# Renal Services (UK) Ltd - Newcastle

## Quality Report

1 Hedley Court,
Orion Business Park,
North Shields,
Tyne and Wear
NE29 7ST
Tel: 07802 813000
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

## Overall summary

Renal Services - Newcastle is operated by Renal Services (UK) Ltd, an independent healthcare provider. It is commissioned by Newcastle Upon Tyne Hospitals NHS Foundation Trust (NUTH) to provide an outpatient satellite dialysis service to their patients. This is a nurse led service with patients remaining under the clinical management of the renal consultants employed at the trust.

The service is delivered from a purpose built facility situated in Orion business park, North Shields. It is a 10 treatment station unit, comprised of nine stations in the general area and one side room, which can be used for isolation purposes.

The unit provides haemodialysis for stable adult patients with end stage renal disease/failure. The service provides renal dialysis for patients over the age of 18 years.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 28 June 2017, along with an unannounced visit to the service on 11 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? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

### Services we do not rate

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

We found the following areas of good practice:

- Staff demonstrated a clear understanding of the importance of incident reporting and learning from incidents was shared across the organisation.

# Summary of findings

- Mandatory training compliance was high and staff received adult and children's safeguarding training to level two.
- Staff worked flexibly and the rota was planned to ensure safe numbers of staff were available to meet patient need.
- Treatment protocols and policies were based on national guidance including the Renal Association Guidance and National Institute for Health and Care Excellence (NICE) standards.
- The unit monitored clinical outcomes for patients in line with and against the Renal Association Standards and referring trust requirements.
- The provider monitored patient transport collection times following treatment, from January 2017 June 2017 over 90% of patients were collected from the unit within 30 minutes of their treatment finishing.
- There was a comprehensive 26-week 'novice to competent dialysis nurse practitioner framework' for registered nurses new to dialysis, which involved theoretical and practical competency assessments and all staff had received an annual appraisal.
- We observed that staff interactions with patients were warm, positive, caring and that staff were always available for patients.
- Patients said there was a good atmosphere on the unit and staff were good at calming people down when they were upset or anxious.
- Patient survey results indicated 93% patient satisfaction for the environment, 91% satisfaction for staff treating them with respect and dignity and 86% for helpful staff.
- There was no waiting list and no treatments had been cancelled for non-clinical reasons from May 2016 to May 2017.
- The clinic had not received any formal complaints from May 2016 to May 2017 and staff and patients told us how informal concerns had been dealt with in a caring and supportive manner.
- Staff were familiar with the organisational mission and values for the service, which was to provide 'Inspired Patient Care' through safety, service excellence, responsibility, quality, communication, innovation and people.
- We found that staff morale was good and there was high regard for the unit manager and senior team. Staff told us they were well supported by the unit manager and the senior team.
- We found the clinic manager and the senior team had a desire to learn and to address any issues as soon as practically possible.
- The service invested in devices to improve care and patient experience. For example, the service had purchased three devices, designed to provide Image-Guided Peripheral Intravenous Access.

We found the following issues that the service provider needed to improve:

- Patients did not have direct access to regular and timely dietetic support and regular contact with a renal consultant.
- The unit did not have individualised care plans or personal emergency evacuation plans (PEEP) for all patients. However, patients with mobility problems did have a PEEP in place and the service told us that it had subsequently implemented these for all patients.
- The clinic's infection control policy did not include comprehensive screening guidance regarding new or holiday patients. However, holiday booking forms did ask for evidence that patients had been screened and were negative for CPE, as well as MRSA and blood borne virus status.
- There was no transport user group for the patients attending the service.
- Not all risks identified during the inspection had been identified and logged on the risk register.
- There had been no medicines audit for several months prior to the inspection and the audit tool in use did not include observation of clinical practice or competence. We did not see evidence of action taken following documentation audits.
- The clinic was not meeting the 'Accessible Information Standard' (2016) and the Workforce Race Equality Standard (WRES) (2015) at the time of our inspection, although immediate action was taken following the inspection to address the 'Accessible Information Standard and understand how the organisation could meet the WRES standard.

Following this inspection, we told the provider that it must take some actions to comply with the regulations

# Summary of findings

and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice. Details are at the end of the report.

**Professor Edward Baker**

Chief Inspector of Hospitals

# Summary of findings

## Contents

# Renal Services (UK) Ltd - Newcastle

**Services we looked at**
Dialysis Services

# Summary of this inspection

## Background to Renal Services (UK) Ltd - Newcastle

Renal Services - Newcastle is operated by Renal Services (UK) Ltd. The service opened in May 2016. It is a purpose built facility situated in Orion business park, North Shields. The service is contracted by NUTH for the provision of outpatient satellite dialysis to their patients in the Newcastle area.

Since the unit was opened in May 2016, the unit had treated 17 patients and 1,276 dialysis sessions had been carried out.

The hospital has had a registered manager, who had been in post since May 2016. A new unit manager had been appointed in June 2017 and it was intended that they register with CQC as registered manager for this unit in the near future.

## Our inspection team

The team that inspected the service comprised two CQC Inspectors and a specialist advisor.

The inspection team was overseen by Amanda Stanford, Head of Hospital Inspections.

## Information about Renal Services (UK) Ltd - Newcastle

Renal services (UK) Ltd – Newcastle is a purpose built unit based on the ground floor of an office block in the Orion business park, North Shields. It provides treatment and care to adults only and the service runs over six days, Monday to Saturday.

The dialysis unit is registered to provide the following regulated activities:

- Treatment of disease, disorder, or injury

There are 10 treatment stations including one side room. The unit had recently increased patient numbers and at the time of inspection, it was dialysing 20 patients per week. The unit had the capacity to expand up to 60 patients.

The unit was able to provide holiday dialysis on request.

There is ample storage, office space and treatment rooms. Access is ground floor to all facilities and disabled car parking is available directly outside the clinic.

The usual times for dialysing patients were Monday, Wednesday, and Friday mornings and afternoons. The service had recently increased its capacity and had introduced further sessions Tuesday, Thursday and Saturday mornings.

During the inspection, we visited the treatment areas where dialysis took place, and the other non-clinical areas of the unit, such as the maintenance room, and water storage area. We spoke with a range of staff including the regional business manager, area head nurse, unit manager and deputy manager and registered nurses. We spoke with eight patients during our inspection and we reviewed six sets of patient records.

There were no special reviews or investigations of the unit during the 12 months before this inspection. This is the first CQC inspection of this unit since it was registered in May 2016.

**Activity**

From May 2016 to March 2017 there were 17 patients treated at the unit all of these were NHS-funded. Ten patients were aged 18 to 65 years and seven were over 65 years. There were 1,276 dialysis treatments carried out in this period.

Renal services (UK) Ltd - Newcastle was a nurse led service with patients remaining under the clinical supervision of the consultant nephrologists based at the

# Summary of this inspection

Freeman Hospital, part of NUTH. The unit employed five whole time equivalent (wte) registered nurses (RN). There was 0.5 wte RN vacancy and one wte HCA vacancy at the unit at the time of inspection.

**Track record on safety**

There were no reported never events or serious injuries at this unit from April 2016 to March 2017.

There had been one expected death of a service user in the 24 months before the inspection. This was not reportable to CQC.

There were six incidents between May 2016 and May 2017 all were low or no harm

There were no incidences of healthcare associated Methicillin-resistant Staphylococcus aureus (MRSA),

There were no incidences of healthcare associated Methicillin-sensitive staphylococcus aureus (MSSA).

There were no complaints were received by the CQC or referred to the Parliamentary Health Services Ombudsman (PHSO) or the Independent Healthcare Sector Complaints Adjudication Service.

The unit had received no written complaints.

**Services accredited by a national body:**

- The clinic had ISO 9001 (quality management system) certification and is therefore subject to regular audit and review.

**Services provided at the hospital under service level agreement:**

- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment

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

We found the following areas of good practice:

- Staff demonstrated a clear understanding of the clinical incident reporting processes and were able to provide examples of incidents reported.
- A proactive approach was taken in relation to clinical variance reduction.
- Learning from incidents was shared across the organisation and actions were implemented to reduce the risk of re-occurrence.
- There was an open and transparent culture on the unit and staff were clear about the principles of 'being open' and 'duty of candour'.
- Mandatory training compliance was high and all staff had received adult and children's safeguarding training to level two.
- Staff worked flexibly and the rota was planned to ensure safe numbers of staff were available to meet patient need.

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

- The unit did not have individualised care plans or personal emergency evacuation plans (PEEPs) for all patients. Following the inspection PEEPs were implemented for all patients.
- The clinic's infection control policy did not include comprehensive screening guidance regarding new or holiday patients. However, holiday booking forms did ask for evidence that patients had been screened and were negative for CPE, as well as MRSA and blood borne virus status.
- Although there was a medicines management, audit tool available there had not been a medicines audit for several months. The audit tool did not include any audit of clinical practice or competence.

### Are services effective?

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

We found the following areas of good practice:

# Summary of this inspection

- Treatment protocols and policies were based on national guidance including the Renal Association Guidance and National Institute for Health and Care Excellence (NICE) standards.
- The unit monitored clinical outcomes for patients in line with and against the Renal Association Standards and referring trust requirements.
- From January 2017 to May 2017 the proportion of patients meeting the standard of URR >65% was between 90% and 94%.
- Data from June 2017 showed that 82 % of the Newcastle dialysis unit patients had an arteriovenous fistula (AVF).
- The provider monitored patient transport collection times following treatment, from January 2017 June 2017 over 90% of patients were collected from the unit within 30 minutes of their treatment finishing.
- There was a comprehensive 26-week 'novice to competent dialysis nurse practitioner framework' for registered nurses new to dialysis, which involved theoretical and practical competency assessments.
- All staff had received an annual appraisal or interim progress reviews depending on their length of service.

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

- There was no provision for pain relief medicines in the unit
- Patients did not have direct regular contact with dietetic or medical staff.
- Not all staff had completed training regarding mental capacity and deprivation of liberty safeguards, however, this was rectified soon after the inspection.

## Are services caring?

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

We found the following areas of good practice:

- We observed that staff interactions with patients were warm, positive, caring and that staff were always available for patients.
- Patients said staff were 'excellent', 'very attentive', responded quickly to concerns, and made them feel confident and cared for.
- Patients said there was a good atmosphere on the unit and staff were good at calming people down when they were upset or anxious.

# Summary of this inspection

- Patient survey results indicated 93% patient satisfaction for the environment, 91% satisfaction for staff treating them with respect and dignity and 86% for helpful staff.
- Patients could visit the clinic with a friend or family member prior to commencing their treatment there.
- Patients who wished to participate in their own care were supported to do so.
- Nurses gave proactive emotional support and referred onto specialist services where needed

## Are services responsive?

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

We found the following areas of good practice:

- Patients could access care and treatment in a timely way and there was a clear referral pathway for new patients.
- There was no waiting list and no treatments had been cancelled for non-clinical reasons from May 2016 to May 2017.
- The unit had good access and facilities for people with a disability.
- The service had offered, open days to GPs, care home staff and patients to raise awareness of what the unit could offer to patients as well as to raise awareness generally about chronic kidney disease and dialysis.
- The unit had enough capacity to be able to offer holiday dialysis and Renal Services (UK) Limited employed a dedicated holiday dialysis coordinator who provided help in arranging holiday dialysis.
- The unit monitored treatment start times and data from January 2017 to June 2017 showed that more than 90% of patients started their treatment within 30 minutes of arrival.
- The clinic had not received any formal complaints from May 2016 to May 2017 and staff and patients told us how informal concerns had been dealt with in a caring and supportive manner.

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

- There was no transport user group for the patients attending the service.
- The unit was not open for evening sessions at the time of our inspection.

# Summary of this inspection

## Are services well-led?

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

We found the following areas of good practice:

- Staff were familiar with the organisational mission and values for the service, which was to provide 'Inspired Patient Care' through safety, service excellence, responsibility, quality, communication, innovation and people.
- Managers understood the corporate service development and clinical governance strategies and could clearly articulate their priorities for the unit.
- We found that staff morale was good and there was high regard for the unit manager and senior team. Staff told us they were well supported by the unit manager and the senior team.
- We saw that managers and team meetings were held regularly and information such as service changes, incidents, complaints, clinical variances and policy updates were communicated and discussed.
- We saw that information and learning was shared across the organisation between units.
- We found the clinic manager and the senior team had a desire to learn and to address any issues as soon as practically possible.
- We saw views and experiences of patients were sought and the last survey indicated 93% patient satisfaction for the environment, 91% satisfaction for staff treating them with respect and dignity and 86% for helpful staff.
- We found the clinic manager and the senior team had a desire to learn and to address any issues as soon as practically possible.

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

- Not all risks identified during the inspection had been identified and logged on the risk register.
- There had been no medicines audit for several months prior to the inspection and the audit tool in use did not include observation of clinical practice or competence. We did not see evidence of action taken following documentation audits.
- The clinic was not meeting the 'Accessible Information Standard' (2016) and the Workforce Race Equality Standard (WRES) (2015) at the time of our inspection, although immediate action was taken following the inspection to address the 'Accessible Information Standard and understand how the organisation could meet the WRES standard.

# Dialysis Services

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Are dialysis services safe?

### Incidents

- Renal Services (UK) Limited had a risk management and incident reporting policy (2017), which detailed the incident reporting process for all types of clinical and non-clinical incidents. They were graded in five categories between the lowest 'no harm' and the highest of 'death'. The policy explained staff's responsibilities in reporting incidents and risks.
- There had been no 'Never Events' at the unit in the 12 months before the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There had been one expected death of a service user in the 24 months before the inspection. This was not reportable to CQC.
- The service did not report any serious incidents in the 12 months before the inspection.
- There had been one patient fall in the last 12 months.
- The management team told us there had been a recent drive to encourage staff to report incidents and to improve the reporting culture, as it was felt by Renal Services (UK) Limited that they were low reporters and the incident reporting system had been improved and reviewed last year to include all 'near miss' events. Staff we spoke with confirmed they understood the process for reporting incidents and could describe incidents which they would report using the online reporting system.
- We saw that there were six incidents reported from May 2016 to May 2017. Two of these incidents were emergency 999 calls and transfer to A&E. All the incidents were low or no harm and one was an equipment incident where an external drainage pump had become blocked and disrupted the service.
- The unit also recorded clinical variances, which included failures to attend for treatment, shortened or interrupted treatment, hypotension (lowered blood pressure), poor line flow, lost circuit, infiltration, prolonged bleeds and over target weight February 2017 to April 2017 showed nine variances or 1.5% with shortened treatment time. Data for May 2017 to August 2017 showed a total of 27 or 4.5% variances from prescription, nine or 1.5% of these were for poor line flow and five or 0.8% for shortened treatment time. A proactive approach was taken in relation to treatment variance reduction. For example, a review of these variations took place at the end of each treatment day and the head of nursing provided feedback to the unit manager. In addition to this, quarterly reports were produced, identifying any trends or patterns emerging.
- Staff told us and we saw from meeting minutes that learning from incidents was shared across the organisation and gave an example of a call-bell being introduced next to the weighing scales following the investigation of a patient fall at another unit.
- An analysis of incidents relating to falls had demonstrated that most falls occurred at the patient self-weigh scales. To reduce the incidence of falls, all weigh scales had a call-bell installed nearby so patients could call for a nurse if they needed help or felt unsteady.
- All staff we spoke with told us that there was an open and honest approach to incident reporting.
- Under the Health and Social Care Act (Regulated Activities Regulations 2014) the duty of candour is a regulatory duty that relates to openness and

transparency and requires providers of health and social care services to notify patients (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support.

- In order to promote and uphold the duty of candour, Renal Services (UK) Ltd had a 'Being Open' policy. This required staff to share information with patients in an honest fashion and that implications or consequences of any untoward incident were explained to the patient, that apologies were given and that remedy or support was offered to make matters right. Staff understood the principles of being open and duty of candour although there had not been any incidents where duty of candour had needed to be applied.
- The head of nursing told us they reviewed all incidents to analyse trends and themes, to ensure duty of candour requirements were met. Reports were made to Renal Services (UK) clinical governance committee and lessons were shared across the organisation through the monthly managers' teleconference. Minutes of meetings demonstrated sharing and learning across the organisation.
- Managers and staff told us that the service was a supportive environment in which all staff were encouraged to report incidents and would be supported throughout should an investigation need to be carried out.
- Staff told us safety alerts were cascaded by email to the unit manager to be shared with all staff and actioned when relevant.

**Mandatory training**

- Mandatory training requirements included basic life support, which covered administration of adrenaline and the use of an automated external defibrillator (AED), health and safety, manual handling, fire training infection control, food hygiene, hand hygiene, protection of vulnerable adults, information governance, equality and diversity, dignity and respect.
- Training records provided after the inspection showed that the three staff who had been in post for some time had recently completed all of mandatory training updates with the exception of two members of staff who had not yet completed their conflict resolution or Caldicott training. The two new members of staff were partway through their induction and mandatory training programme and still had several elements to complete.
- All staff had received basic life support training.
- All staff were supported through a six-month induction period and were expected to complete the 'Novice to Competent' training programme.
- Clinical skills were supported through a series of away days, which were focused around specific clinical areas. In addition to this training was provided around Sepsis Six initiative.

**Safeguarding**

- There was a 'Vulnerable Adults Protection Policy' and a 'Vulnerable Children Protection Policy' in place, which gave staff direction regarding raising alerts to relevant safeguarding teams and reporting mechanisms within the organisation. We saw that both of these policies had been reviewed March 2017.
- However the Children's policy did not reference the intercollegiate guidance document "Safeguarding Children and Young People" (2014) and there was no stipulations regarding level of staff training for either adults or children. Although, the service did not treat patients under the age of 18 years some patients may have been parents or carers and the policy needed to stipulate that level two children's safeguarding as mandatory for all clinical staff. Despite this, all but the two new staff members had undertaken level two training and the training was planned for those new in post.
- The two new staff had not yet undertaken their level two adult and children's safeguarding training, but all other staff were up to date with this. Staff we spoke with were clear who their safeguarding lead was and which local authorities they would contact The service lead for safeguarding vulnerable adults and children was the head of nursing was trained to level three in adult safeguarding. The new unit manager was to take over this role at local level on completion of required training.
- One member of staff was trained to children's safeguarding level three, which they had undertaken as a special interest. The head of nursing was also trained to level three and told us that advice and support could be obtained from the trust safeguarding lead if necessary.
- There had been no safeguarding concerns raised by or against the unit in 2016/17.
- Local safeguarding team contact numbers were accessible for staff within the unit.

- Staff underwent disclosure and barring checks (DBS) just prior to appointment as part of the pre-employment checking process, but there was no policy or process in place to revisit these. The clinical Head of Nursing told us their contracted Human Resources Team completed these checks.

**Cleanliness, infection control and hygiene**

- Renal Services (UK) Limited had an infection control policy (2017) which outlined the processes for staff to use when patients were positive to blood borne viruses. The policy contained guidance about patient immunisation, methicillin resistant staphylococcus aureus (MRSA) and hepatitis screening, the segregation of patients and machines for positive or post-holiday patients.
- We found the unit was visibly clean and tidy and patients were satisfied with standards of cleanliness. Patients told us the unit and equipment was clean and well looked after.
- There was a single patient side room on the unit, which could be used for isolation purposes if patients had or were suspected of having an infectious condition.
- Patients were screened for MRSA (Methicillin-resistant Staphylococcus aureus) and blood borne viruses (Hepatitis C and HIV) on admission to the unit.
- There were no cases of healthcare acquired infection (MRSA) in the 12 months before our inspection.
- We saw staff using personal protective equipment (PPE), including face visors to protect them against splashes when initiating and completing dialysis. Staff were seen to adhere to the uniform policy, were bare below the elbows and wore clean uniforms.
- We observed staff washing their hands at appropriate points of care and we observed two members of staff discontinuing treatment using good aseptic technique and infection prevention measures when removing lines.
- We saw that staff used an assessment tool, which helped them observe for signs of infection at vascular access sites.
- Staff assessed patients for infection risk on referral to the unit and confirmed their current Hepatitis B status. This was retested following admission to hospital or post-holiday. The unit had an isolation room for the use of infectious patients. Staff told us patients who were classed as high risk for cross infection would have segregated and labelled dialysis machines for their use only.
- The clinic's infection control policy did not include comprehensive screening guidance regarding new or holiday patients. However, holiday booking forms did ask for evidence that patients had been screened and were negative for CPE, as well as MRSA and blood borne virus status.
- The director of quality and regulation undertook audits of cleaning, uniform and hand hygiene audits when they visited the unit. Monthly, hand-hygiene, audit results from February 2017 to June 2017 showed 100% compliance with policy and hand washing at all points of care. Uniform and environmental cleanliness audits from February 2017 to June 2017 showed 100% compliance most months. Managers told us the local trust infection prevention and control team would undertake an annual spot-check audit, however they had not received a visit yet.
- Renal Services UK had guidelines for water testing and disinfecting water plant and dialysis machines (2017). We saw dialysis machines running disinfection programmes, and staff cleaning them thoroughly and appropriately between patients.
- Staff told us dialysis machines were cleaned between each patient and at the end of each day. They followed manufacturer and IPC guidance for routine disinfection. Single use consumables such as blood lines were used and disposed of after each treatment
- Staff carried out daily water tests in line with the UK Renal Association clinical practice guidelines and we saw records that checks were carried out and water quality was within recommended standards.
- Staff told us if they had any queries with test results or if there were any faults with the water plant, they could ring a water plant technician for advice or support with basic fault finding and rectification.
- We saw that spill kits were available for staff to use in the event of a spillage of blood or bodily fluid and that waste was handled and segregated appropriately.
- All staff were up to date with infection prevention and control training.

**Environment and equipment**

- The unit was accessed through a main external door; there was a secured door, which led into the waiting area. There was a second door into the treatment area; all doors were protected with a secure lock code.
- The unit had nine dialysis chairs / stations in the main area and a single isolation room. There was plenty of space around each station to allow for patients, staff, and equipment, in line with DH requirements.
- We saw the unit had two spare dialysis machines, which were ready for use.
- The unit had a consulting room, staff office, toilets for staff and patients, and a kitchen area.
- Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. Dialysis equipment and other medical devices are serviced annually.
- Renal Services (UK) Ltd had a service level agreement in place for technical services incorporating the servicing and maintenance of the water plant and dialysis equipment. This included emergency repairs in and out of hours. We saw evidence that maintenance was carried out as scheduled.
- The service had maintenance agreements in place for other equipment such as weighing scales, pulse oximeters, centrifuge, thermometers, suction units and medicine fridges.
- We saw that staff kept records to confirm they checked domestic, sample and medicine fridges, glucometers and alarms daily. A member of staff was nominated on the daily patient allocation sheet to ensure these checks were carried out.
- We saw that daily, weekly and monthly equipment checks, maintenance and servicing, and logging faults were maintained as part the internal audit process. Daily checks included water testing, medicine fridges, resuscitation equipment, alarms and lighting. Monthly checks included water quality and stock.
- We checked the resuscitation trolley and found the equipment was checked daily and records were kept. We could not see dates of last service on the defibrillator or suction equipment. There were emergency medicines on the trolley, in an unsecured pouch, for hypoglycaemia and cardiac arrest / anaphylaxis but no needles or syringes for administration of adrenaline. There was no flowchart, on the trolley for nurses to follow to administer adrenaline in an emergency. These concerns were brought to the manager's attention and this was rectified by the time of the unannounced inspection.
- Alarms on the machines would sound for a variety of reasons, including, sensitivity to patient's movement, blood flow changes, or leaks in the filters. We saw the alarms were used appropriately and not overridden; when alarms went off, we saw nursing staff check the patients and the lines before cancelling the alarms.
- All staff we spoke with told us that there were adequate supplies of equipment and they received good support from the maintenance technicians. Staff told us breakdowns were repaired promptly.
- There were no spare weighing scales however, staff told us if they could not get them repaired quickly, they would ask the local trust if they could borrow some until repairs were made.
- All patients had access to the nurse call system and we observed that systems were working at the time of inspection.
- We saw that all dialysis machines were new when the unit opened in 2016 and that there was a regular maintenance plan in place.
- Staff felt they had all of the equipment they needed and there were no compromises on patient safety. We reviewed the clean and dirty utility rooms and found them to be well organised, visibly clean with sufficient stock levels.
- Staff tested water quality daily. There was a monthly laboratory test for microorganisms, bacteria and endotoxins. The results showed no incidents of water contamination this year, between January 2017 and May 2017.

**Medicine Management**

- There was an organisational medicines management policy, which included patient identification in relation to medicine administration.
- Although there was medicines audit tool available this audit had not been carried out for several months due to the lack of a local clinical manger. The tool did not include any audit of practice or competence.
- The unit manager was the lead for the safe and secure handling of medicines. The nurse in charge who was

always an experienced nurse would be the key holder for the medicines cabinet on a day-to-day basis. When the unit was closed, the medicine keys were stored securely in a key safe.

- The Freeman Hospital pharmacy department and a number of licensed and registered suppliers provided medicine required for haemodialysis. Pharmacy support was available from the Freeman Hospital pharmacy department; staff confirmed they could access pharmacy support for advice relating to dialysis medicines when necessary.
- There were a small number of medicines routinely used for dialysis, such as anti-coagulation and intravenous fluids. The unit also had a small stock of regular medicines such as EPO (erythropoietin – a subcutaneous injection required by renal patients to help with red blood cell production). The unit did not store any controlled drugs. We found medicines were kept safely in locked cupboards.
- Medicines requiring refrigeration were stored in a fridge that recorded minimum and maximum temperatures, which was locked and the temperatures were checked daily. Staff were aware of the action to take if the temperature recorded was not within the appropriate range. Records we reviewed showed fridge temperatures were checked daily and were within the recommended range.
- We saw that stock checks were undertaken monthly and medicines were rotated to ensure they did not go out of date.
- Patient group directions (PGDs) were not used at this unit. Patient specific directions (PSDs) were available for 0.9% sodium chloride for flushing of fistulas / lines and 0.9% sodium chloride infusion for symptomatic hypotension. A PSD is a written instruction signed by a doctor allowing for medicines to be administered to a named patient after an assessment of their individual condition/ needs.
- Patients receiving dialysis treatment had all dialysis medicines prescribed by their renal consultant prior to transfer to the unit. Staff were clear about the process to follow if they required a prescription change or new prescription. The consultant or registrar would give a verbal instruction to two registered nurses who would transcribe and administer the treatment in line with the verbal instruction. The doctor would then change the prescription on the electronic record at the earliest opportunity. As soon as the electronic record was changed this was visible to staff at the unit.
- Staff told us that if prescription changes were made at the monthly multidisciplinary team meeting / review then the consultant would notify the patient's GP.
- We looked at the prescription and medicine administration records for six patients on the clinic. These records were fully completed and were clear and legible.
- All non-dialysis related medicine was prescribed and dispensed by the GP; patients told us they took these medicines at home or brought them into the unit, if they were likely to need them during treatment. Patients were responsible for keeping and taking their own medicines.
- The Renal Services (UK) Limited's medicine management policy (2017) stated that staff must confirm the patient's name, date of birth and postcode before administering medicines. We observed a registered nurses checking patients' identity against the medicines to be given, when administering medicines. Patients confirmed that nurses checked their identity by asking for date of birth when putting them on dialysis and when giving medicines. We did not see that patients were asked to confirm their postcode.
- We observed and staff told us that two nurses always checked medicines and these were administered immediately, which was in line with best practice guidance.
- Staff told us an adverse incident form would be completed should there be any medicine errors. There were no medicine errors reported in the last 12 months.

**Records**

- The unit used a combination of paper and electronic records. Data was shared between the electronic the NHS hospital database and the unit. This meant the consultant had access to the patient results and variances and the unit had access to records from the consultant's monthly review of the patient and any prescription changes.
- The unit staff used secure passwords to access the trusts electronic record system; the team leaders entered the patients' outcomes and their weights. They printed out the dialysis prescriptions following any

amendments by the trust staff. The unit staff told us that trust medical staff including consultant nephrologists regularly accessed and viewed the system for any updates and recent blood results.

- The paper records included the dialysis prescription, patient, and next of kin contact information, and GP details. There were also nursing assessments, medicine charts, and patient consent forms.
- We saw nurses completing paper and electronic treatment records with recorded pre and post dialysis observations. We saw entries were signed dated and legible.
- We saw that the electronic records contained patient medical history, referral letters, consent, dialysis treatment prescription and treatment plan, notes of multi-disciplinary team meetings and daily nursing notes. From within a patient record, outcomes could be tracked and treatment variances and incidents could be viewed and monitored.
- We looked at six sets of records and found that all patients had regular observations recorded pre, during and post treatment. Records contained a new patient admission assessment and relevant risk assessments however, this did not include a holistic assessment of health and social care needs. Although this was technically an outpatient service, patients would attend the unit three times a week for potentially several years.
- We saw risk assessment documentation for manual handling, pressure ulcer risk, nutrition. However, did not see individual care plans for patients with needs outside of the usual pathways / care plans for anaemia, risk of anaemia and fistula management. We saw two patients were diabetic but there were no corresponding assessment of needs and care plans relating to this issue.
- We saw that monthly records audits were undertaken and results between March 2017 and June 2017 ranged from 95% to 99% compliance. We did not however see evidence of what action was taken to improve areas of non-compliance.

**Assessing and responding to patient risk**

- 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.
- Patients who had additional needs such as those living with severe dementia, or who had challenging behaviour were not treated at the unit.
- Patients weighed themselves before treatment began. This was to establish how much excessive fluid had built up in between treatments. An agreement of how much fluid would be removed during the session was reached with the patient, taking in to account the patients well-being and their starting weight.
- Observations of vital signs such as blood pressure and pulse were recorded before, during and after dialysis treatment.
- Staff told us they contacted the on-call registrar, easily through the hospital switchboard.
- There were pathways and protocols in place for adverse reactions such as hypoglycaemia, and anaphylaxis. Other adverse reactions, assessment and management were covered as part of the novice to expert training programme given to all registered staff when they started work at the unit.
- Whilst the staff did not use the national early warning scoring system for monitoring the patient's observations, staff we spoke with said that if they had any concerns about a patient's condition, they would immediately contact the on call renal team at the local NHS trust. Nursing staff we spoke with were experienced and able to articulate the clinical condition of a deteriorating patient. Staff could describe how they would escalate concerns and access paramedic services for deteriorating patients.
- There was no formal tool used for the recognition and treatment of sepsis, however staff closely monitored patients and told us they escalated when patients' observations indicated any raised risks. Staff we spoke with could describe clearly their actions for the escalation of these patients. One patient told us how the staff on the unit had responded with speed and expertise to their medical emergency and of their transfer to an acute hospital.
- The senior nurse leaders told us the organisation was rolling out training in sepsis and a recognition tool was being designed to comply with National Institute for Health and Care Excellence (NICE) NG51. Three of five staff had received training regarding sepsis and the others were expected to complete this as soon as possible.
- The unit did not have an personal evacuation plans for all patients however we saw that all patients assessed as having mobility problems had personal emergency evacuation plans in place.

- In case of a medical emergency all of the staff on the unit were trained to provide basic life support and administer adrenaline if required. The process was to call 999 and request an emergency ambulance for patients to be transferred to the nearest acute A & E department.
- There had been two 999 calls and emergency transfers to A&E since the unit opened in May 2016.
- Staff told us if patients did not attend (DNA) their treatment unexpectedly then they would call their home and the local hospital if necessary to check on their whereabouts and well-being. Staff told us they would escalate this to the police for a welfare check if they could not locate the patient.
- We observed staff monitoring alarms on equipment in the unit. Staff we spoke with was knowledgeable about equipment and setting alarm parameters.
- Staff explained risks to patients if patients opted not to complete their prescribed dialysis and asked them to sign a form to say this had been discussed and they understood the risks.

**Staffing**

- Renal services (UK) Ltd - Newcastle was a nurse led service with patients remaining under the clinical management of the consultant nephrologists at the commissioning trust.
- The unit employed five (five whole time equivalent (wte)) registered nurses (RN). The unit had one 0.5 wte RN vacancy and one wte healthcare assistant vacancy at the time of inspection. Three RNs had joined the service relatively recently as the service had increased its provision from three days a week to six days a week.
- The staffing ratio was determined by the contract in place with the referring trust, patient and dependency, ratios and skill-mix identified by the British Renal Workforce Strategy group. The recommended staff: patient ratio is 1:4 with 70% registered and 30% non-registered staff.
- The unit's ratio was 1:4, of all registered nurses at the time of the inspection, in line with guidance.
- The unit manager told us that a deputy manager had recently been appointed and was due to commence in the very near future.
- When staff shortages were identified, staff were flexible and covered extra shifts. If permanent staff could not maintain staffing levels, requests were made to the Renal Services bank, who arranged for cover.
- Over the three months prior to the inspection, the unit had used bank nurses on eight occasions. Staff told us that the bank staff used were regular workers, familiar with the unit.
- We checked three months of rotas, which demonstrated planned staffing levels were maintained.
- The local trust's consultant nephrologists supplied the medical support for the unit. They provided remote review of patients' bloods, direct contact for advice, onsite unit visits and direct referrals. The renal on call team were available for patient escalations and advice in and out of core working hours.
- The unit staff told us they were able to access the referring consultant nephrologist via telephone, bleep and email. In the event the consultant was not available, the staff would discuss patient concerns with the on-call renal consultant. Staff told us that the consultant had visited twice during the last six months and patients commented that they did not see the consultant often now they had moved to the satellite unit.
- Patients had access to dietitian and social work services through the trust. Staff told us that patients might need to wait to see a dietician. However, we were told and saw that the social worker visited the unit regularly.

**Major incident awareness and training**

- There was a contingency planning policy and a risk register for facilities, water treatment, power and staffing. Managers told us of an incident where a blocked external drain had interrupted service provision. The situation had been well managed and patients had received their dialysis later in the day, there had been no loss of treatment time or harm to patients.
- Managers told us that due to the essential requirement for the supply of water and electricity in order to treat patients, the unit was on the critical/priority list of the local water authority and electricity board.
- There was a minimum of 20% machines not in use in the unit. The water plant alerted staff if there was a break in water supply, there was a 'break' tank, which contained 20 minutes further water to discontinue patients' dialysis safely. If there was an electricity failure, the dialysis machines had reserve batteries, which allowed time for the staff to discontinue patients' dialysis safely.
- The unit as part of the building neighbourhood had regular building fire alarm tests. There were in date fire extinguishers at fire alarm points close to the exit doors.

- In the event of a total shut down, the unit could transfer patients to their sister unit at Alnwick.
- Not all patients had a documented personal emergency evacuation plan.

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

### Evidence-based care and treatment

- NHS consultant nephrologists led the patients care, and in accordance with the latest national guidance. Renal Services (UK) Limited - Newcastle monitored and aimed for compliance with the Renal Association Standards.
- The unit offered patients Haemodiafiltration, which is dialysis that promotes the efficient removal of large as well as small molecular weight solutes from blood. Clinical evidence indicates that Haemodiafiltration achieves better outcomes for patients.
- Treatment protocols and policies were based on national guidance including the Renal Association Guidance and NICE standards. The service offered all patients dialysis three times a week, which was in line with the Renal Association Guidelines.
- Patients came to the unit with fistulas for vascular access already created at the local NHS trust. The unit staff assessed patients' vascular access in line with National Institute for Health and Care Excellence (NICE) Quality Standard 72 statement 8. Staff took consented photographs to help assess any changes or access problems, such as poor blood flow and infections.
- The nurses monitored patients' blood results and submitted monthly samples for analysis. Blood results were monitored for urea removal, as recommended in the Renal Association Standards, to measure how effective the dialysis treatment had been in removing waste products. The unit also measured dialysis adequacy and urea reduction.
- Dry needling was not carried out at this unit, which was in line with the organisation's policy and best practice guidance.
- We saw a diabetic resource file was in place at the nurses' station. This provided staff with guidance and advice in relation to the care and treatment of the diabetic patient.

### Pain relief

- The head of nursing had developed a new pain assessment-scoring tool; this was still being embedded in practice.
- There was no provision for pain relief medicines in the unit, patients were asked to bring their own medicines for self-administration when having dialysis.
- Staff told us if patients suffered from a headache or pain from a chronic condition, they would encourage them to self-medicate using their own analgesia.

### Nutrition and hydration

- Patients who have renal failure require a strict diet and fluid restriction to maintain a healthy lifestyle. The unit were able to refer patients to a dietician when required and some of the nursing staff had additional knowledge and expertise in dietary needs and gave advice to patients depending on blood results.
- Dietetic services were provided by the commissioning trust and the renal dietician did not visit the unit, patients had to attend the outpatient department at the hospital to see a dietician. Staff told there were waiting lists for patients to see a dietician and one patient told us they did not get to see a dietician regularly. Several magazines and leaflets were available, which provided nutritional advice for patients
- Patients were offered hot and cold drinks and toast and or biscuits, while they were having their treatment. Patients told us they were able to bring their own food into the unit.

### Patient outcomes

- The unit monitored clinical outcomes for patients in line with and against the Renal Association Standards and referring Trust requirements.
- The dialysis patients were part of the NHS trust's activity and their outcome data was entered into the Renal Registry by the trust rather than by the individual unit. Therefore, specific unit details from the Renal Registry were not available to the unit or patients.
- The unit reported patients 'clinical variances' to treatment outcomes every day to the senior team. The main clinical patient outcomes monitored were patients' monthly blood results, dialysis adequacy, vital signs, target weights and nutritional status. Data was collated for all Renal Services (UK) Limited units on a monthly report.
- The head of nursing told us they reviewed patient results daily and monthly reports were sent to the

consultant nephrologists for monthly multi-disciplinary review. This was a remote service and patients did not receive regular face to face contact from the consultants. Patients were allocated to a team of nurses with a team leader who oversaw the review of blood results and dialysis prescriptions.

- The head of nursing produced customised reports and trend analysis to monitor and audit patient outcomes and treatment parameters. The multidisciplinary team used this to improve outcomes and in turn quality of life. The report provided specific unit scores in areas such as infusion / volume, albumin, weekly treatment, vascular access, and haemoglobin.
- The head of nursing told us that the reports and themes were also shared with all unit managers during their monthly teleconference / managers meeting.
- Renal Association guidelines to monitor the quality of dialysis include measurement of the urea reduction rate (URR). From January 2017 to May 2017 the proportion of patients meeting the standard of URR of >65% was between 90% and 94%.
- Other comparative data was that 62% to 78% of patients had haemoglobin within the recommended range, 65% to 88% had calcium in the recommended range and 69% to 81% had phosphate levels in the recommended range.
- Data from June 2017 showed that 82 % of the Newcastle dialysis unit patients had an arteriovenous fistula (AVF). The Renal Association standard for the proportion of patients with an AVF or AVG is 80%. An AVF is the formation of a large blood vessel usually in the arm, created by surgically joining an artery to a vein, this form of vascular access is considered the best form of access for haemodialysis. An AVG is a connection of the artery to a vein using a looped plastic tube.
- The unit did not provide Kt/v data.
- We found that 60% of patients were on high flux Haemodiafiltration. High flux Haemodiafiltration (HDF) may provide beneficial outcomes to patients in the long term.
- The provider monitored patient transport collection times following treatment, from January 2017 June 2017 over 90% of patients were collected from the unit within 30 minutes of their treatment finishing. The staff told us they would contact the transport service if patients had been waiting a long time for their pick-up.
- There was no formal transport group but the unit manager told us they had previously had a good response from the liaison officer when issues had arisen. One of the patients told us that that the unit manager had resolved their transport problems, as soon as they had taken up post. Staff told us that they would contact the local patient-transport liaison officer if there were any transport delays.
- The unit manager told us that patient transport issues could be discussed as part of the quarterly contract review meetings with the trust if there were persistent issues, as the trust also commissioned the patient transport service.
- Patients told us that they felt the unit was not always well staffed especially at handover times and that this meant delays occurred starting dialysis for afternoon patients. They said that the wait could sometimes be around one hour. Although they did acknowledge that, there were three nurses on duty.

**Competent staff**

- New staff were provided with an induction programme and a six-month preceptorship period with an identified mentor, to ensure staff became confident and competent in carrying out their role. The induction was a four-week supernumerary period to allow new staff to observe and learn about their role and to be assessed as competent prior to undertaking unsupervised duties.
- There was a comprehensive training programme for registered nurses new to dialysis 'the novice to competent dialysis nurse practitioner framework'. This was a 26-week programme, which involved structured training days and comprised of theoretical and practical competency assessments. Staff were reviewed at three-months and were expected to achieve full competence by the end of six months.
- Records we reviewed showed that staff underwent annual competency reassessments for 'aseptic no touch technique' and intravenous medicine administration.
- Staff we spoke with told us that Renal Services UK Ltd provided them with on-going professional development opportunities for improving and maintaining their competence.
- The Clinical Nurse Lead told us that registered nurses were supported to undertake the Advance Renal Course. We saw that arrangements were in place with several universities to support this. Two members of staff had received this training and a further two staff were currently undergoing this training.

- Renal services (UK) Ltd provided an induction and assessed competency package for bank and agency staff during their first shift. Managers told us this included haemodialysis and vascular access, medicine calculation and intravenous competencies and was signed off by the shift or unit manager.
- Managers told us staff training was supported by annual performance reviews (appraisals) and 1-1 meetings to review targets and professional development. Staff had personal development plans and targets, which were set around the performance review, taking into account career progression and patient/service needs.
- Data submitted by the provider indicated that all staff had received an annual appraisal or interim progress reviews depending on their length of service. Staff we spoke with felt appraisals were worthwhile.
- We looked at four training files, which showed all staff received initial training and showed that assessment of staff competence was assessed against clear practical and knowledge based assessments. There was evidence of up to date training attendance and sign off by senior nursing staff and mentors was evident.
- All RNs had their NMC registration status checked in the last 12 months and all had current registration. Managers told us the contracted human resource service made monthly checks of when nursing revalidation was due and they reminded managers and staff when they were nearing renewal dates.
- Patients overall felt that staff were experienced and competent, making them feel reassured.
- No staff had undertaken intermediate or advanced life support training.

**Multidisciplinary working**

- The satellite unit was nurse led; nurses provided prescribed treatments for patients who remained under the clinical management of their consultant nephrologist.
- We observed effective teamwork on the unit and observed the specialist outpatient nurse from the trust and a renal social worker visited the unit regularly.
- Staff told us there were remote monthly multidisciplinary team meetings, held at the trust, to review the patient outcome reports and where changes to treatment, medicines and diet were discussed and agreed. Staff from the unit did not attend these meetings. Patients did not attend these meetings and did not have direct medical contact each month. However, blood results and communications following the meetings were available through the shared IT system.
- Staff we spoke with said they could easily speak to the medical team at the NHS trust both for routine and urgent issues.
- GPs were sent a monthly review letter following these meetings and named nurses shared any information directly with patients at their next treatment.
- Managers told us the patients were seen by their consultant nephrologist at least every three months at an outpatient appointment and a consultant would visit the unit once a month. Staff and patients were not sure that the consultant had visited the unit every month during the previous three months.
- Dietetic, pharmacy and other supporting services were provided by the commissioning trust as part of the contract agreement. The unit manager told us that there were staffing shortages within the NHS dietetic department and patients had to be referred to the department for an outpatient clinic appointment if they needed one. Dieticians did not visit the unit.
- Patients commented that they did not see doctors or dieticians regularly although staff would arrange this for them if there were a need.

**Access to information**

- All staff had access to an information management system, which held all current policies and procedures. This meant staff could easily access the most recent version of these documents. We reviewed six policies and saw that they had all been reviewed within the last six months.
- Staff told us they had the information they needed to look after patients.
- Results of blood tests carried out at the local NHS trust were sent to the unit electronically and were accessible to staff on the unit.
- Staff told us the patient treatment database sent information to the NHS trust, which was accessed by the consultant who then notified the GP of any relevant changes.
- We saw the unit had a process in place to share information for patients going to other units for holidays or for acute care and vice versa.

### Consent, Mental Capacity Act and Deprivation of Liberty

- Each patient had a 'consent to treatment' signed document in their paper records, this covered consent to dialysis treatment, the sharing of their information such as blood results and the use of photographs in fistula management. The patient signed this at their initial visit prior to commencing treatment.
- Not all staff had completed training regarding mental capacity and deprivation of liberty safeguards; however, this was rectified soon after the inspection.
- However, staff we spoke with were aware of the Mental Capacity Act 2005 and what this meant in terms of decision-making; they understood the rights of a patient to decline treatment. If a patient wished to miss or shorten a session, staff ensured that, they were fully aware of the risks and then recorded this as a clinical variance.
- Staff we spoke with told us that patients with declining capacity or understanding such as those living with dementia would not normally be considered suitable for dialysis in this unit.

## Are dialysis services caring?

### Compassionate care

- The Renal Services (UK) Limited described their approach as delivering 'inspired patient care'. They collected patient feedback using several different methods, a local suggestion box, directly to the trust and in the patient satisfaction survey annually in December. The last survey in December 2016 indicated 93% patient satisfaction for the environment, 91% satisfaction for staff treating them with respect and dignity and 86% for helpful staff.
- We spoke to eight patients who had been using the service for several months up to one year. All patients were complimentary about the care and compassion shown to them by all staff at the service.
- Patients said staff were 'excellent', 'very attentive', responded quickly to concerns, made them feel confident and cared for. They said there was a good atmosphere on the unit and staff were good at calming people down when they were upset or anxious.
- We observed that staff were near to the patients at all times and interaction was warm, positive, caring and almost continuous.
- We observed good interaction between patients and staff at all levels including senior managers who were clearly well known to the patients.
- We saw that patient screens were available to provide patient privacy and dignity when needed.
- Patients concerns were relating to access to consultants and dieticians and transport issues. They told us they had no complaints about nursing staff. There did not appear to be a plan for managers to escalate this with the medical team to address these concerns.
- The majority of patients we spoke with were very happy to have to have their care provided at the unit. One patient was waiting to have their care transferred back to the main hospital unit.
- A patient told us staff had recognised when they were unwell and arranged transfers to hospital for them. The patient had required admission.
- Staff we spoke with felt they had time to deliver a good standard of care.

### Understanding and involvement of patients and those close to them

- We saw staff speaking with patients about their treatment and blood results in a way they could understand. Patients were encouraged to ask questions and we observed staff checked their understanding.
- When patients first started treatment, they could come to visit the unit with a family member or friend for a look around. There were information packs available so patients knew what to expect from the service and what the anticipated benefits and risks of treatment were.
- One patient told us they used to get a print out of their monthly blood results with an explanation, following the MDT review, but said this no longer happened. When we asked staff about this, they said they did not routinely give patients their results every month but did routinely discuss results and any changes to treatment with patients.
- Patients who wished to participate in their own care were supported to do so. Patients could be involved in shared care activities as much or as little as they wanted or felt confident about.
- There was a range of information and magazines available regarding dialysis, such as healthy eating, supported holidays and self-care information.

**Emotional support**

- Patients could be referred to counsellors or psychology support if needed. Nurses identified the need and accessed support for the patient through the trust's consultants or referred directly to social workers and mental health services.
- Staff gave examples of how they had provided emotional support and how they had worked with other agencies and made referrals when patients needed specialist support. We saw that staff had made appropriate referrals to other services and that the renal social worker visited the unit to support patients.
- The manager told us that one of their priorities was to implement a named nurse system to help build relationships with individual patients and named staff and enable to staff to provide better support for people's individual needs.

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

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

- Renal Services (UK) Limited- Newcastle is delivered from a purpose built facility situated in Orion business park North Shields; internally there were clearly defined patient and staff only areas. The unit was compliant with the NHS Estates guidance (Health Building Note 07-01).
- The building location had adequate designated parking spaces for those patients who chose to drive themselves to the unit and was accessible for wheelchair users.
- The service was commissioned by Newcastle Upon Tyne Hospital NHS Foundation Trust in response to the need for further capacity to deliver renal dialysis. The number of patients had recently increased in size, in response to the trust's growing demand for more capacity. The Chief Operating Officer told us that an additional dialysis session was created at short notice to accommodate the needs of the local NHS referring trust.
- The service had provided open days to GPs, care home staff and patients to raise awareness of what the unit could offer to patients as well as to raise awareness generally about chronic kidney disease and dialysis.
- There was no transport user group for the patients attending the service; the local NHS trust commissioned patient transport. The staff could provide feedback regarding any transport issues through the contract meetings but were unaware of how the trust followed up any issues raised. Staff told us they approached the transport liaison officer at the transport service to address any serious issues.
- A number of patients were dissatisfied with the transport service (which was a third party provider) and we were given an example of a patient being brought to the unit 30 minutes before opening time. Fortunately, a member of staff was at the unit to bring the patient into the unit. A member of staff told us that the unit took immediate action to ensure the transport provider was aware of this incident.
- Another patient told us that due to misunderstanding and confusion around free transport, they had been paying for their own transport for a period of time and this had caused financial hardship. The unit manager had since been able to access funded transport and the service was helping the patient claim back the money spent

**Access and flow**

- Patients could access care and treatment in a timely way. There was a clear referral pathway for new patients. There were no patients on the waiting list and the utilisation of the unit capacity for the months of January to March 2017 was 22-28%.
- Referrals for admission came from the consultant nephrology team at the commissioning trust. Admissions were arranged directly between the referring team and the clinic manager or deputy. Patients needed to meet acceptance criteria to have dialysis at the satellite unit.
- From April 2016 to March 2017 there were 17 patients treated at the unit all of these were NHS-funded. Ten patients were aged 18 to 65 years and seven were over 65 years. There were 1276 dialysis treatments carried out in this period.
- There had been no patients cancelled or delayed for their dialysis sessions for a non-clinical reason over this period.
- All patients were offered three sessions per week, each for a minimum of four hours. Patients were able to dialyse at times to suit their personal commitments and

lifestyle. Patients told us that there was also flexibility to change the occasional session for a special event or appointment. However, the unit was not open for evening sessions at the time of our inspection.
- Any patients who did not attend for dialysis were reported as incidents and followed up by staff.
- The unit monitored treatment start times and data from January 2017 to June 2017 showed that more than 90% of patients started their treatment within 30 minutes of arrival.

**Meeting people's individual needs**

- Patients were able to visit the toilet before dialysis commenced, as it was located in the waiting area.
- Although there are no dedicated beds allocated solely for holiday dialysis, the unit could offer holiday dialysis around the availability of extra capacity.
- The Renal Services (UK) Limited employed a dedicated holiday dialysis coordinator who provided help in arranging holiday dialysis. They liaised with patients, trusts consultants and units to book sessions for patients wanting to take a holiday. Although there was no set holiday availability, the unit was usually able to accommodate holiday patients.
- There were acceptance criteria for holiday patients, to prevent cross infection and to ensure that the patients' needs could be safely cared for in a standalone unit.
- Patients had access to an individual TV set, personal lighting and there were DVD players on request. Wi-Fi was available for those patients wanting to access the internet or their treatment information within 'Patient View' on laptops or tablets.
- Patients who wished to participate in their own care were supported to do so. On their initial visit, they would be asked about the level of involvement they wanted. We saw five patients were part of the shared care directive at the time of inspection. Staff told us patients received training and were assessed as being competent before taking over aspects of care.
- The unit aimed to help patients achieve and maintain a realistic and recognisable state of physical, psychological and social well-being.
- Staff told us they had all the equipment necessary to meet patient's needs.
- We asked for evidence how the centre met the 'Accessible Information Standard'. From 1st August 2016 onwards, all organisations that provide NHS care were legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment, or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services. Senior managers confirmed that they were not meeting this legal standard during our inspection.
- The company had a register of translation services that could be used and knew they could contact a number of organisations such as the Tyneside Kidney Association, the British Kidney Patient Association (BPKA) and the National Kidney Foundation (NKF) for written information in other languages and formats. Managers told us they could also approach the NKF for patient advocacy if needed. Immediately following the inspection the provider developed a policy to ensure its services are meeting the Accessible Information Standard.
- Staff we spoke with told us that patients were allocated dialysis appointment times to fit in with social care and work commitments and that they would change these if a patient's needs required it. One patient told us how staff responded to their requests and swapped their treatment times to meet their needs.
- Patients were offered visits to the clinic as part of the pre-assessment process prior to commencing dialysis.
- The clinic was accessible for people with limited mobility and people who used a wheelchair. Disabled toilets were available.
- Every dialysis chair had access to a nurse call bell. Patients said that staff did not take long to answer call bells or equipment alarms

**Learning from complaints and concerns**

- There were no formal complaints in the last 12 months and one verbal complaint. Patients told us of occasions when staff had solved problems for them when they had raised concerns.
- Staff were able to provide us with examples when patients had raised concerns with them and they had been able to take action to make improvements.
- The organisational complaints procedure was included in the patient's guide, which was given to patients on their first visit. The complaints procedure was a four staged escalation approach with clear timescales and named individuals for responses. If the service could not resolve a patient's complaint, the process signposted patients to the PHSO.

- Renal Services (UK) Limited reviewed all units' complaints and responses at the organisation's monthly clinical governance meetings; the minutes were circulated to all units' staff for learning.

## Are dialysis services well-led?

### Leadership and culture of service

- At the time of the inspection, the unit manager was new in post. The registered manager, a unit manager from the Alnwick unit, the head of nursing and the quality & regulatory manager and the chief operating officer, provided support and had been covering the unit prior to their appointment. The unit manager was to be supported by a deputy unit manager who was being recruited to the team at the time of the inspection and a regional manager who was on maternity leave at the time of the inspection. The unit manager told us they were receiving good support and induction to their new role.
- The newly appointed unit manager was a very experienced renal nurse with a specialist qualification and would take over the day to day running of the unit when their induction was completed. The unit manager told us that human resource training was being included as part of their induction and coaching.
- The organisational structure was described by the senior team as flat and 'nurse led'. The unit manager reported into the regional clinical manager and then into the head of nursing. The head of nursing and the head of contracts (quality and regulatory) reported to the chief operating officer. At the top of the organisation, there was a partnership of medical director, chief executive officer and the board of directors. The chief operating officer told us that they report directly to the board on a monthly basis.
- We found that staff morale was good and there was high regard for the unit manager. Staff told us they were well supported by the unit manager and the senior team.
- Patients told us that staff worked well as a team.
- We observed interactions between senior managers, staff and patients and it was apparent that managers were well known to staff and patients and visited the unit regularly. We saw good rapport between staff, patients and managers and staff told us that managers were supportive and approachable.
- The new manager told us they felt welcomed by the team and that they had established good working relationships quickly. Staff told us the managers were supportive regarding incidents and they felt there was a no blame culture.
- The average rate of sickness was very low over the three months before the inspection was 2.5%.
- We saw that managers and team meetings were held regularly and information such as service changes, incidents, complaints, clinical variances and policy updates were communicated and discussed. We saw that information and learning was shared across the organisation between units.
- The head of nursing told us that there were bespoke training days for managers. The most recent had been in relation to financial governance, corporate governance and incident and risk management.
- We found the clinic manager and the senior team had a desire to learn and to address any issues as soon as practically possible.

### Vision and strategy for this core service

- Staff were familiar with and understood the organisational mission and values for the service, which was to provide 'Inspired Patient Care' through safety, service excellence, responsibility, quality, communication, innovation and people.
- The unit displayed the organisational aim and values in the patients waiting area in and within the patient guide.
- Renal Services (UK) Limited had developed a service development strategy, which aimed for growth linked to a response in demand.
- The unit manager was clear about their top three priorities, which were to implement the named nurse process, to upskill junior staff and to help grow the business.

### Governance, risk management and quality measurement (medical care level only)

- Renal Services (UK) Limited described their governance framework as having two streams, clinical governance and corporate governance. There was a named organisational lead for both streams. The clinical governance lead was responsible for compliance with Renal Association Guidelines, clinical risks, incidents, patient satisfaction, clinical audits, infection control, information governance, and policies and procedures.

The corporate governance lead was responsible for quality management for example covering health and safety, non-clinical risks, business continuity, environmental, human resource and financial management.

- Renal Services (UK) Limited clinical governance strategy was dated 2017, and outlined their aims as
  - Demonstrating outcomes of patient care
  - Continually monitor and improve practice and services against National and European standards
  - Ensuring staff are skilled and trained
  - A commitment to sharing information and having supervision from NHS trusts
  - Auditing clinical outcomes for patients'
- The strategy did not include details of the governance framework and the lines of accountability and oversight.
- The organisation held a quarterly clinical governance meeting; chaired by the chief operating officer and attended by the medical director, head of nursing and regional clinical manager. Although the minutes showed that they discussed local incidents and unit clinical variances, complaints, audits and operational issues, any actions agreed did not appear to be monitored for local unit completion.
- The head of nursing held monthly teleconferences with the unit managers where incidents and variances were shared for learning and the managers received updates on operational issues such as recruitment, appraisals, and rosters.
- One of the new manager's priorities was to introduce regular team meetings for Newcastle staff to ensure cascade of information and learning to all staff.
- Staff from the unit were not attending the monthly multi-disciplinary review meetings at the trust, or receiving minutes, but did receive information from these meetings through patient notes.
- Clinical patient outcome results were available for the unit; the head of nursing was able to benchmark the Newcastle clinic's results / performance against other clinics.
- Monitoring meetings took place with the trust to review performance against the service contract. Other arrangements were in place with to monitor maintenance of equipment, provision of medicines and other stores and waste management.
- However, we found some areas for concern relating to governance.
  - Although Renal Services (UK) Limited had an organisation wide risk register and a local Renal Services (UK) Limited Newcastle risk register. Not all risks identified during the inspection such as lack of capacity for dieticians and consultants to visit the patients at the unit on a regular basis, patient reported transport issues and lack of user group, the need to upskill junior staff and the lack of a staff survey were logged.
  - There had been no audit of medicine administration practice for several months prior to our inspection and we did not see evidence of what action was taken to improve areas of non-compliance following records audits.
  - There was no process in place to ensure patients had individualised care plans and the unit did not have personal evacuation plans for all patients.
- The unit was not fully meeting the Workforce Race Equality Standard (WRES) (2015) at the time of our inspection. This is a requirement for locations (providing care to NHS patients with an income of more than £200,000) to publish data to show they monitor, assure staff equality, and have an action plan to address any data gaps in the future. The organisation did have an equal opportunities policy and this was covered in staff contracts and handbooks. Since becoming aware of this requirement, the director of quality and regulation had asked the contracted human resource company to look at how they could meet this standard.

**Public and staff engagement**

- We saw that patients and staff were actively engaged in decision making about the treatment plan before starting dialysis, recording any decisions on the dialysis prescription.
- The unit encouraged patients to participate in the local patient group, which was part of the NKF. Patients were also supported to attend the NKF conference.
- There was an annual patient satisfaction survey undertaken, the last survey in December 2016 indicated 93% patient satisfaction for the environment, 91% satisfaction for staff treating them with respect and dignity and 86% for helpful staff. There was one positive patient comment and one comment from a patient who would like evening dialysis (not currently offered at the unit). There were no identified actions from the survey.
- There were no actions identified following the last patient survey in December 2016.

- The unit had a confidential suggestions box in which patients could post feedback/complaints/comments. Staff told us they felt patients were able to provide feedback/raise concerns verbally with them and staff would aim to resolve any issues.
- The new manager told us they had spoken to all of the patients to get to know them and their likes and dislikes, to promote an honest dialogue. They had also spoken to all staff in their first week and introduced a communication huddle each morning to cascade information and briefings from the managers meetings and other information relevant to patient care and staff issues.
- The senior team told us that when new equipment was to be purchased they ensured trials with patients were undertaken before final decisions were made. Patients had been involved in choosing artwork commissioned at several of the units and were trialling pressure relieving cushions and exercise bikes at other clinics.
- There had not been a recent staff survey and the Renal Service (UK) Limited described this being a priority for later this year. There were details within the staff handbook relating to staff whistleblowing and raising concerns.
- We reviewed the files of four staff and saw that support processes were in place to aid effective working in accordance with staff individual needs and requirements.
- The senior team told us they held annual awards for all Renal Services staff in conjunction with one of the NHS Trusts.

**Innovation, improvement and sustainability**

- The provider took a proactive approach to the recruitment of the current unit manager's position by advertising using a large banner displayed in a public place, which could be viewed by a large audience.
- We observed the Clinical Nursing Lead using a new device designed to provide Image-Guided Peripheral Intravenous Access. Renal Services UK had purchased three of these devices and staff told us the device was extremely helpful when intravenous access was difficult. The device enabled image guided access which staff reported made the process easier, much more comfortable for patients and would lengthen the life of the access port as there would be less friction/ trauma than when introducing needles blind.
- We spoke with the patient receiving support from this device who told us that their intravenous access had been 'difficult' and felt 'relieved' with the results and the reduced number of attempts having to be made to achieve vascular access..
- The chief operating officer told us that dialysis sessions were now offered six days a week from the three offered originally. There was some discussion about the possibility of commencement of twilight sessions depending on patient demand and increasing numbers of patient referrals.
- The management team had a good understanding of opportunities threats and challenges facing the service and where improvements could be made. For example, the organisation needed to undertake a staff survey, patient acuity was increasing and this may affect staffing numbers and skill mix, recruitment and retention of staff was challenging, changes in national guidelines and trust policies, provision of holiday dialysis, home dialysis and procurement.
- Staff and managers were focussed on continuous learning and improvement and wanted to provide the highest quality service possible for their patients.

# Outstanding practice and areas for improvement

## Outstanding practice

- There was a comprehensive training programme for registered nurses new to dialysis 'the novice to competent dialysis nurse practitioner framework'. This was a 26-week programme, which involved structured training days and comprised of theoretical and practical competency assessments. Staff had a review at three-months and were expected to achieve full competence by the end of six months.
- We saw that the service invested in devices to improve care and patient experience. For example, the service had purchased three devices, designed to provide Image-Guided Peripheral Intravenous Access.

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure patients have direct access to regular and timely dietetic support and regular contact with a renal consultant.
- The provider must ensure all patients have individualised care plans to cover their needs outside of usual pathways and which include personal emergency evacuation plans.

### Action the provider SHOULD take to improve

- The provider should ensure all clinical staff complete SEPSIS training as soon as possible as part of mandatory training requirements and continue to roll out implementation of a SEPSIS toolkit.
- The provider should review its local risk register to ensure risks identified by this inspection and any other risks identified by staff are included, so appropriate actions can be taken and mitigation can be put in place where necessary.
- The provider should review its local audit programme with a view to implementing regular audit of medicines management, including administration practice, and ensure action is taken to improve areas of non-compliance following all audits (including records audit).
- The provider should carry out a survey of staff views to identify areas for improving staff engagement.
- The provider should consider revising the infection control policy to include guidance regarding the screening of new and holiday patients, prior to admission.
- The provider should discuss with the commissioning trust and patient transport provider how patients could take part in a transport user group or other method of eliciting their views and experience.
- The provider should consider how it can best meet the Accessible Information Standard (2016) and the Workforce Race Equality Standards (2015).

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. Regulation 12 (1) (2 a, i)<br><br>· Not all patients had up to date, holistic, individualised care plans to cover their health and social needs. Not all patients had personal evacuation plans in case of emergency.<br><br>· Patients did not have direct access to regular and timely dietetic support or regular contact with a renal consultant. |