Epsom and St Helier University Hospitals NHS Trust

Mayday Satellite Dialysis Unit

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**

Our findings

Overall summary of services at Mayday Satellite Dialysis Unit

Inspected but not rated

Mayday Satellite Dialysis Unit is operated by Epsom and St Helier University Hospitals NHS Trust. The unit is located within the premises of another NHS Trust. The service moved to its current premises on 2 March 2021. This new dialysis unit consists of 28 dialysis stations which includes four isolation rooms located across two floors. The unit has capacity to dialyse 84 patients daily, although staff informed us the unit was not yet working at full capacity.

This is the first inspection of Mayday Satellite Dialysis Unit. Epsom and St Helier University Hospitals NHS Trust was last inspected in May 2019 and the report was published on 19 September 2019. The trust was rated Good overall, with Requires Improvement in Safe.

We carried out an unannounced, focused inspection of Mayday Satellite Dialysis Unit on 29 April 2021, as we had received information that gave us concerns about the safety and quality of services at the unit. These concerns arose from a serious incident which occurred in September 2020.

We did not rate this service at this inspection. We found:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills to provide the right care and treatment. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs.

However,

- Less than 50% of staff had completed resuscitation training for the location where the unit was based.
- Although staff were aware of what should be done in the event of a patient safety incident involving a patient on dialysis, they were not aware of the trust's policy describing the process.

How we carried out the inspection

During the inspection we visited Elizabeth Ward dialysis unit across two floors. We interviewed three ward nurses, three senior staff and the resuscitation officer for Epsom and St Helier University Hospitals NHS Trust. We also spoke to two patients receiving care at the time of our inspection. We checked the resuscitation trolley, reviewed guidelines and three patient records on the electronic system and observed patient care.

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

Renal

Inspected but not rated

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- Less than 50% of staff had completed resuscitation training for the location where the unit was based.
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Is the service safe?

Inspected but not rated

We did not rate this service at this inspection. We found:

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All clinical areas we inspected were visibly clean and tidy. There was a personal protective equipment (PPE) station on each floor of the unit and staff had easy access to PPE such as masks, face shields, gowns and gloves. There was also sufficient access to antibacterial hand gels, as well as handwashing and drying facilities.

Staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces and wearing PPE when caring for patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

Renal

The service moved to a new dialysis unit on 2 March 2021. This was a 28 bedded unit across two floors. Staff accessed the unit by using a swipe card and visitors pressed the buzzer to alert staff. There was sufficient space between beds/ chairs to reduce infection risks. Each patient area was equipped with a new chair, television, Haemodialysis (HD) machine, antibacterial hand gel and curtain. There were handwashing sinks between each patient area.

We observed there was a resuscitation trolley on each floor of the unit. Equipment inspected had maintenance stickers showing they had been serviced in the last year. We checked a random sample of supplies on the two trolleys within the unit and saw they were all in their original packs and in date. We reviewed equipment checks in the last two months and we found staff maintained a documented programme of daily checks.

We also reviewed monthly resuscitation trolley audits between January 2021 and March 2021. These showed staff were regularly monitoring the availability, cleanliness and expiratory date of equipment on each trolley. Staff also rechecked the trolleys after use. However, one question "Is the red top up box checked weekly?" was never answered in all three audits we reviewed. We therefore did not know if staff were aware whether the red top up box was checked, or this question was not applicable. However, following the inspection, the trust us that the above question was not applicable for the audit.

The service had updated the contents of the resuscitation trolley. This was in line with recommendations made following an investigation into a serious incident which occurred in September 2020.

We noted equipment was arranged in four categories with each drawer labelled (Airway, Breathing, Circulation, and Drugs, Fluids and Miscellaneous). In addition, the resuscitation folder contained pictures and details of all items in the trolley, so that staff could easily identify them. PPE was included on the resuscitation trolley in line with recommendations for staff to wear full PPE when performing CPR. Staff informed us they could recognise equipment on the resuscitation trolley and felt well trained to carry out resuscitation.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff identified and quickly acted upon patients at risk of deterioration. Staff conducted patient safety checks within 30 minutes of any line connection during haemodialysis (HD) treatment and hourly thereafter. This included vital signs and checking to make sure HD line connections were secure and intact. In addition, a dedicated member of staff conducted routine ward rounds to make sure patients were comfortable and their line connections were secure.

Staff had completed competencies which covered actions to take in the event of a HD machine alarm. Staff informed us they would check to make sure the patient was alert and responsive, check their vital signs, review information displayed on the HD machine to identify any issues, and check that the connection line was secure and well connected. Staff informed us they would escalate any concern to senior staff.

Staff were also aware of actions to take in the event of patient deterioration. This included pressing the alarm to get assistance from other staff, calling the cardiac team via 2222, downing full PPE and commencing CPR prior to the resuscitation team's arrival.

Staffing

Renal

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

There were three nurses and one associate practitioner on each floor of the unit during our inspection. Staffing levels were sufficient and operated on a ratio of one nurse to four patients.

We reviewed the staff rota for April to May 2021 and noted enough staff with the right skill mix were rostered to cover shifts during the period.

Senior staff informed us consultants visited weekly to review patients. Staff could contact consultants on phone when required.

Records

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

The unit's electronic record system was connected to the weighing scale and HD machine. This meant that information regarding patients' weight, temperature checks and vital signs were automatically transferred to the electronic system. Staff could see patients' indicators on the electronic system. The system also had hazard signs to alert staff about any abnormality.

We reviewed three electronic patient records and observed staff had updated records to reflect patient safety checks.

Incidents

Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff told us they were aware of the learning from the incident that prompted our inspection. In addition, the trust had implemented most of the recommendations made following the incident.

One of the recommendations made following the serious incident was for staff to complete resuscitation training organised by the trust on whose premises the dialysis unit was based. Although over 80% staff had completed resuscitation training, only 50% had completed Basic Life Support (BLS) training organised at the host trust. This was significant because resuscitation procedures at both trusts were different. Senior staff mitigated this risk by ensuring BLS trained staff were rostered to cover each shift.

Is the service effective?

Inspected but not rated

We did not rate this service at this inspection. We found:

Renal

The service provided care and treatment based on national guidance and evidence-based practice. Staff had access to clinical guidelines on the trust's shared drive and electronic system. We reviewed records which showed staff had signed to indicate they understood guidelines.

During our inspection, we reviewed the following renal clinical guidelines:

1. Connection; 2. Disconnection: HAEMODIALYSIS via a Central Venous Catheter using the 'ONE Nurse Technique'

1. Connection; 2. Disconnection: HAEMODIALYSIS via AVF, AVG

The first policy described the correct technique for aseptically preparing a central venous catheter for commencement, subsequent care and discontinuation of haemodialysis treatment using the one person technique.

The second policy described; a) the correct technique for aseptically preparing an arteriovenous fistula (AVF) or graft (AVG) for commencement of Haemodialysis treatment and; b) the correct technique for aseptically preparing a central venous catheter for discontinuation of Haemodialysis treatment.

These guidelines were amended in March 2021, to strengthen visibility at connection and safety checks.

Senior staff told us they were aware of what should be done in the event of a patient safety incident involving a patient on dialysis. However, they were not aware of a policy that described the process of retaining dialysis equipment involved in a patient safety incident. They were also not aware of a policy that requires staff to isolate and check machines involved in patient safety incidents, before being reused.

Following our inspection, we requested information regarding the trust policy for retaining and isolating equipment involved in patient safety incidents. The trust provided us with 'The Reporting and Management of Clinical Incidents Policy' (the clinical incidents policy) which sets out the trust approach to recording, reporting and management of incidents. This included the requirement for staff to isolate and retain any medication, medical device or equipment, involved in patient safety incidents.

The trust informed us they had considered how they could strengthen staff awareness of the specific requirements of the clinical incidents policy. They had implemented actions to assess new staff against a comprehensive set of haemodialysis competencies. These competencies have been reviewed and amended to ensure that all renal nursing staff knew how to escalate patient concerns, seek assistance if required and take appropriate action in the event of a patient deterioration. The trust provided us with a copy of the HD clinical skills competency record document (May 2021), which confirmed the amendments.

The trust also provided us with updated clinical guidelines for Haemodialysis via a Central Venous Catheter using the 'ONE Nurse Technique' and via AVF, AVG. We reviewed the guidelines and noted it was amended in May 2021 to strengthen retention of machine, lines and consumables in the event of a patient safety incident.

Competent staff

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

Renal

New starters informed us they were supernumerary for three weeks and went through an induction and competency period. These included specific haemodialysis competencies which covered actions to take in the event of haemodialysis machine alarm. All staff we spoke to confirmed they had completed training to use the HD machines available within the unit. We also reviewed staff training records, which confirmed staff had completed the training.

All staff had access to the trust's electronic records system that they could all update. This included two systems used by the provider and the location in which the dialysis unit was based. Staff training records indicated all staff had completed training to use the system.

Senior staff informed us they did not use agency staff. They had only one bank nurse working on the unit at the time of our inspection. The unit only used the trust's own bank staff, who have a good recommendation and had completed their competencies. Senior staff informed us the trust made sure bank staff were up to date with their mandatory training.

One senior staff member told us that although staff completed competency-based training at the start of their employment on the unit, the service did not undertake a review of these competencies. However, following the inspection, the trust stated and sent evidence that action had been undertaken to strengthen staff competencies, which included the requirement for staff to complete an annual self-assessment and observation/assessment on a two-yearly basis.

Is the service caring?

Inspected but not rated

We did not rate this service at this inspection. We found:

Compassionate Care

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

Patients informed us staff were very attentive, friendly and dedicated. They said they quickly sorted out issues when they felt uncomfortable. Patients were happy with the care received.

The service had recently moved to a new dialysis unit by the time of our inspection. There was sufficient space between beds, and curtains around each patient area to maintain privacy and dignity.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should improve staff completion rate for the basic life support training provided by the host trust.

Renal

- The trust should improve staff awareness and access to guidelines and procedures. In particular, the trust should check that staff are aware of the policy which describes the process of retaining and isolating dialysis equipment involved in patient safety incidents.

Our inspection team

The team that inspected the service comprised an Inspection Manager, a CQC lead inspector, and another CQC inspector. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.