Renal Services (UK) Ltd - Alnwick

Quality Report

Unit 6G, Greensfield Court
Greensfield Industrial Estate
Alnwick
Northumberland
DE66 2DE
Tel:01665 604508
Website:www.renalservices.com

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Alnwick Dialysis Unit is operated by Renal Services (UK) Limited. The unit is a satellite dialysis unit contracted by Newcastle upon Tyne NHS Foundation Trust to provide haemodialysis to NHS patients over the age of 18. The service has been open since February 2015 and has six stations, located in one bay and one side room. The NHS trust refers clinically stable patients with end stage renal disease or failure who need haemodialysis. This is the most common type of renal replacement therapy offered to patients.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 11 July 2017, along with an unannounced visit to the clinic on 25 July 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?

Throughout the inspection, we took account of what people said to 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 also found the following areas of good practice:

- We found the unit to be visibly clean and arrangements for infection prevention and control were in place with no incidence of infection. The environment met standards for dialysis units and equipment maintenance arrangements were robust. Staff we spoke with were clear about their responsibilities for keeping the patient safe from harm, record keeping was thorough. Mandatory training was completed by staff working in the unit.
- Staff understood their responsibilities to raise concerns and report incidents and near misses. We observed systems that supported staff to learn lessons from incidents which were communicated to the team by senior staff.
- There was a good track record of safe practice, patient outcomes and access to treatment in the unit.
- Staffing levels were of an appropriate number for the unit and staff were knowledgeable, skilled and competence was assessed.
- Patient care and treatment was planned and delivered in line with evidence based guidance, standards and legislation. We reviewed evidence of effective multidisciplinary working and the team worked well together.
- We observed staff compliance with the medicines management policy and positively identify patients when administering medicines during treatment.
- We observed good practice to assess on-going competence of staff. The unit manager documented this.
- A culture of putting the patient first was evident in the unit. Staff showed commitment to providing high quality care for patients and demonstrated a caring and thoughtful approach in the delivery of care to patients with whom they had fostered positive relationships.
- Patient feedback was consistently positive in the unit with no formal complaints since the opening of the unit in 2015.
- Nursing staff had a high regard for their colleagues and for the senior team at a local unit level and across the organisation.

Summary of findings

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

- A formal staff survey system was not in place at the time of inspection. However, there were plans to formally capture the views of staff across the organisation and at a local level.
- The waiting area for the unit was small and patients had commented about this during inspection.
- The team did not utilise a formal national early warning score to support the recognition of the deteriorating patient.
- The team did not have a formal arrangement with dietetic services. This would mean that patients were not always supported by the multidisciplinary approach to treatment around their nutritional needs.. Staff we spoke with told us that dietetic services was part of a proposed business case.

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

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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Background to Renal Services (UK) Ltd - Alnwick

Alnwick Dialysis Unit is operated by Renal Services (UK) Limited. The service provides haemodialysis treatment to patients, is a located in Alnwick, Northumberland. The unit primarily serves the communities of Northumberland and in addition gives access to treatment for patients referred for holiday dialysis.

The unit has had a registered manager in post since February 2015. Renal Services (UK) Limited has a nominated individual for the location and the unit is registered for the following activities;

- Treatment of disease, disorder or injury.

The CQC have not inspected this location previously and there were no outstanding enforcement associated with the service at the time of the comprehensive inspection in July 2017.

Our inspection team

Two CQC inspectors carried out the inspection. Amanda Stanford, Head of Hospital Inspection, oversaw the inspection team.

Information about Renal Services (UK) Ltd - Alnwick

The Alnwick Dialysis Unit is located on the ground floor of an office complex in a business park in Alnwick. It is a small service and provides treatment and care to adults only and the service runs over six days, Monday to Saturday. There are no overnight facilities. There are two dialysis treatment sessions a day. There are a total of 17 patients currently attending the unit for treatment, with six patients receiving dialysis at each session.

The unit has six stations in total, five stations in a main treatment area and one isolation room. The building is modern in design and was commissioned in 2015 by a local NHS trust. There was good storage, office space and treatment rooms. Access to the unit is on the ground floor and there is private car parking directly outside. There is a water treatment plant and access to dedicated safe storage for waste on the premises. The main referring unit is the Freeman Hospital, which is part of the Newcastle upon Tyne NHS Foundation Trust. This trust provides the renal multidisciplinary team (MDT), with a consultant nephrologist visiting the dialysis unit once a month. MDT meetings are held each month where consultants and the unit manager review patient outcomes and blood results.

There are on average 72 sessions a week, 312 dialysis treatment sessions delivered a month. The service delivered 3,297 haemodialysis sessions in the 12 months prior to inspection. There were 17 people in total using the service with seven patients aged over 65. The clinic does not provide peritoneal dialysis or services to children.

During the inspection, we spoke with nine members of staff including registered nurses and senior managers. We spoke with six patients. We also received five 'Tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed 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. The service has not been inspected previously.

Renal Services (UK) Limited – Alnwick employed three registered nurses. At the time of inspection the unit was

Summary of this inspection

managed by a clinic manager with the support of the registered manager. The plan was for the clinic manager to take over the responsibility of the registered managers role with the CQC.

Activity (April 2016 to March 2016)

- In the reporting period April 2016 to March 2016, There were on average of 312 dialysis sessions delivered every month.
- The service delivered 3,297 sessions in the same reporting period delivered to adults aged 18-65 and over.
- At the time of the inspection, 17 people were using the service, 10 aged 18-65 and seven above 65.
- There were no patients on the waiting list for treatment and there had been no patient transfers to another healthcare provider in 2016/17.

Staffing

- The unit employed three registered nurses, the service did not employ any health care or dialysis assistants or reception staff. As part of the contract clinicians and specialist nurses were available to support patients. The unit did not employee any medical staff. Consultant nephrologists attended the unit monthly for MDT meetings and were available via telephone contact.

Track record on safety (April 2016 to April 2017)

- In the reporting period April 2016 to March 2017 there had been no never events or serious incidents requiring further investigation.
- In the same reporting period there had been six clinical incidents reported. All incidents were low harm.
- Four in-service (expected) patient deaths had occurred in the reporting period.
- There were no reported incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), or Escherichia-Coli infections.
- There were no complaints received during the reporting period by the unit.

Services provided at the unit under service level agreement:

- Social worker provided by a health and social care agency.
- Counsellor provided by a local NHS trust.
- Clinical and domestic waste SLA with a private company.
- Cleaning provided by a private company.

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 found the following areas of good practice:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons from incidents were learned and communicated throughout the team including opportunities to learn from safety incidents that had occurred in other dialysis units across the organisation.
- Performance showed a good track record in safety. There were clearly defined systems, processes and standard operating procedures in infection prevention and control, medicines management, equipment and patient care records to ensure patients were protected from avoidable harm.
- Staff identified and responded appropriately to changing risks to deteriorating patients including those patients with suspected sepsis.
- Safeguarding vulnerable adults, children and young people was given sufficient priority. All staff were trained to an appropriate level and demonstrated an understanding of how to protect patients from abuse. Staff could describe what safeguarding was and the process to refer concerns.
- Staff we observed followed the medicines management policy for the positive identification of patients whilst they were administering medicines during treatment.
- Staffing levels were of an appropriate number for the unit and staff were suitably skilled. Staff were up to date in mandatory training.
- There were arrangements in place to respond to emergencies. Business continuity plans were in place to advise staff of actions to be taken in the event of a utilities failure.

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

- The waiting area was small and the weigh scales were positioned in this space at the entrance to the unit. One patient complained about this during inspection and we observed that the space was small.
- There was no formal national early warning score (NEWS) to support the recognition of the deteriorating patient.

Are services effective?

We found the following areas of good practice:

Summary of this inspection

- Patients' care and treatment was planned and delivered and clinical outcomes monitored in line with evidence-based guidance, standards, best practice and legislation.
- Patients had an assessment of their needs which included pain, nutrition and hydration and consideration of individual physical health needs. In addition, care and treatment was appropriately monitored and updated.
- Information about patients care and treatment, and their outcomes, was routinely collected and monitored. Outcomes for patients were consistently positive.
- There was effective multidisciplinary working with the unit and the referring trust working together to deliver effective care and treatment.
- Staff were qualified and had the skills they needed to carry out their roles effectively and were supported to develop through timely performance reviews.
- We observed on-going competency-based assessments to ensure staff were up to date. A record was kept by the unit manager.
- Staff had good access to all the information they needed to assess, plan and deliver treatment and there was appropriate sharing of information between the unit and the referring trust.
- Consent to care and treatment was carried out in line with legislation and guidance and appropriately monitored.

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

- The team did not have a formal arrangement with dietetic services. This would mean that patients were not always supported by the multidisciplinary approach to treatment around their nutritional needs. Staff we spoke with told us that dietetic services was part of a proposed business case.

Are services caring?

We found the following areas of good practice:

- Feedback from patients was consistently positive about the way staff treated them.
- Patients were treated with dignity, respect and kindness during all interactions with staff.
- Patients understood their care and treatment; staff spent time talking to patients, communicating information in a way that patients could understand.
- Staff were sensitive to the individual needs of patients including those patients living with a disability, sight impairment or living with dementia.

Summary of this inspection

- Staff responded in a compassionate, timely and appropriate way to calls for help, alarms on dialysis machines and any non-verbal signs of distress.

Are services responsive?

We found the following areas of good practice:

- The unit was commissioned with the needs of the local population in mind and offered flexibility and choice to its group of patients.
- The facilities and premises were appropriate for dialysis treatment.
- The needs of different patients were taken into account when delivering treatment. For example, patients who did not speak or understand English.
- A wide range of patient information leaflets were available in the unit including information on how to raise a concern or complaint.
- The unit had received no complaints in the past year. However, patients were aware of how to raise a complaint and there were processes in place to ensure that patients could offer feedback.
- Patients could access dialysis treatment at the right time. The unit did not have a waiting list and there had been no delays or cancellations to treatment in the last year.

Are services well-led?

We found the following areas of good practice:

- There was a governance framework in place to address performance, safety and risk and staff were aware of their responsibilities.
- Local leadership at this unit was effective with senior staff having the appropriate skills and qualifications to undertake their roles.
- Staff were committed to 'doing the best' for their patients and passionate about delivering high quality care, a culture of putting the patient first was evident throughout the unit.
- There was an organisational vision in place for the unit, to deliver "inspired patient care". This was supported by seven organisational values: safety, service excellence, responsibility, quality, communication, innovation and people.
- There were supportive relationships amongst staff and we observed good morale and staff satisfaction.

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

Summary of this inspection

- A formal staff survey was not carried out to capture the views of the team.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- 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. During the reporting period, April 2016 to July 2017 there had been no never events reported.
- Serious incidents are incidents that require further investigation and reporting. There were no serious incidents reported within the unit during the reporting period April 2016 to March 2017.
- The unit accessed a clinical incident reporting system. The team had access to an updated policy and told us how to access this. Staff reported incidents by completing an incident form document which was then sent electronically to the unit manager, the head of nursing and the governance lead. There was a clear flowchart for the process which staff understood.
- The unit manager completed an internal review of all incidents and if needed an investigation within 48 hours of reporting and the head of nursing completed a further review within five days. Staff we spoke with told us that any serious incidents were dealt with immediately and 'fast-tracked' outside the expected timeframes. All reported incidents were reviewed quarterly at the Renal Services (UK) Limited clinical governance committee.
- Of 80 incidents reported in 2016/17 across Renal Services (UK) Limited, six (7.5%) were recorded against the Alnwick site. These related to access issues, an episode of epistaxis, one needle stick injury and a transport incident. We reviewed the associated incident forms and found these to contain relevant information to patient demographics, incident classification, description, grading of incident, patient injuries and immediate actions taken. The form also detailed head of nursing review and clinical governance committee review. The entries made following review were succinct. The head of nursing logged all incidents on a service-wide spread sheet which acted as a log and detailed actions and progress with relevant timeframes.
- Staff confirmed incidents were discussed locally and there was evidence of wider learning from incidents from other services. These were shared during the monthly clinical managers conference call and at quarterly manager away days. Such learning had brought about a review of the use of the falls assessment tool and needle stick injury policy. The introduction of call bells near to weigh scales was introduced as a result of learning shared across the organisation and we observed this to include a patient instruction to call for assistance if feeling unwell whilst weighing before and after treatment.
- There were no notifiable safety incidents that met the requirements of the duty of candour regulation in the reporting period. The unit had a policy that directed staff to trigger the duty of candour process for any incident categorised as moderate or above.
- The duty of candour is a regulatory duty; Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) introduced in November 2014. This Regulation requires the healthcare provider to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology in cases of serious and moderate harm.

- Staff had received duty of candour training and those we spoke with had an understanding of the regulation and valued being open and transparent with patients, offering an apology when things went wrong in healthcare and treatment.
- The clinic monitored performance against patient harms, they reported against the number of pressure ulcers and falls that occurred on the unit. In the reporting period, April 2016 to April 2017 there had been no reported patient falls or pressure ulcers on the unit.

Mandatory training

- Renal Services (UK) Limited held annual classroom based mandatory training days for staff to access in locations across the UK. We noted that regular bank staff also attended mandatory training sessions.
- All staff employed at the time of inspection had completed all aspects of mandatory training within the annual reporting period.
- Basic life support training was a mandatory training requirement that all staff were required to undertake on an annual basis. All staff had completed this training and were competent to use all items of emergency equipment. For example, the automated external defibrillator .
- Mandatory sessions covered core topics such as health and safety, information governance, infection prevention and control (to include additional aseptic non-touch technique, ANTT), manual handling, fire prevention, food hygiene, protection of vulnerable adults (POVA),basic life support, (BLS), equality and diversity and dignity and respect. The unit had also included additional mandatory training elements regarding intravenous device training and patient group directions (PGDs)and patient specific directions, although no PGD's were applied in practice in the Alnwick unit.
- Staff had also received training in identifying and managing the patient with sepsis. Sepsis is a severe infection that can spread in the bloodstream. Training included screening for sepsis and actions to be taken by nursing staff where sepsis was suspected. Staff we spoke with had a good understanding. .

Safeguarding

- All staff had been trained to recognise adults at risk and were supported with effective safeguarding policies for vulnerable adults and children. All staff we spoke with could give us examples of raising safeguarding concerns with the local authority. Safeguarding contact numbers and a flow chart were visible on the unit in Alnwick.
- The head of nursing was the safeguarding lead for the organisation, supported by the registered manager at individual locations and had been trained to safeguarding children, level 3.
- Safeguarding level 4 support was provided at this location by the referring NHS trust in Newcastle. Safeguarding level 4 gives managers within the health and social care sector training to a higher capability level of knowledge with adult safeguarding procedures.
- The service did not treat patients who were under the age of 18. All staff had received safeguarding children training (level 2).

Cleanliness, infection control and hygiene

- Renal Services (UK) Limited had an infection prevention and control (IPC) policy in place which provided staff with structured arrangements for the monitoring, prevention and control of infection and followed the recommendations of the Renal Association in the treatment of hepatitis B, hepatitis C and HIV positive patients.
- The unit manager took responsibility for IPC standards and audit of standards in the unit. The nursing team were involved in audit and knowledgeable about the policy, process and audit results. Audits for IPC included, hand hygiene, sharps disposal, uniform standards, ANTT practice and environmental cleanliness standards. Quality assurance of the process was signed off by the senior quality manager who repeated the audit regularly. Results were consistently good across all elements (100% from March 2017 to July 2017) and in all aspects of practice and IPC standards. We observed standards and practice that were in line with these results during the inspection.

- The unit was visibly clean and tidy in all areas. Domestic cleaning staff performed their duties after the unit closed every day, over the six days the unit was open.
- We observed staff carrying out hand washing prior to and after patient contact and clinical procedures. personal protective equipment (PPE) was observed to be used in accordance with local policy (including eye protection). Waste and sharps were segregated and disposed of correctly.
- We observed staff cleaning medical devices and all items of equipment inspected were visibly clean. There was a proposed new audit process for environmental cleanliness to include an improved scoring system.
- Patients we spoke with were consistent in their feedback about the high standard of cleanliness in the unit and the IPC practices of nursing staff. The provider monitored infection prevention and control as part of their annual patient satisfaction survey. Results from the 2016 patient satisfaction survey showed 94% of patients, at this unit, felt the cleanliness of the unit, their chair space and the toilet facilities were either "good" or "excellent".
- The unit had a water treatment room. The nursing staff monitored the safety elements required in accordance with local guidelines and the guidance of the local NHS trust. We reviewed a history of records that gave evidence of thorough checking of systems with clear responsibilities and actions if any issues were identified. All water testing for the unit was carried out in line with the recommendations by the UK Renal Association and European standards for the maintenance of water quality for haemodialysis.
- Senior staff we spoke with gave us two examples were issues were actioned promptly by staff by contacting the water treatment helpline team or manufacturer. There had been no issues with annual maintenance. Guidelines for water testing and the disinfection of water plant and dialysis machines were readily available to all staff. These guidelines had been reviewed by Renal Services (UK) Limited's water treatment specialist, medical director and an independent technician.
- During the period April 2016 to March 2017 there had been no incidences of healthcare associated Methicillin-resistant Staphylococcus aureus (MRSA). MRSA is a bacterium responsible for several difficult-to-treat infections. There had been no incidences of healthcare associated Methicillin-sensitive staphylococcus aureus (MSSA).
- Procedures were in place to assess patients as carriers of MRSA and/or blood born viruses (BBV) such as Hepatitis B and C. This included routine testing of susceptible patients in line with best practice guidelines. Patients were screened three-monthly for BBV. All six patient care records we reviewed confirmed this had taken place.
- MRSA positive patients would be dialysed in the side room, with appropriate isolation precautions in place to prevent the spread of infection to other patient's. Hepatitis B virus positive patients were also dialysed in isolation. Hepatitis C virus and human immunodeficiency virus (HIV) positive patients were dialysed in isolation but not on a designated dialysis machine unless specified by the referring trust. This practice was in line with company guidance.
- Patients who had been dialysed in the European Union (EU) would have a hepatitis screen on their first treatment in the unit and the machine would be isolated until the results were available; all patients who had been on holiday to a non EU destination would be dialysed in isolation on a designated machine for a period of three months; new patients to the unit would have a hepatitis screen before treatment as part of the admission criteria.
- All staff were trained and competent in aseptic non touch technique (ANTT). ANTT is the standard technique used for the accessing and attaching of all venous access devices regardless of whether they are peripherally or centrally inserted and is considered best practice in line with the National Institute for Health and Care Excellence (NICE).
- During the inspection, we observed that staff were compliant with arms bare below the elbows and PPE practices. We observed good aseptic technique processes when staff were connecting patients to, or disconnecting them from dialysis machines. Aseptic techniques are methods designed to prevent

contamination from microorganisms. They involve actions to minimise the risks of infections. We observed the ANTT practices of nursing staff to be good as a method to prevent contamination to dialysis lines. This included using gloves, sterile and clean, aprons and eye visors by all staff.

Environment and equipment

- The unit was situated in a small business park on the outskirts of Alnwick. There was ample parking, including disabled parking spaces. Designated ambulance transport space was not provided, however it was not reported that this was an issue.
- The reception area was small with limited seating. This space was also compromised due to large weighing scales being housed in the seating area, although there was not an alternative space in the main unit.
- There was a call buzzer system in the waiting area for patients to use and security key pads to the internal doors of the unit to secure access. There was not an entry system, but staff were aware of patients arrival and discharge, with sight from the main unit. The call buzzer system was used to alert staff if someone needed them in the waiting area. The clinic was accessed via a single entrance to a corridor directly outside the main doors for the unit and easily visible to staff. Staff and visitors signed in and out of the unit. There was CCTV outside the main building.
- The unit met standards for space in line with health building notification (HBN07-01) guidance. A nurses' station allowed visibility of all patients during dialysis and privacy screens were available when required. Patients had enough space for privacy but were also able to be social with others in nearby stations. The unit had natural light and appeared warm and welcoming for patients and visitors on the day of inspection. There were five dialysis stations in the main bay and one isolation room with large comfortable chairs that were observed as being in good condition.
- All single use equipment observed in treatment areas were observed as in date for expiry. A record of batch numbers of dialysis sets used was recorded by nursing staff in the health care records we reviewed. There was no issue with stock levels and ordering of essential items was done by the clinic manager.
- Maintenance of dialysis machines and chairs was scheduled and monitored using a maintenance, servicing and calibration plan, this detailed the dialysis machines by model type, serial number along with the scheduled date of maintenance. A similar plan existed for dialysis chairs and other clinical equipment for example; patient thermometers, blood pressure monitors and patient scales.
- We observed an annual servicing plan for dialysis equipment and water treatment which was carried out by external companies. All equipment checked during inspection was service tested and in date. Staff we spoke with could tell us how they would report equipment faults through an email system or urgently through a telephone helpline.
- In the event there was a failure of a dialysis machine whilst a patient was receiving treatment two 'back up' dialysis machines were available. We reviewed the replacement machines and saw they had been appropriately safety tested and were visibly clean, primed and ready to use.
- The unit had a seven years or 25,000 to 40,000 hours replacement programme for dialysis machines. This was in line with Renal Association guidelines.
- Patient weigh scales were available on the unit and we saw where they had been appropriately service tested. Staff told us, in the event the weigh scales developed a fault or were unfit for use, a replacement set was available as a matter of priority through the helpline system and the fault would be reported to an external company for repair. There were no spare scales on site.
- We checked the resuscitation and suction equipment on the unit. There was good supply of oxygen bottles. The resuscitation equipment appeared visibly clean. Single-use items were sealed and in date, and emergency equipment had been serviced. Records indicated resuscitation equipment had been checked daily by staff and was safe and ready for use in an emergency. Oxygen supplies were stored safely and securely in a locked area directly outside of the unit.
- During inspection we observed staff responding to the alarms generated by safety limits on the dialysis machines. The machine alarms had a pleasant tone (with 15 tunes to choose from) and were responded to promptly by the staff. There was no evidence or

incidence to suggest that alarms were overridden by staff or patients. This supported the detection of problems with treatment early, to include the detection of dislodged needs to reduce the risk of significant blood loss.

Medicines

- We observed staff administering medicines in line with Nursing and Midwifery Council (NMC) standards for medicines management. This included patient identification, not leaving medicines unattended and confirming all prescriptions were administered during dialysis.
- Medicines were stored in a clean utility room; all cupboards containing medicines were locked. We did not observe any medicines unattended during our visit.
- Medicines, including intravenous fluids were stored securely. Controlled drugs were not stored within Renal Services (UK) Limited – Alnwick. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs.
- We reviewed six prescription charts, as part of the daily dialysis record sheet and saw consistent, individually prescribed documentation.
- Lead responsibility for the safe and secure handling and control of medicines was the unit manager and registered manager. The nurse in charge held the keys for the medicines cabinet and was identified on the rota. We observed good practice for two nurses checking medicines from the prescription for individual patient administration. The nurse in charge, which varied dependant on shift pattern was an experienced member of staff.
- Patient group directions (PGDs) were not used at this unit. A PGD allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predetermined group of patients without them seeing a doctor.
- Medicines requiring refrigerated storage were stored at the correct temperatures to ensure they would be fit for use. We reviewed fridge temperature and room temperature records for March to June 2017 and saw where staff had signed daily to indicate minimum and maximum temperatures and room temperature had been checked and were within the required range. We spoke with staff who told us that where temperatures were not within the required range this would be escalated to the nurse in charge. We observed evidence of escalation to the local NHS trust pharmacy support and consistent record keeping by the clinic manager.
- Renal Services (UK) Limited – Alnwick were responsive to the initial feedback that had been given in recent UK wide CQC inspections and were improving audit processes for medicines. Audit was carried out under the documentation and environment audit but further draft audit templates were being rolled out by the head of nursing.
- Pharmacy support was provided by the local referring trust. The patients' consultant nephrologist prescribed specific dialysis medicine for treatment. The prescriptions were reviewed in the monthly MDT meeting or less often at specific request by nursing staff to the consultant for review outside of the MDT.

Records

- Patient records were consistently compiled and well organised to include sections for; patient information, haemodialysis booklet, drug charts, monitoring bloods, patient assessments, letters and correspondence. We reviewed six records and found documentation was thorough, written legibly and dated and signed by staff. These entries also included treatment sheets, observations and risk assessments.
- We found clinical observations recorded for all patients before and after treatment however we observed that there were two paper treatment charts where the intra-treatment clinical observations were not recorded, although we had observed these being performed and were recorded in the electronic system.
- The unit recorded patient data on the organisation patient treatment database. They also used the local NHS trust clinical database system to record daily treatment data. The consultant had easy access to this information. The paper records included the dialysis

prescription, patient, and next of kin contact information, and GP details. There were also nursing assessments, medicine charts, dietetic review and patient consent forms.

- Paper records were stored with the patient during dialysis and then stored in a locked cupboard once they had completed this treatment.
- There were plans in place across Renal Services (UK) Limited to introduce the named nurse system where experienced nurses in the unit would take responsibility for a caseload of around 10 patients. This would support the update and monthly detailed review of individualised care plans. We reviewed care records that gave evidence patients' needs were assessed and treatment was planned and delivered in line with their individual care plans. There was a comprehensive care pathway in the six care plans we reviewed.
- The service was registered with the Information Commissioner's Office (ICO). The ICO is responsible for the promotion and enforcement of the Data Protection Act 1998.

Assessing and responding to patient risk

- All patients referred into the service were initially assessed by the referring trust renal team This arrangement also applied to out of region holiday patients.
- Comprehensive risk assessments were carried out for patients and risk management plans developed in line with national guidance. For example, in the six patient care records we reviewed we saw evidence of risk assessments in all records for falls and pressure ulcers and patient specific risk assessments in records where patients had specific health needs. Where one patient had diabetes, a risk assessment was in place advising staff of the actions to take in the event of a hypoglycaemic episode.
- We observed that nursing staff monitored patients closely. The unit allowed for continued visual observation of patients receiving treatment. Clinical observations were recorded and captured in the electronic system for a minimum of three occasions during treatment (pre, during and post dialysis) to assist in identification of any deterioration. In the event of patient deterioration, staff followed local escalation procedures (medical emergency policy) agreed with their partner NHS trust. Staff knew this procedure and confirmed when they would call the renal registrar or the responsible consultant. The unit did not use a nationally recognised early warning scoring system to monitor deterioration in the patient's condition.
- Only clinically stable patients were dialysed on the unit; if someone was acutely ill with renal problems, they were treated at a main NHS hospital. This was to ensure that patients who required additional support received their treatment at the local NHS trust where medical staff were available 24 hours a day.
- Patients weighed themselves before treatment began. They inserted an electronic card, which identified them, into the electronic walk- on weighing scales.This was to establish any excessive fluid, which had built up in between treatments. This was also a first method of staff being able to identify patients. The unit in Alnwick was small with 17 patients receiving treatment in total. Staff explained that they felt that they were familiar with each patient, having built a thorough assessment over time. We observed staff confirming date of birth and name prior to treatment. The risk of wrongly identifying a patient for treatment was felt to be low. A process of second checks of patient, equipment and prescription made by nurses prior to commencing treatment also supported this view.
- Patients did not receive blood transfusions at this unit. Where a blood transfusion was required this would be carried out at the referring NHS trust.
- Staff followed the referring NHS trust's sepsis policy and screening toolkit which they accessed through the trust's electronic renal database. All the staff demonstrated a good understanding of sepsis and the actions they would take were a patient to present with or develop sepsis.
- There was a process in place for the emergency transfer of a patient to an NHS acute trust. Guidance was provided through the provider's medical emergency policy. There were no patients requiring an unplanned transfer from the service to another health care provider in the 12 months preceding this inspection.

Dialysis Services

Staffing

- The nurse staffing ratio was determined by the service level agreement the unit had in place with their referring NHS trust and patient dependency. The ratio was currently one nurse to three patients, which met recommended standards of one registered nurse to four patients. We reviewed staffing rotas for the period 1 March 2017 to the date of this inspection.
- The unit manager confirmed they had no vacancies currently and had recently recruited to posts. The unit did not use agency staff however did have regular cover from long term specialist bank staff who were known to the unit and had completed local competencies. There were no assistant or support roles in the unit.
- Staff we spoke with commented how some shifts often extended beyond rostered hours to meet patient need and in order to complete necessary unit administration. Staff also added how nursing rotas were not always published in a timely manner however acknowledged this did afford some flexibility within the team. We noted through observations and interviews that it would be difficult on occasion for staff to have a rest break, with only two members of staff on duty for six patients.
- The unit manager reviewed duty rotas on a daily basis to assess staffing levels as being safe at all times. Rota requests from staff and the management of nursing leave were reviewed through a central system in Renal Services (UK) Limited, with the unit manager having oversight.
- Staff shortages due to sickness were infrequent and managed including rearranging shifts with the cooperation of clinic staff. Bank staff from other units across the UK and in the local renal units would cover and this was managed well by the team. The clinic had used 83 registered nurse bank shifts in the three-month period prior to inspection visit.
- There were appropriate arrangements in place for using bank and agency staff in order to keep patients safe at all times. An induction was provided for all bank and agency staff during their first shift. Competency assessments were also carried out using service specific checklists.
- There was appropriate provision in place for medical cover for dialysis patients. This was provided by the consultant nephrologist from a local NHS trust. The unit staff were able to access the referring consultant nephrologist by telephone, bleep and email. In the event the consultant was not available the staff were able to discuss patient concerns with the on-call renal consultant or registrar.

Emergency awareness and training

- There were arrangements in place to respond to emergencies. Business continuity plans were in place detailing actions to be taken by the unit staff in the event of a utilities failure.
- Due to the essential requirement for the supply of water and electricity in order to treat patients, the unit was on the 'critical or priority' list of the local water authority and electricity board. If the supply of water was interrupted, the water plant would alert staff. The break tank would continue to provide water for dialysis for a further 20 minutes; this would enable staff to safely discontinue patients' treatment. In the event of power failure, the dialysis machines and chairs had reserve battery packs, which would enable staff to discontinue patient treatment safely.
- All staff were aware of the plan, and there was a requirement within it for training and site evacuation drills. The plan included defined roles and responsibilities; emergency contact details for emergency services, public services and utilities, key headquarter personnel, and neighbours. The plan addressed a number of situations that could arise including fire, loss of services and systems. The plan had been tested in Alnwick with the event of a flood in 2015 and subsequent loss of power where patients were redirected for treatment to the nearby unit. We did not see personal evacuation plans for patients in the health care records we reviewed.

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

Evidence-based care and treatment

- Services, care and treatment were delivered and clinical outcomes monitored in line with and against the Renal Association standards, National Institute for

Health and Care Excellence (NICE) and the referring NHS trust's requirements. The Renal Association is the professional body for UK nephrologists (renal physicians, or kidney doctors) and renal scientists in the UK.

- Renal Association guidelines were followed for the management of 'life-threatening' haemorrhage from arteriovenous (AV) fistula and AV grafts. An AV fistula is an abnormal connection or passageway between an artery and a vein. An AV graft consists of a synthetic tube implanted under the skin, connecting between the artery and the vein, and providing needle placement access for dialysis. Patient care records demonstrated where regular discussions had taken place with the patient regarding this risk. A system of taking photographs of the condition of fistulas was in place to support assessment and discussion with the renal consultant or trust vascular access nurse.
- All staff monitored patients' vascular access as part of their pre-dialysis assessment and following treatment. We saw an assessment of the patient's vascular access included in all six patient care records we reviewed. This followed NICE Quality standard [QS72]: Renal replacement therapy services for adults. Where there were concerns identified regarding the patient's vascular access this was escalated to the referring consultant nephrologist for advice.
- Each patient's weight, temperature, pulse and blood pressure was checked at the beginning and end of dialysis. In addition to continual electronic monitoring during the haemodialysis session. The recordings were documented on the patient's daily dialysis record sheet, We observed two out of six patients had not had the recordings of mid-treatment observations in the paper record.
- At the time of this inspection, 80% of patients had an arteriovenous fistula. This was in line with Renal Association guidance of over 70%.
- The unit did not provide assistance or support to patients who were dialysing in their own home but did offer support to those requiring dialysis whilst on holiday.
- The clinic had a local audit programme; nursing audit results for example; infection prevention and control practices, medicine and pressure area care were shared with the consultant and MDT and displayed for patients in the unit.
- Monthly multidisciplinary meetings were held, staff we spoke with said that all patients' blood results were reviewed; progress and general condition was discussed. The nursing staff and consultant discussed outcomes and changes with all patients. Staff we spoke with were very clear about the changes for patients in their care. Written information was also provided as standard to ensure the patient had an on-going record of their treatment outcomes. Patients we spoke with were clear about their treatment and care plans.

Pain relief

- An assessment of pain was documented in all six patient care records we reviewed. The pain assessment tool used provided a pictorial as well as numerical scale to assess a patient's level of pain. A pictorial scale is useful for patients who cannot verbalise or may have a cognitive disorder.
- We observed nurses supporting patients to be comfortable during dialysis treatment with positioning and pillow support. Simple analgesia such as paracetamol was prescribed for all patient's. Where a patient required a stronger form of pain relief a discussion would take place with the referring NHS trust and a prescription would be written and faxed to the unit or referred to the patients GP.

Nutrition and hydration

- Staff provided patients with hot drinks and light snacks during treatments however there was no facility to provide meals for those on longer treatment sessions (over 4-5 hours).
- Patients were not reviewed regularly by a dietitian as this service was not consistently available through the current contract arrangements and MDT. The agreement was not secured for dietetic support which would be provided by a nearby NHS trust. Staff told us that they could call the service for advice but a formal arrangement was not in place.

- However, following a review of a patient's blood results, the dietitian would provide support remotely through telephone advice and during visits for patients who the unit manager referred. Where indicated a referral would be made to outpatient dietetic services. Staff we spoke with told us that dietetic services were part of a proposed business case.
- We reviewed six patient care records and saw evidence of a nutritional assessment and appropriate care plans. Care records also demonstrated patients were seen when referred by nursing staff.

Patient outcomes

- The unit participated in the UK Renal Registry through the referring NHS trust. The UK Renal Registry is a resource for the development of patient care in renal disease. It provides a focus for the collection and analysis of standardised data relating to the incidence, clinical management and outcome of renal disease.
- The unit did not directly submit data to the UK Renal Registry; the 'parent' NHS trust undertook this. The data from the unit was combined with the NHS trust data and submitted as one data set. This data set included patients under the direct care and supervision of the trust i.e. it would not include for example those patients undergoing dialysis away from either the trust or the unit. Due to the inclusion with other units, the unit was not able to benchmark the effectiveness of the service against other providers.
- For the reporting period April 2016 to March 2017.100% of patients were treated within 30 minutes of their appointment times for treatment.
- Clinical patient outcomes were monitored by the service, in order to benchmark services provided across the organisation, and included for example, target weights, hypotension (low blood pressure) and prolonged bleeds.
- Monthly blood sampling was carried out and results were checked by the nursing staff. Urea reduction ratio's (URR's) were calculated and checked against the Renal Association (RA) guidelines. The URR is one measure of how effectively a dialysis treatment removed waste products from the body. For April 2016 to March 2017, an average of 95% of patients achieved a URR of greater than 65% as indicated by RA guidelines.
- Clinical outcomes for renal patients on dialysis can be measured by the results of their blood tests. The blood results were monitored on a monthly basis as directed by the NHS trust. Results were collated on the electronic patient database used at the unit. The data was available for the clinic manager and consultant to review so they could see individual patient outcomes. Changes in treatment were planned as a required.
- For the reporting period April 2016 to March 2017, 98% of patients received three dialysis sessions per week, each for a minimum of four hours duration.

Competent staff

- New staff completed a 'novice to competence' practitioner programme over a six month period. This included a four week supernumerary period, a mentorship and preceptorship package and clinical competencies. All competencies were assessed and signed off locally by the unit manager. On completion of the initial training package, staff were encouraged to complete an advanced specialist renal nurse course. All staff at Alnwick, had completed or were enrolled to complete the advanced course (three complete and one member of staff commencing in 2017). All staff had received sepsis training, the content of which had been agreed with the partner NHS trust.
- New staff received corporate and local induction, which included aspects of their mandatory training such as fire, health and safety issues. A new deputy manager in post at the Alnwick unit told us that induction, training and support had been good in the unit
- Training and supervision in for example, catheter dressing, vascular accessing techniques, taking blood samples, safe injection practices, management of intravenous cannula and arteriovenous fistula was included as part of the comprehensive renal competency programme. A review of staff personal competency files indicated staff had been trained and assessed as competent in these procedures.

- Staff training was supported by annual appraisals. In addition to these, regular meetings took place to review targets and professional development. To support on-going training and education, personal development plans and targets were set around the appraisal, taking into account career progression and service needs. In the 12 months preceding our inspection all eligible staff had received an annual performance review, including regular bank staff.
- Arrangements for supporting staff through revalidation and checking Nursing and Midwifery Council (NMC) PIN numbers was carried out by the provider's human resource department. These processes provide assurance that nursing staff are fit to practice.
- Staff we spoke with told us they felt supported by managers and that they were assessed as experienced and competent to carry out their role. We observed competent staff in practice during inspection. Training and assessment methods were observed to be comprehensive as part of the Renal Services (UK) approach. There had been additional improvements introduced by the head of nursing since their appointment in 2016 and these were embedded into practice in the Alnwick unit.
- All staff had received training on the use of dialysis equipment and staff competency files we reviewed confirmed this. On-going competency-based assessments to ensure staff were up to date with using, for example, dialysis machines was undertaken and documented in training files.
- All staff had training in recognition and management of sepsis.

Multidisciplinary working

- Whilst on the unit we observed good communication and support between members of the team, nursing staff and patients we spoke with described good working relationships amongst all staff involved in care and treatment, including clinical and transport services.
- The unit had close contacts with the referring NHS trust's multi-disciplinary team (MDT). Where indicated, patients would be referred to a social worker, counsellor, dietitian and other members of the MDT.
- MDT meetings, between this unit and the referring trust, were held monthly with the consultant nephrologist. Dietitian and pharmacist advice was accessed as required.
- Renal Services (UK) Limited - Alnwick was a 'nurse-led' dialysis unit. Overall responsibility for the patient's care lay with the patient's consultant nephrologist at the referring NHS trust.
- On a day-to-day basis, where advice or support was required, staff told us they had good access to the referring renal consultant or a renal specialist at a nearby NHS trust. We observed staff accessing a consultant by telephone on one occasion during the inspection.
- The staff we spoke with confirmed they accessed specialist nurses, therapists, dietetics and social support where a patient need warranted wider MDT input. Trust clinicians were said to attend the unit frequently to meet patients especially at weekends.

Access to information

- Renal Services (UK) Limited policies and procedures were accessible, in paper format, in the unit. Policies and procedures for the referring NHS trust were accessible electronically through the trust's renal database. We saw where local policies included a signature sheet confirming staff had read updated policies.
- Following treatment patient information was documented in paper format and directly on to the referring trust's electronic patient information management system. Patient information was communicated to the GP by the referring consultant nephrologist in the form of letters.
- Dialysis staff accessed the patient's NHS clinic letters, blood results and dialysis prescriptions through the referring trust's renal database. We observed this taking place during this inspection. Information was shared with the patient's GP.
- Staff we spoke with told us that they had good access to systems and information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff gaining consent before completing treatment or procedures. This was further reinforced with a written and signed treatment consent held in the patient notes.
- A consent policy written in line with the Mental Capacity Act 2005, Mental Health Act 1983 and Department of Health guidance documents on consent was available to all staff. We reviewed six patient care records and saw all patient records included a consent to treatment record.
- Nursing and medical staff obtained consent via both verbal and written routes. The staff we spoke with were aware of how to gain both written and verbal consent from patients and their representatives.
- During the time of this inspection there were no patients who lacked capacity to make decisions in relation to consenting to treatment.
- Where patients lacked capacity to make their own decisions, staff we spoke with said they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. Staff said that where this was not possible staff had to make best interest decisions however there was no opportunity to review this in practice during inspection.
- At the time of this inspection the unit had no patients who had an active 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place.
- Medical advance planning and end of life care decisions were made jointly with the patient and the referring consultant nephrologist. Staff told us of experiences with patients where advance decisions had been put in place and how this had been communicated to staff in the unit. Patients would be cared for in the local NHS trust at the end of life.

Are dialysis services caring?

Compassionate care

- Patient privacy and dignity was maintained at all times. Patients received treatment in an open clinical area. Privacy screens were available in the event of an emergency to maintain the patient's dignity during any emergency treatment or when required to maintain privacy at any other time. We observed the use of privacy screens during this inspection.
- During this inspection we observed all staff treating patients with dignity, kindness, compassion, courtesy and respect. Staff interacted with patient's and were inclusive of patient's during general conversation. Staff commented how they really knew their patients well and got to know the whole person through building relationships with them. Patients did not know who their designated 'named nurse' was but stated they knew all staff very well and could approach any member of staff for assistance. They found the unit manager particularly helpful and supportive.
- We spoke with six patients in the unit during the announced and unannounced visit. Feedback we received was consistently positive about aspects of care and treatment. Patients commented staff were "excellent" and "can't say nothing bad about it".
- It was clear that staff we observed were aware of the individual needs of patients, including those living with sight impairment and mobility problems. We observed nurses assisting patients with their comfort, adjusting chair positioning and ensuring nurse call systems were in reach and placed on the correct side. Patients living with sight impairment had the lights dimmed in the single room as requested. There was no delay in attending to patients' needs or alarm calls during dialysis treatment.
- The unit took part in the service patient satisfaction survey. Responses showed 95% of patients felt overall that they had been treated with respect and dignity. Staff were pleased to share thank you cards, press cuttings and letters of gratitude received from patients. We read "thanks for making my holiday go so much easier", "staff were so kind and attentive", "I would definitely recommend this to others!" and "Spoke so warmly…loved the chat and treatment with you."
- We received four "tell us about your care" comments cards and these were positive with the exception of one remark made about the waiting room being small. One patient stated that they 'could not fault anything. I feel very lucky to have such wonderful care".

- Staff we spoke with told us of supporting patients with birthday and seasonal celebrations. One member of staff told us that they had personally purchased an audible clock from the Blind Society to assist a patient in telling the time in the unit during treatment.

Understanding and involvement of patients and those close to them

- Staff stated they did everything to ensure "patients were always put first" and told us that they always worked flexibly to meet patients' needs and requests.
- Patients we spoke with said that they had been fully involved in their care decisions. This included discussion of the risks and benefits of treatment as part of consenting to treatment.
- Patients said they would know who to approach if they had issues regarding their care, and they felt able to ask questions, however they were clear about having no issues or concerns. Patients could access the internet or 'Patient View' through the use of a laptop. Patient View allows renal patients to view their latest test results online, along with clinic letters and information about diagnosis and treatment. Most patients we spoke with told us they chose not to access 'patient view' because the nursing staff always discussed and explained their blood results to them.
- Staff we spoke with said that as many of their patients attend the unit over a long period of time, staff built up a good relationship with the patients and they got to know patients very well and understand any changes in the patients emotional, social, cultural, spiritual, psychological and physical state.
- At the time of this inspection the unit did not have any patients requiring additional support to help them understand and be involved in their care and treatment. Staff told us were this the case they were aware of how to access additional resources such as for example, language interpreters, sign language interpreters, specialist advice or advocates.
- During treatment, there were activities available, albeit there are recognised limitations on what can be undertaken during dialysis. We observed patients using television, radios and internet access on their own electronic portable devices. Patients had newspapers and magazines or books that they accessed and most patients were sleeping during treatment. Staff made efforts to keep noise levels low, respected the patient's privacy and gave additional pillows where needed.
- The unit had a quiet room where patients could have confidential discussions about their care with any members of the multidisciplinary team should they so wish.
- A number of information leaflets were available for patients offering information and support around renal disease and dialysis. Patients we spoke with told us of these leaflets and how staff had gone through the leaflets with them to ensure they understood the information.

Emotional support

- Staff at the unit worked in partnership with the renal consultant of the local renal unit to arrange for the relevant emotional support for patients.
- As most patients had a long-term relationship with the staff working on the unit, staff were able to identify emotional changes in the patient and to offer support. Patients had access to a counselling service prior and during dialysis through the local NHS trust or via a GP referral.
- Patients we spoke with said that they had been supported in accessing holiday dialysis services as required.

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

Meeting the needs of local people

- Renal Services (UK) Limited, Alnwick opened in 2015 to meet the specific demands of people in Northumberland who required a satellite dialysis service local to them, thus significantly reducing travelling distances and time for patients to Newcastle services previously. It was a six station unit, with one isolation room.
- The unit was a nurse led service in the 'north cluster' providing haemodialysis on behalf of the local NHS trust for the patients of Northumbria. One patient

commented "being only minutes away from Alnwick means I get a huge part of my life back." Not having to travel long distances for appointments can significantly enhance the quality of the patient's life.

- The unit did not have a transport user group. However, the provider monitored transport services as part of their annual patient satisfaction survey. Results from the 2016 patient satisfaction survey showed 87% of patient's at this unit, using transport services to attend for dialysis, were collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis.
- The unit manager reported changes to the transport service as part of monitoring and engagement with the transport provider.
- The unit met the recommended practice for haemodialysis facilities: Health Building Note 07-01: Satellite dialysis units. For example, the unit was located on the ground floor and had its own dedicated entrance, the entrance was easily accessible to patient's using wheelchairs or walking aids and parking spaces were available, including disabled parking.
- Dialysis sessions were available six days a week from 6.30am to 6pm for patients, taking into consideration the working, cultural and family responsibility needs of the patients currently receiving treatment at the unit. Staff and patients told us of times when session's would be changed to accommodate a patient's individual circumstances, for example to accommodate a patient's football match fixtures. The team would stay longer for specific patient circumstances when required.

Service planning and delivery to meet the needs of individual people.

- There was provision for patients attending for haemodialysis to be able to visit the toilet before dialysis commenced. We observed nursing staff providing assistance and a number of patients told us staff were always helping them.
- Dialysis patients may be susceptible to cold as such the unit performed on-going monitoring of the temperature of the unit. During this inspection the unit temperature felt comfortable. None of the patients we spoke with, who were receiving treatment at the time of this inspection, expressed concerns regarding the temperature of the unit.
- The provider had a dedicated holiday dialysis co-ordinator who liaised with trust holiday coordinators, the patients, consultant nephrologists and other dialysis units, including overseas, for treatment bookings. The co-ordinator ensured that all necessary administration arrangements were in place and would follow up on any outstanding information prior to the unit being given the go-ahead to treat the patient. The information was requested four weeks prior to the holiday dates and all information was checked by the nursing staff prior to accepting the patient. All the staff were aware of the holiday co-ordinator and the process for arranging holiday dialysis.
- There were no dedicated beds allocated solely for holiday dialysis. Holiday dialysis was offered around bed availability and extra capacity.
- Individuals had access to televisions and portable entertainment devices during sessions and were encouraged to bring any items that would support their comfort.
- Patients were encouraged to participate in their treatment. Staff encouraged patients to take responsibility for parts of their treatment, such as weighing themselves prior to dialysis.
- The unit provided haemodialysis treatment to patients following an individualised treatment prescription. Changes to prescriptions were made during multi-disciplinary meetings. The outcome of these meetings and changes to care were discussed with the patients. Consent for treatment changes was documented at all stages with patients.
- Staff could access interpreting services for patients who did not speak or understand English. The service was provided externally and included the provision of British Sign Language.
- Patient information was available in four main languages but staff we spoke with said they were able

to obtain information in other languages if required, Access to translation and interpreter services was arranged via the parent unit. We spoke with staff who had arranged interpretation services through the GP.

Access and flow

- The unit used an appointment system which staff we spoke with said ensured structure, timeliness and minimised delays as far as possible. The unit offered a flexible approach to the patient's dialysis sessions changing dialysis days and or times as far as possible to accommodate external commitments or appointments or social events the patients may have. Sometimes this may have necessitated a dialysis session being relocated to the referring hospital.
- The unit was open Monday to Saturday from 6.30am until 6.00pm.
- The utilisation of capacity in the unit a the three month reporting period in 2017 was as follows: January 56%, February 56% and March 56% and so had spaces to accommodate holiday treatment sessions, for people staying in the local area, provided this had been medically approved, there was session availability and all relevant information was available. The unit had not cancelled or delayed any dialysis sessions for non-clinical reasons in the 12 months prior to the inspection.
- The local NHS trust renal unit contacted the unit to inform that it has new patients that they want to admit into the satellite unit. The unit in Alnwick provided outpatient haemodialysis therapies for patients in end stage renal disease who were either already established on renal replacement therapy or new patients who had been assessed by the referring doctor to be fit to commence treatment in a satellite setting. Referrals were made as part of the contract with the referring acute NHS trust.
- There was no waiting list for treatment at the clinic and staff we spoke with said that this was consistent.
- Patients did not complain about delays in treatment start times, and told us that the unit was efficiently managed, although some patients we spoke with complained about the delays created by the transport service. These were monitored by the unit manager.

Learning from complaints and concerns

- A complaints procedure was in place and made available to all patients at their first treatment session. The complaints procedure had a staged approach to complaints and outlined the timescales appropriate to raise them, and also the timescales for a response from the service. Complaints followed an escalation procedure in order to progress those that were not resolved in the initial stages.
- The service monitored compliments and verbal and written complaints. For the reporting period April 2016 to March 2017 the service received no written compliments. There had been no complaints received during the 12 months preceding this inspection. However the unit manager was aware of the actions they should take should a complaint be raised.
- It was the responsibility of the clinic manager to ensure all complaints were sympathetically dealt with within maximum 20 working days.
- Staff we spoke with described their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required. Staff we spoke with recognised that lessons for continuous quality improvement for people using the service might develop as a direct result of concerns or complaints.

Are dialysis services well-led?

Leadership and culture of service

- Renal Services (UK) Limited – Alnwick was led by a clinic manager, supported by a regional clinical manager and head of nursing. Clinical governance of the unit was consultant led.
- The current unit manager was soon to be the replacement registered manager for CQC. The current registered manager had oversight and worked locally in Renal Services (UK) Limited. Both nurses were experienced in renal nursing with formal qualifications. The clinic manager responsible for the day to day management of the service was a registered nurse with formal specialist renal and mentorship qualifications.

- Local leadership at this unit was effective and staff felt supported by their leader. We received many positive comments about senior leaders at provider level and staff we spoke with were all encouraged by the attitudes of the executive team.
- Staff described the culture of "patient first" and a new member of staff confirmed he joined the organisation because of their "professional reputation".
- The unit manager was described as open, approachable and visible. The senior team were also accessible and staff told us that they were happy to be contacted. The senior team at executive level were predominantly former specialist clinicians so had a real understanding of day to day issues in the renal service. They were visible in units throughout the year.
- Staff reported a strong working relationship and 'team togetherness', not just in Alnwick, but across wider units. Staff commented how this had been strengthened with the appointment of the head of nursing in 2016 who staff told us had "really pulled together the nursing team".
- The unit staff meetings were managed monthly by the senior nurse. We reviewed three sets of meeting minutes and saw a clearly written agendas and good evidence of discussion held on staff concerns and improvements required from recent audit results.

Vision and strategy for this this core service

- There was an organisational vision in place for the unit, to deliver "inspired patient care". This was supported by seven organisational values: safety, service excellence, responsibility, quality, communication, innovation and people. We saw the vision and values displayed in the clinical area.
- Whilst staff were unable to recite the exact wording of the vision and values they all demonstrated to us what the organisation wanted to achieve and all consistently demonstrated the values of the organisation. For example, at this unit staff were keen to increase the level of utilisation within the unit and to work collaboratively with the referring trust to promote dialysis in the patient's own home.

Governance, risk management and quality measurement

- Governance is a term used to describe the framework, which supports the delivery of the strategy and safe, good quality care.
- The unit followed Renal Services (UK) Limited clinical and corporate governance structures and policies and procedures. Some had been adopted from their partner trust and ratified internally. We reviewed the local policy folder and all paper policies therein were current however the associated staff sign sheets to confirm these had been read had not been completed by all staff at the announced inspection, although this was resolved at the unannounced visit
- The unit had a local risk register which fed into the corporate document. This aligned to the corporate business continuity plan. The risk register was held at provider level and maintained by the regulatory and quality manager and reviewed by the chief operating officer, and chief executive monthly.
- A local Renal Services (UK) Limited – Alnwick, risk register was in place. The unit manager was aware of the local risks and risks aligned to the provider risk register. Risks identified at location level were discussed six-weekly with the clinic manager, chief operating officer, clinical governance manager and regional manager. Risks identified were; recruitment, electrical failure or loss of water supply, premises unavailable due to fire, flood or any other incident, pandemic illness of staff and failure of the air-conditioning system. We did not see evidence that the lack of provision of dietetic services was considered a local risk, this was not on the risk register.
- There was a comprehensive assurance system and service performance measures, which were reported and monitored, and action taken to improve performance. We reviewed the results of audits that were completed monthly by the unit manager. Examples of audits included: Documentation, environment, health and safety, central venous catheter and infection prevention and control. Results for the months between March and July 2017 were consistently above 95% with most audits achieving results of 100%.
- The clinical governance framework included processes that ensured patient outcomes and

experience were monitored and supported by appropriately qualified staff. The service's medical director who was a consultant nephrologist was a member of the organisation's clinical governance committee.

- The unit manager received feedback on metrics results (patient observations, falls assessments, pressure area care, nutritional assessments, medicine prescribing and administration) through a six-monthly quality assurance meeting with the referring NHS trust. In addition staff were familiar with their performance in relation to other dialysis units and as such able to benchmark their performance. The nominated NHS consultant nephrologist clinical lead for the unit had oversight of this governance process.

Patient and staff engagement

- The unit engaged with the British Kidney Patient Association advocacy service. Information received before our inspection described a well led service, said patients were receiving safe care, all patients were happy with their care and staff were observed to be caring.
- The unit did not have an active 'patient user group'. A patient user group consists of a number of patient representatives who meet to share their views to positively influence change. The unit has patient representation in local meetings, at open days and got involved in local community events with partner organisations such as the British Kidney Foundation and the UK Kidney Group.
- A pilot staff survey was being undertaken but had not included the renal unit in Alnwick. It was expected that this would be rolled out across all units in 2017.
- The unit had a number of different methods in which to collect feedback. There was a confidential suggestions box in the unit in which patients could post feedback or complaints and comments. This was in addition to patients being able to provide feedback or raise concerns verbally with staff members in the unit, by telephone or in writing. All feedback was recorded, reviewed and responded to.
- The patients also had the ability to provide feedback of the service directly to the referring NHS trust's renal team. In order to measure patient satisfaction formally the first annual patient satisfaction survey was carried out in the month of December 2016.
- Unit manager and sister/charge nurse 'away days' were held quarterly with the provider executive team. These allowed individual managers to share experiences with other unit managers, provided 'scenario-based' training on performance management and gave an update on the organisation, governance and the current situation on recruitment. Staff told us they enjoyed these days and felt privileged that the organisation was willing to invest time and resources when organising them.
- Where staff needed additional support to progress clinically or in the event of poor performance, the unit manager discussed this with the staff member concerned. Support would be provided in the form of extending probation, additional mentor support, goal and action plan setting and where necessary involving HR processes.
- The organisation produced a six-monthly newsletter for staff. We reviewed the latest newsletter and saw reference to, new staff, a message of thanks from the executive team, information on the organisations new company logo and birthday messages from a number of dialysis clinics within the organisation.

Innovation, improvement and sustainability

- The organisation encouraged improvement and innovation. Close links with local universities had enabled nurses to complete an accredited renal course, there were plans for a third member of staff to complete this course in 2017.
- Recycling of suitable goods was in operation from the unit through an external contract.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The team should secure a formal arrangement with dietetic services for patients to support the multidisciplinary approach to treatment and planned case. This local risk should be added to the risk register.
- A formal staff survey system should be introduced to formally capture the views of staff across the organisation and at a local level.
- The provider should ensure a recognised early warning score reflecting the risks of the dialysis patient is implemented to prompt recognition of the deteriorating patient.