalation plan and electronic do not resuscitate (DNAR) forms shared with other service providers to ensure all staff were aware of patients' wishes. The unit manager worked with consultants in such cases to ensure they had a full understanding of need.

Seven-day services

Key services were available to support timely patient care.

Staff could call for support from doctors at the referring NHS trust and the provider's on-call team.

The clinic delivered care six days a week on a planned basis.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. This included printed information from relevant specialist organisations such as Kidney Care UK and The Renal Association to help patients manage lifestyle choices relating to long-term conditions.

Staff assessed each patient's holistic health at every appointment and provided support for any individual needs to live a healthier lifestyle.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They completed training in obtaining consent and the Mental Capacity Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients received care on a long term basis and did not need to consent to treatment at each dialysis appointment.

Staff clearly recorded consent in the patients' records. The provider had implemented a new audit to monitor how frequently staff reconfirmed consent from each patient.

Dialysis services

All patients were under the permanent care of an NHS trust and their lead consultant carried out substantive consent processes. The provider had a consent and Mental Capacity Act policy that guided staff in working with host NHS trusts to ensure they followed consent processes. This included where a trust used best interest decision making processes for patients with limited capacity to make decisions.

Staff worked with referring consultants to manage care for patients on palliative pathways and with advanced care planning for the end of life. They undertook specific consent processes alongside the consultant, which reflected each patient's unique circumstances.

Are Dialysis services caring?

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. Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential. The design of the unit meant most patients were dialysed in a shared bay in one room. Each dialysis bay had a privacy curtain and staff asked each patient if they wanted to use this. They carried out discussions with respect and discretion.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed this during our inspection and saw staff were naturally empathetic and caring.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Most patients received care in the unit on a long-term basis and staff got to know them well. For example, they knew which patients preferred to undergo dialysis in the private room and who preferred to remain in the bay with fellow patients.

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. They understood the demands of dialysis treatment on patients and delivered care with kindness to help reduce frustrations and anxiety.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed this during our inspection when staff skilfully deescalated a situation in which a patient became distressed.

Dialysis services

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. This was part of staff training and they used updated information from the referring trust to ensure they maintained a good understanding of each patient's latest needs.

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. Staff followed a 'named nurse' process, where individual nurses had allocated patients to support care planning, changes to treatment prescription and to identify changes in social needs. Each paired nurse and patient discussed their needs monthly and staff documented outcomes in patient notes.

Staff talked with patients, families and carers and provided information and advice. Staff proactively offered support where they observed social problems or familial tensions.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Posters in the clinic encouraged people to speak with staff or contact the provider with feedback.

The provider promoted the national shared haemodialysis care guidance from Kidney Care UK and The Renal Association. The programme empowered patients to take as much responsibility with which they felt comfortable in leading their care alongside the service. For example, nurses trained patients to take their own blood pressure and to assess changes in symptoms that might indicate a change in condition. This applied to all patients who wished to participate.

The referring trust gauged each patient's level of interest in self-care using surveys and communicated this with the dialysis team. Staff used a self-care training booklet to support patients with aspects of care such as weight management.

Are Dialysis services responsive?

Good 

Service delivery to meet the needs of 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 had 20 long-term patients and planned clinics for patients who visited the region on holiday. All patients were under the care of NHS trusts; the provider did not accept private referrals.

Facilities and premises were appropriate for the services being delivered. The unit was self-contained, and all areas were accessible by wheelchair.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff understood various routes of escalation within the provider and with referring NHS trusts.

Dialysis services

Managers monitored and took action to minimise missed appointments. The provider had a comprehensive standard operating procedure for patients who did not attend (DNA) appointments. Managers ensured patients were contacted and used a clinical escalation process that reflected the potential health implications of missed dialysis appointments. The procedure incorporated good standards of consent, such as when staff contacted a patient's next of kin if they could not be reached following a DNA incident. DNAs were the third most common incident reported nationally and accounted for just under 1% of all appointments.

The referring trust allocated patients based on where they lived to reduce the treatment burden through the most appropriate travel times possible.

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 sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff completed training in providing care to patients living with dementia. The provider offered training in understanding learning disabilities, but staff had not yet completed this.

The service had one private dialysis room and staff ensured patients could use this when needed to help with privacy or reducing anxiety.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

The associate director of clinical services and the head of nursing were the leads for dementia and mental health for the provider. The head of nursing said it was very rare patients required additional help or support at this clinic.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. They arranged this in advance when patients were referred from the trust.

The service provided short-term dialysis for patients visiting the region on holiday. The patient's home NHS trust liaised with the provider to arrange this and the clinic's nearest NHS trust provided on-call support in the event of a problem. For example, sometimes patients arrived without a prescription or with an unexpected need that could delay treatment. The local clinical relationship meant such delays were minimised while an appropriate doctor reviewed the patient.

Staff carried out an accessible information assessment for each patient to assess needs in relation to clinical information and care discussions. This assessment included needs relating to learning disabilities. The local NHS trust provided access to a learning disability lead nurse through a service level agreement. Staff could obtain dedicated support on demand.

Access and flow

People could access the service when they needed it and received the right care promptly.

The service provided care and treatment for NHS patients already under the care of a named consultant. The referring trust managed capacity and demand within the clinic's staffing structure and opening availability. The clinic did not initiate patients onto dialysis pathways and was not responsible for waiting lists or times.

Dialysis services

The service had no cancelled appointments or clinics in the previous 12 months. The provider had a staffing contingency plan to prevent this happening due to the potential for patient harm.

The provider used a standard operating procedure to triage requests for holiday patient dialysis. Where patients did not meet eligibility criteria, the provider's medical director worked with referring consultants to identify if they could arrange safe care.

The service monitored delays to appointments. In the previous 17 months staff had started treatment with 100% of patients within 30 minutes of arrival.

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.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff in the unit were responsible for all aspects of the daily operation and were trained to resolve minor issues and deal with complaints.

The unit had not received any formal complaints. Managers shared feedback from complaints in other units with staff to support learning. Staff could give examples of how they used patient feedback to improve daily practice. The provider recorded 53 formal complaints in 2021 across all clinics. The service monitored these at a national level and found the most common complaint, reflecting 10%, related to staff attitude, conduct, and care. Equipment or facilities and overall service were the next most common complaint themes.

Are Dialysis services well-led?

Leadership

Senior leaders did not demonstrate they understood and managed the priorities and issues the service faced. They were rarely visible and approachable in the service for patients and staff. However, staff spoke positively of local leadership.

The registered manager was the unit manager and a registered nurse. They led the clinic at the same time as delivering care and did not have protected time for management duties.

During our unannounced inspection, an agency nurse led the unit. They ran the patient list and unit effectively but there was very limited access to support from the senior or national teams. In our discussions with senior managers, they used terms such as "self-sufficient" and "isolated" to describe this unit. We were not assured the local team had access to adequate, consistent leadership support. After our inspection the provider sent us details of how centralised teams support the clinic, including the on-call availability of senior managers.

The provider's corporate leadership team had not recognised the vulnerability of the local team in relation to their low numbers and working hours.

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The associate director of clinical services, the head of nursing, a nurse specialist, and the clinical governance manager formed the senior leadership team (SLT) and worked across all the provider's locations. We were not assured the SLT had a good grasp of local issues. They visited the unit rarely and a senior manager had been present on two occasions in the previous three months. The nurse specialist visited the unit quarterly. After our inspection, the provider told us staff had access to the contact telephone number for each senior manager and support team.

The provider had recently changed ownership and the senior and local leadership teams spoke positively about related changes. While this resulted in processes that impacted staff in this unit, it was not clear how the provider was assured local staff were included in corporate-level developments. After our inspection the provider told us the registered manager had joined two management meetings in the 20 months since the provider change to enable them to brief the local team. The provider said they facilitated the participation of all staff in events such as the Queen's Jubilee.

The registered manager met colleagues from other clinics at quarterly leadership days, which enabled them to keep up to date with national priorities and challenges.

Vision and Strategy

The service had a vision for what it wanted to achieve. The vision was focused on sustainability of services and aligned to local plans within the wider health economy and was focused primarily at corporate level.

The provider had an overarching mission and a set of seven core values to which staff subscribed to. Senior staff said the values had been developed with NHS trusts recognising the close working relationships of services. Staff recognised this as a national focus, with the new owner's drive to change working culture. This was not always translated locally, and staff said they worried about their professional future.

Senior staff were demonstrably focused on the corporate-level development of the organisation and it was not clear they had applied this to the unit. For example, senior managers said this unit was "isolated" and then spoke about a need for greater staff belonging at corporate level. There was very limited evidence a strategy was in place to bridge such different priorities.

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.

The senior provider team said they felt morale amongst staff was very good. They said staff could call them at any time for support or a chat. While staff spoke similarly, it was not clear this worked in practice.

Staff were invited to weekly virtual huddles and communication exercises with colleagues nationally. The provider had tasked the registered manager with leading a local culture change as the new owner became more embedded.

The provider had a clear focus on promoting equality and diversity in the workforce and corporate communications and exercises reflected this. However, the SLT did not demonstrate an appropriate understanding of how such work was applied at local clinic level. This meant the corporate approach was ineffective and did not have a positive impact. For example, a senior manager told us, "You won't see diversity [in this unit]," although the registered manager

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demonstrated how the team was diverse. This reflected the lack of presence of the senior team. After our inspection the provider sent us a range of information that reinforced the corporate focus on equality and diversity and said this was cascaded to the team at this clinic, through clinic manager meetings. While this reflected good practice, we were not assured of the impact at a local level.

The provider had introduced a new peer recognition and reward system that enabled staff to nominate colleagues who demonstrated the core values. The system required a manager to approve the recommendation, which meant the system did not enable or empower staff to share feedback independently. The provider told us this system ensured fairness in the nomination and awards system and noted staff could provide positive feedback using other systems at any time, which did not require management approval.

Governance

Leaders operated inconsistent governance processes. Local staff were clear about their roles and accountabilities but opportunities to meet, discuss and learn from the performance of the service were limited to senior staff at corporate level.

The integrated governance committee was responsible for implementing the clinical governance and quality assurance strategy. While the strategy incorporated clinical aspects such as the role of a medical director and clinical nephrologist in reviewing clinical issues, it did not provide a suitable framework from which the provider gained assurance of consistent standards.

The SLT was responsible for an integrated governance system including the management of policies and procedures and acting on audits. They used a centralised system that provided oversight of all clinics in the provider's network.

The head of nursing led a monthly clinical manager's meeting to review incidents, complaints, audit results, policy updates and learning. They sent meeting minutes and presentations to all staff afterwards. However, we were not assured there was an effective system of assurance that staff of all grades read and understood this information. For example, the provider told us monthly updates included a signature sheet for staff to denote they had read and understood updates. However, the provider did not audit or check this.

The provider's integrated governance committee met quarterly although it was not evident how this contributed to local outcomes and working practices. After our inspection the provider sent us evidence of wider communications and processes within the clinical services team that included systems for sharing information and key performance indicators. While this indicated a more structured governance framework, it was not clear from the wider evidence that this supported care from this individual clinic.

We were not assured the provider's senior nursing team had regular, meaningful governance-level engagement with this clinic. For example, most senior staff we spoke with did not know how often the clinic opened and could not tell us about local issues and governance challenges.

Management of risk, issues and performance

Leaders did not use effective systems to manage risk and performance. They identified generic risks and mitigating strategies were limited.

We were not assured the provider had a good understanding of risks and challenges specific to the Holsworthy location. For example, a member of the SLT told us they had very few concerns about the location and the team tended to work

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without the need for regular leadership visits. While the unit had a risk register, this had not identified a clear security risk we found during our inspection and did not reflect the risks associated with the staffing structure. For example, the senior team had recognised risks to performance and infection control standards caused by low staffing levels, without identifying risks to staff.

A member of the SLT told us they were unaware of any incidents reported at this clinic. However, the provider submitted data that included an incident log. This meant appropriate senior staff were not always aware of the running of the service. After our inspection, the provider sent us evidence of more consistent incident reporting and improved senior leadership input.

Staff used an electronic risk management portal to grade potential levels of harm from risks. The registered manager audit entries and presented these to the governance committee for consideration.

The senior corporate team maintained a local risk register that included contingency plans for issues such as local weather disruption and service interruption in the event of a utilities failure. This was appropriate to the location, which was a standalone unit isolated from other health providers.

Integrated clinical governance committee meeting minutes indicated the senior team discussed learning and incidents at national, provider level. It was not evident how they translated such areas to specific clinics. For example, in April 2022 they noted a key safety area for improvement was for units to be “generally cleaner.” There was no further detail about the problem or how it applied to each clinic.

The SLT were in the process of reviewing policies and procedures as part of a quality improvement programme. This led to new standards of infection prevention and control and new guidance for staff on supporting carers who visited with patients.

Staff performance was a key element of the provider’s corporate objectives and the service performed well in this area in 2021. This included over 90% retention of staff who had been with the provider for fewer than 12 months.

Information Management

Information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff completed training in documentation, data protection, record keeping, and information governance and had 83% compliance at the time of our inspection.

Staff shared data with referring NHS trusts using secure systems.

Engagement

Leaders did not effectively and openly engage with staff and patients.

Senior staff said they felt engagement was consistent with local teams. However, the service had not reinstated practical, in-person training with staff and there were very limited opportunities to meet. Staff said they felt the senior team were approachable.

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We were not assured the provider had consistent engagement with the local team. For example, they were excluded from a provider-level engagement exercise aimed to establish areas staff wished to see improve. While the provider requested the team take part in a national survey, they disregarded the results because of the small size of the team. While the registered manager was empowered to adapt the engagement processes to the local team, it was not evident this resulted in structured communications and opportunities locally.

The registered manager was working with their team to create an action plan for staff engagement based on the themes of diversity and belonging. This was an alternative to the provider's corporate engagement strategy.

The service had suspended a rolling programme of patient feedback using an electronic tablet due to COVID-19. The senior team said they were considering reintroducing this in July 2022. There was no alternative to obtaining on-going feedback.

Learning, continuous improvement and innovation

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

The provider used the integrated governance framework to identify opportunities for learning and service improvements. This demonstrably worked well at corporate level and for larger clinics, but it was not evident this clinic benefited from the work.

The provider registered all clinical staff with the Association of Nephrology Nurses UK. This enabled staff to access professional and clinical support, education, training, and developments in kidney care through forums, e-learning and other innovative training.

The provider supported scholarships and awards with various NHS trusts and national organisations. These did not directly benefit staff in this unit although the senior team said they were open to local adaptations.

The provider company had an environmental and sustainability policy and was ISO140001:2015 accredited.

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The provider's senior leadership team did not have an understanding of the pressures on the local team and did not provide effective support.
- The service did not maintain accurate training records for bank and agency staff.
- The service had not always recognised key risks to patients and staff and taken action to mitigate these.
- Documentation and monitoring of equipment servicing, and maintenance was inconsistent and did not provide assurance of a safe working system.
- The service did not engage well with patients and staff and there was a clear focus on corporate-level drives that did not always reflect local work at this unit.