

Norfolk Dialysis

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Norfolk Dialysis is operated by Norfolk Dialysis Limited. Services are commissioned by NHS England. The service has two renal dialysis stations and offers short-term holiday dialysis for patients aged 18 years and over. The service does not offer regular, long-term dialysis services.

The service is open all year round and patients book their holiday dialysis in advance, with sessions available from Monday to Saturday. Morning and afternoon dialysis sessions are provided, with twilight sessions available on request.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 23 May 2017 and an unannounced inspection on 05 June 2017.

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

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

Services we do not rate

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

We found the following areas of good practice:

- Clinical areas were visibly clean and there were established processes in place for the cleaning and maintenance of equipment.
- There were clear criteria for admission to minimise the risks of patients with more complex needs being treated at the service.
- There were clear processes in place for ensuring that patients accepted for holiday dialysis had been appropriately screened for infections such as Methicillin-resistant *Staphylococcus aureus* (MRSA) and blood borne viruses.
- Staff were up to date with mandatory training, including basic life support, Mental Capacity Act (MCA) 2005 and safeguarding adults training (level two).
- Dialysis sets were single use and CE marked and checked by staff to be intact and within sterility date. This was in line with Renal Association Haemodialysis Guidelines (2009).
- Staff kept delivery notes with batch numbers for consumable items of dialysis equipment. This meant that if there were any problems identified with consumable items, staff could contact the manufacturer and refer to the batch number.
- Staff kept detailed records of care. We reviewed four patient records and found that all were signed, dated and legible.
- Patients received one to one nursing care. This was better than the nurse to patient ratio outlined within the Renal Workforce Planning Group guidance (2002) of one nurse to four patients.
- Policies and standard operating procedures were up to date and based on national guidance.
- Staff completed relevant local audits, for example audit of patient booking forms and prescription charts and identified recommendations for improving practice.
- Staff communicated with each patient's local dialysis unit to make sure they had all the relevant information about the patient's care, whilst adhering to data protection requirements.

Summary of findings

- Staff obtained written consent to treatment from patients before starting their first session of dialysis treatment. We reviewed six patient consent forms and found that all six were signed, dated and correctly completed.
- Feedback from patients about the service was consistently positive. An audit of patient satisfaction surveys for 2015 to 2016 showed positive results, with 100% of patients saying they would recommend the service.
- Patients were encouraged to self-manage aspects of their care if they wished to do so. Staff told us how they would be flexible to patients' needs and preferences, for example by offering flexibility in the timing of dialysis sessions, so that patients could enjoy their holiday.
- Staff offered patients support and reassurance while they were away from home. For example, the clinic manager told us they were available as a point of contact for patients outside the hours of their dialysis sessions.
- There was a clear complaints procedure, which was outlined in the complaints policy and shared with patients via a patient information leaflet. The service had not received any complaints from May 2016 to May 2017.
- No dialysis sessions were cancelled or delayed for non-clinical reasons from May 2016 to May 2017. An audit of patient satisfaction surveys for the period 2015 to 2016 showed that 100% of patients were satisfied with their dialysis times.
- There were clear objectives for the service, which were shared by the clinic manager and the deputy manager.
- Staff were experienced in renal dialysis. The clinic manager held the certificate in renal nursing.
- Staff were open in their approach to discussing the service and told us they were confident to challenge each other.
- There was external oversight of the service through yearly meetings with NHS England to review policies and ensure that quality standards were being met.

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

- Staff at the dialysis unit did not oversee or directly check resuscitation equipment because this was owned and maintained by the health centre where the dialysis unit was located. This meant that staff could not be assured that equipment was easily accessible and fit for use in the event of an emergency.

Staff completed competencies at a local NHS unit where they were separately employed. However, we were not assured that these competencies related specifically to Norfolk Dialysis or had been signed off in relation to the work staff carried out at this service.

- Translation services were not provided. Staff told us they used relatives to translate, which is not best practice.
- Staff had regular informal meetings to discuss the service, but did not keep records of these meetings. Staff did not keep a risk register to record and monitor risks to the service.

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

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to Norfolk Dialysis

Norfolk Dialysis is operated by Norfolk Dialysis Limited. The service opened in 2011. It is a holiday dialysis service in Kings Lynn, Norfolk, commissioned by NHS England. The service accepts patients aged 18 and over, for short term dialysis treatment while they are on holiday in the area.

The service is registered for the regulated activity of Treatment of disease, disorder or injury and has had a registered manager in post since 11 April 2011.

We previously inspected the service in 2013 and found that the service was meeting all standards of quality and safety we inspected against.

Our inspection team

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

Information about Norfolk Dialysis

The service consisted of a dialysis unit with two dialysis stations. The service was run by a clinic manager and a deputy manager, who were both registered nurses and were the only two members of staff.

We visited the dialysis unit. We spoke to both members of staff and two patients. We also received four 'tell us about your care' comment cards, which patients had completed before our inspection. We reviewed six consent forms and four sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

- Dialysis sessions were NHS funded, under a contract with NHS England. From 2016 to 2017, the service was commissioned to provide 250 sessions of dialysis.

- In the reporting period May 2016 to May 2017, staff carried out a total of 94 sessions of dialysis. Staff carried out 24 haemodialysis sessions for adults aged 18 to 64 years and carried out 70 haemodialysis sessions for adults over the age of 60 years.
- The provider reported no never events, clinical incidents or serious injuries in the reporting period May 2016 to May 2017.
- The provider reported no incidences of hospital acquired Methicillin-resistant *Staphylococcus aureus* (MRSA) or blood borne viruses in the reporting period May 2016 to May 2017.
- The provider received no complaints for the reporting period May 2016 to May 2017.

Services provided at the unit under service level agreement:

- Maintenance, calibration and electrical safety testing of equipment was provided by a third party, under a service contract.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We found the following areas of good practice:

- Clinical areas were visibly clean and there were established processes in place for the cleaning and maintenance of equipment.
- Patient selection was appropriate for a nurse led service. There were clear criteria for admission to minimise the risks of patients with more complex needs being treated at the service.
- There were clear processes in place for ensuring that patients accepted for holiday dialysis had been appropriately screened for infections such as MRSA and blood borne viruses.
- Staff were up to date with mandatory training, including basic life support training.
- Staff were trained in safeguarding adults (level two) and understood how to recognise and report safeguarding concerns.
- Dialysis sets were single use and CE marked and checked by staff to be intact and within sterility date. This was in line with Renal Association Haemodialysis Guidelines (2009).
- Staff kept delivery notes with batch numbers for consumable items of dialysis equipment. This meant that if there were any problems identified with consumable items, staff could contact the manufacturer and refer to the batch number.
- Staff kept detailed records of care provided. Records were signed, dated and legible.
- Patients received one to one nursing care. This was better than the nurse to patient ratio outlined in the Renal Workforce Planning Group guidance (2002) of one nurse to four patients.

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

- Staff at the dialysis unit did not oversee or directly check resuscitation equipment because this was owned and maintained by the health centre where the dialysis unit was located. This meant that staff could not be assured that equipment was easily accessible and fit for use in the event of an emergency.

Are services effective?

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

We found the following areas of good practice:

Summary of this inspection

- Policies and standard operating procedures were up to date and based on national guidance.
- Staff completed relevant audits, such as audit of patient booking forms and prescription charts and identified recommendations for improving practice.
- Staff communicated with each patient's local dialysis unit to make sure that they had all the relevant information about the patient's care.
- Staff obtained written consent to treatment from patients before starting their first session of dialysis treatment. We reviewed six patient consent forms and found that all six were signed, dated and correctly completed.
- Staff were up to date with training on the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.

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

- Staff completed competencies at a local NHS unit where they were separately employed. However, we were not assured that these competencies related specifically to Norfolk Dialysis or had been signed off in relation to the work staff carried out at this service.

Are services caring?

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

We found the following areas of good practice:

- Feedback from patients about the service was positive.
- An audit of patient satisfaction surveys for 2015 to 2016 showed positive results, with 100% of patients saying they would recommend the service.
- Patients were encouraged to self-manage aspects of their care if they wished to do so.
- Staff offered patients support and reassurance while they were away from home. For example, the clinic manager told us they were available as a point of contact for patients outside the hours of their dialysis sessions.

Are services responsive?

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

We found the following areas of good practice:

- Staff met patients' preferences by offering flexibility in the timing of dialysis sessions.

Summary of this inspection

- There was a clear complaints procedure, which was outlined in the complaints policy and shared with patients via a patient information leaflet. The service had not received any complaints from May 2016 to May 2017.
- No dialysis sessions were cancelled or delayed for non-clinical reasons from May 2016 to May 2017.
- An audit of patient satisfaction surveys for the period 2015 to 2016 showed that 100% of patients were satisfied with their dialysis times and 100% of patients were happy with the information provided before they attended for treatment.

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

- Translation services were not provided. Staff told us they used relatives to translate, which is not best practice.

Are services well-led?

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

We found the following areas of good practice:

- There was a clear vision for the service, which was shared by both the clinic manager and the deputy manager.
- Staff were experienced in renal dialysis. The clinic manager held the certificate in renal nursing.
- Staff were open in their approach to discussing the service and told us they were confident to challenge each other.
- Staff met with NHS England annually to review their policies and ensure that quality standards were being met, in line with Renal Association guidance .

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

- The staff had regular informal meetings to discuss the service, but did not keep records of these meetings. Staff did not keep a risk register to record and monitor risks to the service.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Summary of findings

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

We found:

- Clinical areas were visibly clean and staff complied with infection control procedures.
- Patient selection was appropriate for the nurse-led service.
- Staffing was appropriate to meet patients' needs.
- Staff were up to date with mandatory training, including safeguarding adults (level two) and Mental Capacity Act (2005) training.
- Policies were based on national guidance and evidence.
- Patient feedback about the service was consistently positive.
- Staff met patients' preferences by offering flexibility in the timing of dialysis sessions.
- The service had not received any complaints from May 2016 to May 2017. There was a clear complaints procedure in place.
- There were clear objectives for the service, which were shared by the clinic manager and the deputy manager.

However:

- Staff at the dialysis unit did not oversee or directly check resuscitation equipment because this was

owned and maintained by the health centre where the dialysis unit was located. This meant that staff could not be assured that equipment was easily accessible and fit for use in the event of an emergency.

- Staff completed competencies at a local NHS unit where they were separately employed. However, we were not assured that these competencies related specifically to Norfolk Dialysis or had been signed off in relation to the work staff carried out at this service.
- Translation services were not provided.
- Staff had regular informal meetings to discuss the service, but did not keep records of these meetings. Staff did not keep a risk register to record and monitor risks to the service.

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Are dialysis services safe?

Incidents

- The provider reported no never events or serious incidents from May 2016 to May 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The service used a paper-based system to report incidents. There were no incidents reported from May 2016 to May 2017. Both staff could describe what constituted an incident and the process for reporting incidents. Staff told us that any incidents would be recorded in an incident book, reviewed and discussed to identify opportunities for learning. This was in line with the incident reporting policy. No incidents had been recorded in the incident book at the time of our inspection.
- Both staff understood their responsibilities in relation to duty of candour, although there was no policy in place regarding duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Mandatory training

- Both staff completed mandatory training provided by a nearby NHS hospital. This training was a mixture of online and face-to-face training. We saw records to confirm that both members of staff were up to date with all mandatory training, including basic life support, infection prevention and control, moving and handling and fire safety, among others.
- The clinic manager had oversight of staff mandatory training. They kept a record of training, including topics and dates of completion.
- The deputy clinic manager was booked to attend a training course in October 2017 on sepsis detection and management.

Safeguarding

- The clinic manager was the lead for safeguarding. Both staff knew how and when to raise a safeguarding concern and could describe the process to us. The clinic manager showed us information for staff on how to contact the local authority for further specialist safeguarding advice.
- We saw records to confirm that both members of staff were up to date with safeguarding adults training (level one and two).
- The service did not treat patients under the age of 18, however both staff were up to date with safeguarding children training (level two). This meant they could identify any child safeguarding issues relating to children who might visit the service, for example relatives of patients.
- There was a vulnerable adults policy in place, dated January 2017. This was in date for review and referenced guidance from the Department of Health.
- We saw a poster about safeguarding, which identified types of abuse and provided advice for staff and patients on how to report any concerns.

Cleanliness, infection control and hygiene

- All the areas inspected were visibly clean and tidy. Hand sanitiser was available on entry to the dialysis unit and at both dialysis stations. Personal protective equipment, including gloves, aprons and face shields were available for staff and staff were observed using them appropriately.
- Both staff were "bare below the elbow" and wore uniforms, in line with the provider infection control policy.
- We saw both staff completing hand hygiene before and after patient contact. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.
- All patients were screened for blood borne viruses and Methicillin-resistant Staphylococcus aureus (MRSA) at their local dialysis unit before being accepted to the service. The service required screening tests to have been completed and results sent to the unit one

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month prior to treatment. Patients testing positive for these conditions were not accepted for treatment because the unit did not have isolation facilities. We reviewed four patient records and found that all four patients had been screened and their results documented.

- Staff had a good understanding of potential infection control risks. For example, the clinic manager was aware of the potential risk created when patients travelled away from their local dialysis unit for longer periods and wished to move between different holiday dialysis units. The clinic manager told us they communicated with patients and their local dialysis units to ensure that appropriate, timely screening for infection took place.
- There were no cases of MRSA reported by the service from May 2016 to May 2017.
- An audit of patient satisfaction surveys for 2016 showed positive results in relation to cleanliness. The audit showed that 100% of patients answered 'Yes' to the questions 'Were you happy with the general appearance and cleanliness of the unit?' and 'Were you happy with staff's approach to cleanliness and infection control, for example washing hands.' Formal hand hygiene audits were not completed, due to the fact there were only two members of staff.
- Waste was clearly segregated and kept in appropriate coloured bags to indicate clinical waste for incineration. Waste was disposed of by the health centre where the dialysis unit was situated.
- Staff wiped down dialysis chairs, tables and dialysis machines with disinfectant wipes between each patient.
- Staff decontaminated dialysis machines using an automated cleaning programme before each patient use. This was in line with manufacturers' guidelines and was a process which could not be overridden.
- Staff monitored water quality for bacteria monthly. We saw water testing records dated March 2016 to May 2017 and found there were no omissions.
- We saw staff using an aseptic non touch technique to minimise the risk of infection when accessing the

patient's fistula or central line. Aseptic techniques are methods designed to prevent contamination from microorganisms. They involve actions to minimise the risks of infections.

- The provider had an infection control policy, which was in date for review and included information on personal protective equipment, hand hygiene and cleaning of dialysis equipment.

Environment and equipment

- There was a service contract in place with a third party for maintenance and repair of dialysis equipment. Records dated April and May 2017 confirmed all three dialysis machines had been serviced as required.
- We reviewed records dated May 2016 to confirm that yearly calibration of equipment, including a blood pressure monitor, weighing scales and a thermometer, was completed and that all pieces of equipment passed. We saw a diary with a confirmed date for the next yearly review in May 2017.
- We reviewed records dated May 2016, confirming that 18 pieces of electrical equipment, including televisions, computers and dialysis chairs, were electrical safety tested and that all pieces of equipment passed. We saw a diary with a confirmed date for the next yearly review in May 2017.
- Dialysis sets were single use and CE marked and checked by staff to be intact and within sterility date. This was in line with Renal Association Haemodialysis Guidelines (2009) which recommend that equipment used in the delivery and monitoring of haemodialysis should be CE marked and approved to ensure compliance with the relevant safety standards.
- Staff kept delivery notes with batch numbers for consumable items of dialysis equipment. This meant that if there were any problems identified with consumable items, staff could contact the manufacturer and refer to the batch number.
- Staff had a plan in place for the replacement of two of the dialysis machines. The two machines were due to be replaced in 2017 because they were six years old. This was in line with Renal Association Haemodialysis

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Guidelines (2009), which suggest that dialysis machines should be replaced between seven and ten years or when they have completed 25,000 to 40,000 hours of dialysis.

- There was a spare dialysis machine, which was visibly clean and had been appropriately maintained. This meant that if there was a problem with a dialysis machine, treatment could continue using the spare machine.
- There was sufficient space between dialysis machines. This was in line with health building note (HBN) 07-01 – satellite dialysis unit guidance regarding patient privacy and the risk of the spread of infection.
- We checked a sample of five consumable items and found that all were in date and stored appropriately. Stock was rotated and expiry dates highlighted in order to avoid missing expiry dates. Flammable liquids were stored securely in a locked area.
- There were no nurse call bells as patients were within sight of staff at all times.
- Staff at the dialysis unit did not oversee or directly check resuscitation equipment because this was owned and maintained by the health centre where the dialysis unit was located. This meant that staff could not be assured that equipment was easily accessible and fit for use in the event of an emergency. For example, when we asked a member of staff to show us the resuscitation trolley, they had some difficulty in locating this as it had recently been moved. We raised this with staff at the time of inspection.

Medicine Management

- The provider stored medicines appropriately and securely in a locked cupboard in a staff only area. We checked a sample of five medicines and found that all five were in date.
- Staff had appropriate processes in place for the storage of medicines requiring refrigeration. At the time of our inspection there were no medicines requiring refrigeration on the premises. However, a refrigerator for storage of medicines was available and records of temperature checks dated April 2017 showed that required checks had been carried out when medicines requiring refrigeration had previously been used.

- Medicines were prescribed prior to admission by the patients' doctor at their local dialysis unit. There were no patient group directions (PGDs) in place. PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. Staff completed yearly audits of prescription charts to monitor completion of prescription forms by patients' local units.
- We observed staff completing formal identity checks on patients before administering prescribed medicines for their dialysis treatment. Patients could register with the local GP if prescription of medicines for other health concerns was needed. Medicines which were not part of the patient's renal dialysis prescription were self-administered by patients.
- There was a medicines management policy dated January 2017, which referenced national guidance from the Nursing and Midwifery Council and was in date for review. The clinic manager was the named lead for safe and secure handling of medicines.

Records

- Clinic records were sent from each patient's local dialysis unit to the service one month before treatment started. This meant that staff had the required information about each patient, including blood tests, medical history and drug prescriptions, before the patient started dialysis.
- Staff kept detailed records of care provided to each patient. This included observations taken during dialysis and a nursing report on each dialysis session, in addition to the information collected from the patient's local dialysis unit before treatment.
- We reviewed four patient care records and found that all four were signed, dated, legible and included a signed and dated prescription from the patient's doctor at their local dialysis unit.
- Patient records were stored and managed appropriately. Records were kept in a lockable filing cabinet. There was a 'Guidance for sharing information' policy dated January 2017, which was in date for review and included a retention schedule for different types of document.

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- Each patient was given a dialysis record sheet at the end of their treatment, which they took back to their local unit. Staff told us they would also fax a copy of this to the local unit and follow this up with a telephone call.

Assessing and responding to patient risk

- Patient selection was appropriate for a nurse led service and was designed to minimise risk of medical deterioration. A letter from the patient's consultant was requested to confirm that it would be safe for the patient to have dialysis in a nurse led clinic. We saw a 'Policy for patient selection', which confirmed this.
- Staff received relevant medical information from each patient's local dialysis unit one month before treatment and communicated directly with each local dialysis unit about any changes to the patient's condition before treatment started.
- The clinic manager gave us an example of when they had declined to accept a patient who required oxygen and had directed them to the local NHS dialysis unit as this was safer for the patient.
- The dialysis prescription form included an area for identifying any problems experienced during dialysis, for example hypotension, so that the patient's local dialysis unit could make the provider aware of any risks to patient safety before the patient was accepted for treatment. Staff told us that they ensured that saline was prescribed before each patient attended the unit, so that they could administer this if the patient's blood pressure dropped. If a patient's blood pressure drops during treatment administering saline replaces blood volume, which improves blood pressure.
- There was an aide memoire on each dialysis machine to prompt staff to ensure that all pre-dialysis checks had been carried out, including observations, checking the patient's identity and ensuring anticoagulation had been given.
- Staff asked patients to formally identify themselves before treatment and to confirm their name and date of birth. This was checked against the patient's records. We observed staff completing this process and checking each patient's identity before treatment, in line with the provider's policy.
- Staff recorded patients' weight at the beginning and end of each session to monitor the amount of fluid removed during dialysis.
- We observed staff monitoring patients' blood pressure and pulse before, during and after treatment and staff monitored temperature for patients who had a central venous catheter (CVC). Staff told us they would increase the frequency of observations based on their clinical judgement as they were with the patient at all times. Staff did not use the National Early Warning Score (NEWS) to monitor observations.
- The dialysis machines had two separate alarms to indicate a change in needle pressure and to indicate if blood pressure was outside of expected range. This meant that staff could be immediately alerted to any problems during dialysis.
- In an emergency, both staff told us they would call 999 and would perform basic life support. This was in line with the resuscitation policy, dated January 2017.
- Both staff had a good awareness of how to identify sepsis and what action to take if sepsis was suspected. However, there was no documented sepsis procedure in place. We raised this with the clinic manager at the time of our inspection. After our inspection, the clinic manager sent us a sepsis policy, which included guidance for staff on actions to take if sepsis was suspected and included a tool for visual inspection of central venous catheter exit sites.

Nurse Staffing

- There were two members of nursing staff (the clinic manager and the deputy manager), who ran the dialysis service and were the only two people employed by the service. Two staff were present at all times during dialysis treatment sessions.
- Staffing was sufficient to meet patient need as there was a maximum of two patients receiving treatment at the unit at any time. Staffing was better than the nurse to patient ratio outlined in the Renal Workforce Planning Group guidance (2002) of one nurse to four patients.
- The service did not employ any agency or bank staff at the time of inspection.

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- Staff told us that in the event of staff sickness, the patient's care would be re-scheduled for another day or the patient would be re-directed either to a nearby dialysis unit or back to their local unit. However, there was no formal process in place for how staff would manage this situation to ensure patients received continuity of care.

Medical Staffing

- The service did not employ any medical staff. Medical staff from the health centre at the same location as the dialysis unit were available to provide support in an emergency, although this was not a formal service level agreement. Patients could temporarily register with the GP at this health centre for routine medical support if required.

Major incident awareness and training

- There was an 'Emergency Measures' document, which included details of actions for staff to take in the event of service disruption due to incidents such as power failure and water failure. This was dated January 2017 and was within date for review.

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

Evidence-based care and treatment

- Staff provided care in line with standard operating procedures, which were evidence based. We reviewed standard operating procedures, including 'Access preparation', 'Taking water samples for analysis' and 'Discontinuation of dialysis' and found that these were in date for review and were in line with national guidance from the Renal Association.
- Both staff were aware of evidence and guidelines relevant to their service. For example, the clinic manager gave us an example of how they had changed the size of dialyser used so that this was in line with best practice.
- The clinic manager reviewed and updated policies every two years, or sooner if new guidance was released. Policies were evidence based. For example,

the 'Safe handling of medicines policy' referenced the Nursing and Midwifery Council standards for medicines management and the 'Vulnerable adults policy' referenced guidance from the Department of Health.

- The provider did not have a vascular access team due to the nature of the service provided. Information on vascular access was collected before accepting patients for holiday dialysis. Staff checked patients' vascular access before every treatment and said they would liaise with the patient's local dialysis unit in the event of any problems.

Patient Outcomes

- Staff collected data on treatment outcomes, for example Kt/V (a measure of how effective haemodialysis is) but they did not directly submit this data to the UK Renal Registry. The data staff collected was sent back to patients' local dialysis units (where patients received the majority of their treatment) to enable those units to collate and submit to the UK Renal Registry.
- Staff audited completion of patient booking forms every year. Results of the audit of patient booking forms for 2016 showed positive results. Out of 50 sets of booking forms, 100% had correctly completed prescription charts and 100% of booking forms were received within one month of holiday dialysis dates. Two percent (one record) did not have a fit to travel letter and 4% (two records) had prescriptions that were completed but not signed. Recommendations for improving completion of booking forms were documented and staff gave us an example of how they had changed their patient booking form to make sure it was completed effectively.

Pain relief

- Staff provided pain relief to patients if they had a prescription for it from their local dialysis unit. Staff told us patients could temporarily register with the GP located in the same building if prescription of any other medication was required.

Nutrition and hydration

- Staff offered patients complimentary refreshments and biscuits during treatment. Patients were also allowed to bring their own food and drink.

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- Specialist dietician services were not available, as these were provided by the patient's local dialysis unit. Staff told us they would discuss any concerns with the patient's local unit.

Competent staff

- Both staff were experienced renal nurses. The clinic manager held the renal nursing certificate.
- Both staff had completed revalidation with the Nursing and Midwifery Council. Staff were supported with revalidation by a clinician who was independent of the unit.
- Both staff told us they attended conferences and used online resources to keep up to date.
- Staff told us they had access to a nurse educator through the third party company that maintained their dialysis machines, although they had not yet accessed this resource.
- Staff completed competencies at a local NHS unit where they worked under separate employment. Competencies were signed off by an independent clinician at this unit. However, we were not assured that these competencies related specifically to Norfolk Dialysis or had been signed off in relation to the work staff carried out at this organisation.
- On our announced inspection, staff told us clinical competency records were not held on site. We raised this with staff at the time of inspection. When we returned for our unannounced inspection, we saw records of staff competencies, completed at the NHS unit, including intravenous (IV) drug administration, ANTT, needle placement, connection via arteriovenous fistula (AVF) and central venous line catheter (CVC), monitoring patients during dialysis, use of dialysis equipment and infection prevention and control. Competencies for the clinic manager were dated November 2014 and competencies for the deputy manager were dated May 2017.
- Formal staff appraisals were not conducted. The clinic manager and deputy manager told us they informally discussed their practice on a regular basis and received a formal appraisal in the NHS unit where they worked in addition to support from an independent clinician with revalidation.

Multidisciplinary working

- The patient's consultant at their local dialysis unit retained overall responsibility for the patient's medical care. Both staff told us they liaised with each patient's local unit to ensure they had all relevant patient information and to confirm that it was appropriate for the patient to receive holiday dialysis in a nurse-led clinic.
- A copy of the patient's treatment was sent back to the patient's local unit with the patient and this was followed up with a fax and a telephone call. Staff told us they would discuss any concerns with the patient's local dialysis unit, with the patient's consent.
- Both staff told us they had good links with the local GP practice (which was situated in the same location as the dialysis unit) and would coordinate care with medical staff at this practice when required.

Access to information

- There was a process in place to ensure that information needed to deliver effective care and treatment was available in a timely manner. Patient records were requested a month ahead of treatment. Patient records were kept in paper format and were accessible to both staff.
- Both staff had access to paper policies, which were kept in paper format in a staff folder.

Equality and human rights

- The provider supported patients with protected characteristics to use the service in line with the Equality Act 2010. We saw records to confirm staff had received mandatory training in Equality and Diversity.

Consent, Mental Capacity Act and Deprivation of Liberty

- Staff obtained verbal and written consent to treatment from patients before starting their first session of dialysis treatment. We reviewed six patient consent forms and found that all six were signed, dated and correctly completed. We observed staff asking patients for consent before treatment.
- Staff recorded information on patients' resuscitation status on the patient consent form. Any patient with a

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community Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place was required to bring this with them. We saw staff updating a patient's consent form to reflect their DNACPR status.

- There was a 'Consent to treatment' policy in place, dated January 2017. This referenced national law and guidance, including the Mental Capacity Act (2005) and Department of Health guidance.
- Both staff had a good understanding of consent and how to assess a patient's capacity to consent to treatment. Both staff were up to date with mandatory training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Are dialysis services caring?

Compassionate care

- Patients were given a patient satisfaction survey after treatment. This included questions about cleanliness, comfort and information received before treatment. An audit of surveys for 2015 to 2016 showed positive results, with 100% of patients saying they would be happy to recommend the unit to others.
- We reviewed eight completed patient satisfaction surveys. All the surveys we saw included positive comments, such as 'Excellent care' and 'Everything was brilliant, could not get any better.'
- We saw staff treating patients in a caring and respectful way. We spoke to two patients during inspection. Both patients gave positive feedback about the service.
- We reviewed four CQC customer comments cards and found that all four contained positive feedback about the service. Two patients commented that staff treated them with respect and three patients commented that the unit was clean and hygienic.
- Patients were positioned at the dialysis stations in a way that maximised their privacy. Staff provided patients with a screen for added privacy if required.

Understanding and involvement of patients and those close to them

- Patients' relatives and friends were allowed to stay with them during treatment. The clinic manager gave us an example of an occasion when they had accommodated a patient with a large family.
- Patients were encouraged to self-manage aspects of their care if they wished to do so. Both staff told us they would be flexible to patients' needs and preferences in terms of how much independence they preferred with their dialysis treatment while on holiday.
- Information provided by the clinic manager before inspection stated "Each patient will have a particular way they like to have their needle tape or their routine for cleaning their fistula so it is important to respect this and not to impose our own way, to make them feel relaxed in our care."
- An audit of patient satisfaction surveys for 2015 to 2016 showed 100% of patients were satisfied with the information provided before they attended for treatment.

Emotional support

- Both staff told us that patient well-being was very important to them and said "we try to make them feel as comfortable as possible especially if this is the first time they have met us."
- Staff were available to speak to patients at times during the patient's holiday when they were away from the unit, so that patients had a point of contact for advice while away from their home environment.

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

Meeting the needs of local people

- The service was directly commissioned by NHS England to provide holiday dialysis. This reflected patients' needs by providing patients with the flexibility to have dialysis away from their local unit for up to four weeks, at any time of year.
- Patients could book their holiday dialysis directly or via the holiday dialysis coordinator at their local unit.

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- The clinic manager had identified that there were few holiday dialysis units that offered dialysis for patients with significant mobility problems. The clinic manager told us they were working on developing the service to better meet the needs of these patients.
- Designated disabled parking was available directly outside the dialysis unit. Parking at the location was free of charge.
- There was level access to the unit and a disabled toilet was available.
- Patients organised their own transport to the unit. Staff told us they would provide patients with contact details for a local company offering disabled access taxis, if required.
- Televisions, headphones and internet access were available for patients. Adjustable electronic chairs or a recliner chair were available to ensure patient comfort.
- There was a waiting area for patients' relatives and friends. Magazines and refreshments were available in this area.
- Patients received an information leaflet before starting treatment, with details about the clinic and information on refreshments and entertainment available during treatment. This also outlined the service patient criteria and information about the local area.
- Both staff were focused on meeting the individual needs of patients. The clinic manager gave us an example of how they arranged for a patient who needed additional support with their mobility to attend the clinic. Staff ensured the required equipment was in place and arranged for the patient's relatives to be on site to provide support.

Access and flow

- The service was open all year round. Dialysis sessions were available Monday to Saturday and the core hours of the service were 7am to 6pm. Staff told us dialysis sessions usually started at 7am and 1pm, although this was flexible depending on patient preference. Twilight sessions were also available on request.
- Staff gave us examples of how they accommodated patients' preferences. For example, offering a patient twilight dialysis sessions to meet their preferences and altering a patient's dialysis session times to allow them to attend a wedding.
- No dialysis sessions were cancelled or delayed for non-clinical reasons from May 2016 to May 2017.
- There was no waiting list for dialysis at the unit because of the nature of the service provided, which was solely holiday dialysis. Patients booked into the unit for short periods on an ad-hoc basis.
- The service was commissioned to provide 250 sessions of dialysis from 2016 to 2017. The service had provided 94 sessions of dialysis in this period. Staff showed us methods they used to advertise and increase awareness of the service, including advertising in a national magazine for patients needing dialysis.
- An audit of patient satisfaction surveys for the period 2015 to 2016 showed that 100% of patients were satisfied with their dialysis times and 100% of patients were happy with the information provided before they attended for treatment.
- There were no unplanned transfers of patients to other healthcare providers from May 2016 to May 2017.
- Both staff had an understanding of how to care for patients living with dementia, although the service had not received any referrals for patients living with dementia.
- Counselling services were not provided because patients were only present at the unit for short periods of holiday dialysis. Staff told us that they would liaise with the patient's local dialysis unit if they felt a patient required support.
- Translation services were not provided. Staff told us they used relatives to translate, which is not best practice. We raised this with the clinic manager at the time of our inspection.

Service planning and delivery to meet the needs of individual people

Learning from complaints and concerns

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- All patients received a patient information leaflet, which included information on the complaints process.
- The service received six compliments from May 2016 to May 2017. There were no complaints received in this period.
- There was a complaints policy in place, dated January 2017, which was in line with the complaints procedure described by both staff.

Are dialysis services well-led?

Leadership and culture of service

- The service was led by the clinic manager and the deputy manager, who independently set up and ran the service. No other staff were employed.
- Both the clinic manager and deputy manager were experienced in renal dialysis. The clinic manager held the certificate in renal nursing. Both staff also worked at a local NHS dialysis service, under separate employment.
- Both staff were open in their approach to discussing the service and both told us they were confident to challenge each other.

Vision and strategy for this core service

- We saw a statement of purpose document, which outlined the objectives of the service. This included an objective for patients, which was “To improve the quality of life for people on long term dialysis by giving them the opportunity to book a holiday in advance” and an objective for the clinic, which was “To manage and expand our business following legal requirements and safety standards to maintain a quality environment.”
- The clinic manager and deputy manager had set up the service in 2011 and developed the service in line with their vision. Both staff were knowledgeable about the aims of their service.

Governance, risk management and quality measurement

- There was limited documentation to show that staff had oversight of the service. Staff told us they had

regular meetings to review the service. However meeting minutes were not recorded and meetings did not include any external partners, to provide challenge and review of the service. We saw minutes for meetings that had taken place in 2014, including standing agenda items for incidents and complaints, but both staff told us that minutes for meetings were no longer recorded. We raised this with the clinic manager at the time of inspection.

- Staff did not keep a formalised risk register to record risks to the service and how they were managed. Staff gave us an example of a previous risk to their business, around contracting of the service, and could explain how this was managed, although there was no documentation of this. Both staff told us that there were not currently any identified risks to the service. However, we identified risks which had not been recorded, for example the lack of oversight of resuscitation trolley checks and the risk of continuity of patient care being affected in the event of staff sickness.
- Staff recorded clinical outcomes including Kt/V but did not directly audit these outcomes. This was because clinical outcome data was sent back to the patient’s local dialysis unit who would submit this information to the UK Renal Registry.
- External oversight was provided by NHS England, who were the commissioner of the service. Both staff told us they met with NHS England annually to review their policies and ensure that quality standards were being met, in line with Renal Association guidance.
- There was a clinical governance policy in place, dated January 2017 which was within date for review.
- Policies and standard operating procedures (SOPs) were reviewed every two years by the clinic manager, or sooner if new guidance became available. We reviewed a selection of policies and eight SOPs and found that all had been reviewed within the last two years.
- The deputy manager completed yearly audits of patient satisfaction surveys and patient booking forms and prescription charts. We saw the patient satisfaction survey audit for 2015 to 2016 and the

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patient booking form/prescription chart audit for 2016. Audit results were clearly documented with recommendations for improving practice, which had been carried out.

- We saw a risk assessment document, which included potential health and safety risks to staff and patients, such as slips, trips and falls. This document contained actions for managing each risk, a named person responsible for managing the risk and the date the action was completed.

- Due to the small size of the service, the opportunities to gather patient and relatives' views and experiences were limited. Staff used patient satisfaction surveys to assess and improve the quality of the service. Staff gave us an example of how patient feedback had been used to improve the service. Following a comment on a patient feedback form regarding the lack of television, staff arranged for an aerial to be installed, meaning that individual televisions could be provided for patients.

Public and staff engagement

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that resuscitation equipment used for providing care or treatment to a service user is safe for such use and that there is oversight of the safety checks and location of this equipment.
- The provider should ensure that there is a process in place for effective monitoring and recording of staff competencies.
- The provider should ensure that appropriate translation services are available for service users who do not understand English.
- The provider should ensure that suitable records are kept of governance processes, including oversight of risk and quality monitoring.