# Renal Services (UK) Limited- Milford-on-Sea

## Quality Report

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

## Overall summary

Renal Services (UK) Limited - Milford-on-Sea is operated by Renal Services (UK) Limited. It is based within the premises of Milford-on-Sea War Memorial Hospital, commissioned by Portsmouth Hospitals NHS Trust. The unit provides dialysis services only. The service has seven dialysis chairs. Facilities include a reception/waiting area with chair weighing scales, the treatment area with six dialysis chairs and one side room with one dialysis chair. Leading from the treatment room is the mixed-sex patient toilet suitable for disabled access, the clean utility room and the dirty utility room. The water treatment plant is located close to the unit, within the hospital premises and the unit has a stores lockup in the car park.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 14 June 2017, along with an unannounced visit to the unit on 26 June 2017.

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

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

**Services we do not rate**

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

We found the following areas of good practice:

- All patients said staff were kind, considerate and professional. They helped reassure patients who were anxious and encouraged patients to be as independent as they wished to be with their dialysis treatment.
- This was a nurse-led unit and all staff followed procedures recommended by the Renal Association and checked the efficiency of each patient's dialysis treatment. They also checked the quality of the water to minimise the risk of infections.

# Summary of findings

- They collaborated and communicated effectively with the renal team at the host NHS trust to support patients with their treatment programme. There was a focus on local governance, with audits and meetings to maintain standards and quality.
- Staff completed their mandatory and competency training and followed best practice with infection control procedures. They worked well as a team and knew how to report incidents including those relating to safeguarding vulnerable people.
- Staff reported a strong culture of patient-focused care, and clear leadership.
- The unit provided a valuable satellite dialysis centre, which improved access to treatment for patients living locally. There was adequate parking and regular patient transport services. Staff monitored delays with patient transport and the arrangements generally worked well. The provider had admission criteria which only patients who were stable on dialysis could be referred for treatment.
- Having a coastal setting, the unit was used for holiday dialysis and there were safe systems to help patients book for treatment from outside the area.
- Systems were in place to service and replace equipment, including the dialysis machines, chairs and water treatment plant.

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

- The risk register for the organisation did not capture the risks specific to the unit, for example the condition of the water treatment plant room, which was small and in need of refurbishment, so it could be easily maintained and kept clean. Also, the risks associated with security of the unit, following an incident and the potential impact of the staffing numbers on safety.
- The policy and procedures for incident management were not clear, detailed and comprehensive, to provide consistent guidance for staff.
- An external service of the dialysis chairs had reported the batteries on two of the chairs had failed, and action had not been taken to replace these.
- Although there was a unit level emergency plan, there were no personal emergency evacuation plans, to guide staff in how best to support individual patients.
- Policies and practices had been reviewed and revised but the medicines management and infection control policies omitted important guidance for staff.
- The corporate audit programme was not targeted to identify and address areas for improvement.
- There had been no staff survey in the past year.
- Staff did not consistently follow the medicines management policy for identifying patients before administering medicines.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements to help the service improve. We also issued the provider with one requirement notice that affected Renal Services (UK) Milford-on-Sea unit. Details are at the end of the report.

Professor Edward Baker

Deputy Chief Inspector of Hospitals

# Summary of findings

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**Services we looked at**
Dialysis Services

# Summary of this inspection

## Background to Renal Services (UK) Limited- Milford-on-Sea

Renal Services (UK) Limited - Milford-on-Sea is operated by Renal Services (UK) Limited. The service opened in 2008. It is a private single speciality service in Milford-on-Sea in Hampshire. It primarily serves the communities of the New Forest and south west Hampshire. It also accepts patient referrals from outside this area, such as for holiday dialysis.

The service is registered to provide the regulated activity: Treatment of disease, disorder or injury and the service's registered manager has been in post since June 2015. The service has been inspected once before, in January 2012. CQC found the service was meeting all standards of quality and safety it was inspected against.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector. A specialist advisor with expertise in dialysis attended for the unannounced inspection with the lead inspector. The inspection team was overseen by Lisa Cook, Inspection Manager.

## How we carried out this inspection

During the inspections, we visited all aspects of the service and spoke with four registered nurses on duty and the registered manager. We also spoke with senior managers from Renal Services UK who were visiting the unit for our announced inspection. We spoke with 11 patients and also received 13 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we observed clinical practice and reviewed 10 sets of patient records. At the time of the inspection there were 15 patients attending for haemodialysis.

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

## Information about Renal Services (UK) Limited- Milford-on-Sea

**Activity (April 2016 to March 2017)**

In the reporting period 1 April 2016 to 31 March 2017 there were 2431 episodes of care recorded at Milford-on-Sea dialysis unit; all of these were NHS-funded.

Renal Services UK employed the registered manager and two registered nurses at the Milford on Sea unit. In addition, the provider had its own bank staff and used agency nurses from nearby renal units.

Track record on safety

- Zero never events
- Zero clinical incidents
- Nine expected deaths
- Zero serious injuries
- Zero incidences of healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of healthcare acquired E-Coli
- Zero complaints

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

• Clinical and or non-clinical waste removal

# Summary of this inspection

- Maintenance and servicing of medical equipment
- Maintenance of the building

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

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

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

- The policy and procedures for incident management were not clear, detailed and comprehensive, to provide consistent guidance for staff.
- Procedures to respond to incidents and mitigate potential risks were not always implemented and reviewed.
- Action had not been taken in a timely way when service reports identified additional work was required to repair dialysis chairs.
- The water treatment room was in a poor state of repair and could not be cleaned adequately.
- The outside clinical waste bins and compound were not adequately secure, which meant there was a risk people could access contaminated or hazardous items.
- Staff did not consistently follow the medicines management policy for identifying patients before administering medicines.
- Care plans were not being developed in response to risk assessment to help manage an identified risk.
- The unit did not have individual emergency evacuation plans for each patient, which meant there was a risk staff would not know how to assist patients safely in an emergency.
- The provider had not risk assessed the staffing numbers to demonstrate that having two staff on duty provided a safe level of cover and supported staff wellbeing.

We also found following areas of good practice:

- Staff showed good practice with infection, prevention and control practices.
- Staff had completed their mandatory training.
- There had been no medication errors reported at the unit in the past 12 months.
- There were systems to share learning from incidents within the unit and across different units.
- Staff understood how to safeguard vulnerable patients and how to report issues of concern.
- Equipment was regularly serviced and the provider replaced the dialysis machines in line with good practice guidelines.

### Are services effective?

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

# Summary of this inspection

We found the following areas of good practice:

- Staff treated patients and monitored their care using procedures and measures recommended by the Renal Association guidelines and other evidence based practice.
- All the renal nurses were competent to deliver the service and received support, regular appraisals, training and development opportunities.
- Staff had two-way communication with patients' consultants at the NHS trust, and effective links with their GPs and with the renal team. Patient information was shared efficiently between the unit and the trust, via shared access to the NHS patient record.
- Patients gave their consent at the start of their treatment at the unit.
- Staff supported patients with pain and also monitored their hydration and nutrition, to help them maintain their dialysis programme.

## Are services caring?

We found the following areas of good practice:

• Staff treated patients with compassion, dignity and respect, and helped them to feel relaxed at the unit.

• Staff encouraged patients to be as independent as they wanted to be with their dialysis treatment. They discussed patients' health and wellbeing in a professional way and patients were consistently positive about the attitude and kindness of staff.

• Although the unit did not have privacy curtains for each station, patient feedback did not indicate this was an issue. Nurses could make arrangements for private discussions in a separate room.

• Staff sought psychological support for patients to help them with their emotional wellbeing.

## Are services responsive?

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

We found the following areas of good practice:

- Services were planned to support the needs of patients living locally, and to promote their quality of life.
- The unit participated in holiday dialysis, and located at the coast, it was popular with holiday patients. The service had recently started a twilight session for holidaymakers over the summer.

# Summary of this inspection

- Admission criteria meant patients attending the unit were stable on dialysis. The nursing staff delivered care to support their individual preferences and needs. The unit offered pressure relieving equipment and supported patients to participate in their own care, in as much as they wished.
- Patients had individual TVs and access to Wi-Fi.
- There was no waiting list for patients to attend the unit, and there was spare capacity.
- There had been a large number of complimentary letters to the unit over the previous year, and no complaints. There was a policy and process for managing complaints.

However,

- There was only one privacy screen at the unit. This might not be enough to provide adequate privacy, particularly in an emergency situation.
- The patient guide had out of date information about the external organisation to contact if they had concerns.

## Are services well-led?

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

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

- The staff had access to corporate policies and procedures but these were not always clear, detailed or comprehensive.
- The risk register did not capture the risks relating to this particular unit. For example, it did not address the issues with the water treatment plant or security.
- There was no written strategy for the service delivered at Milford-on-Sea.
- The clinical governance strategy did not fully describe the clinical governance framework, and the scrutiny and risk management arrangements.
- The audit programme did not include audits to check compliance with regulations and identify areas for improvement, such as use of risk assessment tools and medicines management.
- There had been no staff survey in the past year.

We found the following areas of good practice:

- The registered manager was knowledgeable, experienced and organised. Staff and patients had a high level of confidence in the manager, with patients commenting on the professionalism of their approach.
- The nursing staff and patients reported a strong culture of patient-focused care, and respect for individuals.

# Summary of this inspection

- The unit operated against an understood governance framework, and nursing staff carried out regular audits to monitor performance and submitted the results each month. There was a meeting structure in place to share learning and for managers to cascade corporate messages.
- The vision and values of the service were on display and staff understood the values and worked to maintain them.

# Dialysis Services

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

## Are dialysis services safe?

**Incidents**

- There had been no reported 'never events' or serious incidents at the unit in the 12 month period to March 2017. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Records showed there had been no patient deaths at the unit. Nine patients who had received dialysis at the unit had died during the two years to March 2017, but their deaths had not been associated with their dialysis treatment. The registered manager understood their responsibility to report a patient death to the CQC should this occur on the premises or where there was a risk it was linked with dialysis treatment.
- Renal Services (UK) Limited had a risk management and incident reporting policy (reviewed and revised March 2017) and a summary incident reporting flowchart, which outlined responsibilities and actions to take when incidents occurred. These documents did not clearly describe clinical and non-clinical incidents, near misses and variances. This meant there was a risk that staff might miss opportunities for learning from incidents.
- No duty of candour incidents had been reported by the unit. 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 reasonable support to that person. The risk management and incident reporting policy had been revised in March 2017 to include reference to the duty of candour, however it did not provide details about the legislation and how it should be applied. The flowchart did not include guidance on when to apply the duty of candour. This meant that staff might not know to offer patients the support they must have, if they experience an incident that results in a notifiable safety incident.
- Staff said they knew to report incidents and near misses and there were on-line forms to complete. They were able to view incident reports on the reporting system. They understood the principles of the duty of candour and the need to be honest and open with patients if things went wrong. They relied on senior staff to make a judgement and provide support on how to implement the duty of candour
- There had been no clinical incidents reported in the year April 2016 to March 2017.
- The unit had reported two non-clinical incidents. These related to a temporary failure of the central water treatment plant and to the security/safety of the clinic, following entry by an intruder. We reviewed the incident report relating to the security and safety incident and saw the incident had been escalated, the incident reviewed and actions agreed to reduce the risk of recurrence.
- In response to the security incident, action had been taken to install a coded lock and buzzer. However, staff said it was not practical to lock the door at the times when patients were entering and leaving the unit. This meant the mitigating action to control the hazard had not been implemented as intended.
- Although staff had reflected on the incident informally, learning from the safety/security incident had not been on the agenda at subsequent team meetings.

- Learning from incidents at other units was cascaded via the clinical governance meetings and the monthly teleconference meeting for unit managers. For example, following a fall at another unit, the provider had set up a falls risk assessment process and within the unit, the provider had fitted a call bell and a hand rail for patients using the weighing chair.
- There was a system for circulating patient safety notices and there was evidence staff reviewed and acted on these.

**Mandatory training**

- The provider arranged classroom mandatory study days. We reviewed the staff files held at the unit and they showed 100% of staff had attended these days.
- The corporate training department prompted staff when they were due to attend an update course. Bank staff were also required to complete the mandatory training
- Mandatory training included: health and safety, information governance, fire safety, equality and diversity, infection control, food hygiene, basic life support, moving and handling, safeguarding vulnerable adults and children, complaints and lone worker safety.

**Safeguarding**

- The head of nursing was the safeguarding lead for the provider, with the clinic manager being the local lead and main point of contact for staff and patients.
- All staff had completed training in safeguarding vulnerable adults, levels 1 and 2. The safeguarding lead had completed further training, to level 3, to enable them to fulfil their role.
- Although the unit did not treat persons under 18, staff had also completed training in safeguarding children, level 2, so they would be able to identify and take appropriate action if they had concerns relating to child safety.
- The provider's vulnerable adults protection policy (reviewed March 2017) included contact details for the local safeguarding team and instructions on who to notify.
- Staff understood their responsibilities in relation to safeguarding vulnerable people and how to raise any concerns.

**Cleanliness, infection control and hygiene**

- The patient areas were visibly clean and tidy. The main unit had washable flooring and the cleaning checklists showed staff completed regular cleaning tasks.
- The water treatment plant however was not designed for easy cleaning, and did not have washable flooring. The fabric of the room was in need of repair, with peeling paint and rusted surfaces, which made it impossible to clean.
- Cleaning materials were stored in a locked cupboard and were colour coded to reflect their purpose. The staff cleaned all equipment associated with dialysis and a contracted cleaner was responsible for floors and non-clinical areas. There was a cleaning checklist on each machine, including the spare machine, showing they had been deep cleaned each week. Other cleaning tasks were listed on the task rotas or daily checklist. These included daily tap flushing to reduce bacterial build up, and monthly changes to water filters on drinking water taps.
- Nursing staff were bare below the elbow and wore protective personal equipment (PPE) such as gloves, aprons and visors appropriately. They adhered to infection prevention and control procedures and changed the PPE when necessary to minimise the risk of infections. The unit had different coloured aprons to use if they cared for patients with an infection risk. There were adequate supplies of PPE.
- Nurses received training in aseptic non-touch technique (ANTT) for connecting patients for dialysis, to minimise the risk of infections. Staff at the unit had completed competencies in the use of ANTT and their certificates were in their staff files. We observed staff complied with ANTT.
- We observed staff followed good hand washing techniques and washed their hands between patients. There were two hand wash basins per bay of six dialysis stations, and antibacterial hand sanitizers on each patient table and at the entrance to the ward area.

- Hand hygiene audits, where the manager carried out 10 observations, showed results of 99%, 100% and 100%, in May 2017, April 2017 and January 2017. The manager advised staff of any shortfalls, such as incorrect use of PPE, to encourage compliance with standards.
- There had been no reported cases of methicillin-resistant Staphylococcus aureus bacteraemia (MRSA) at the unit in the period April 2016 to March 2017.
- The unit did not have a dedicated dialysis machine to use with patients who had tested positive for the hepatitis B virus (HBV), or were at risk of having HBV (for example following a holiday to a high risk area), as stated in the provider's infection control policy. There was only one spare dialysis machine.
- Staff disinfected all dialysis machines after each treatment and cleaned all equipment surfaces between patients.
- The nurses screened patients for MRSA every three months. Patients were also tested for blood borne viruses before going to another unit for holiday dialysis, or before being accepted at Milford-on-Sea for holiday dialysis. This meant appropriate infection control procedures could be put in place to minimise the risk of cross infections.
- Nursing staff monitored the water supply for the dialysis units. They completed daily, weekly and monthly water testing, in line with corporate guidance, to test for chlorine, water softness, bacteria and mineral contaminants. We saw the log that recorded the results, and the results were also reported to the commissioning trust. Staff were aware of the processes for obtaining samples, and what to do if samples were outside the accepted range. The manager said contractors attended promptly to attend to the water treatment plant, if they had any concerns with water quality.

**Environment and equipment**

- The unit consisted of a ground-floor treatment area, with ward space for six dialysis stations located in a line facing the windows and a single, enclosed side room with one station. The water treatment plant was located outside the unit, but still within the hospital, and dialysing fluids and disposable equipment were stored in a securely locked garage in the car park.
- Although the door to the unit could be locked, staff generally left it unlocked so that patients could enter the small reception area, where there were two seats for waiting patients and visitors and the electronic weighing chair.
- Access to the treatment area could be secured by an entry key pad, but staff generally left it unlocked. Regular patients and staff knew to wait or ring for assistance before entering the treatment area. There was a window so anyone waiting could be seen from inside the unit.
- Entry from the unit to the clean and dirty utility room and the water treatment room was secured using a keypad so that only staff had access to these areas.
- Patients could recline and raise/lower the dialysis chairs and had access to call buttons. Service records showed that two chairs had faulty batteries, which meant they could not be adjusted if there was a power failure. There had been no actions taken in response to these reports. This might mean that patients would not be able to adjust the chairs to enable them to leave the building easily in an emergency.
- The dialysis chairs had adequate space between them, in excess of 900mm as set out in the Health Building Note 07-01 – Satellite dialysis unit. This meant there was space for staff to access patients and equipment and also adequate space to minimise the risk of cross infection. The unit provided chairs only, but patients could have pressure relieving cushions or additional mattresses if necessary.
- There was a ceiling mounted TV for each patient and the unit offered Wi-Fi. Patients brought in their own headphones and blankets. Staff used new, disposable pillow covers for each patient.
- The unit had one patient toilet, suitable for disabled access. There was not enough space to provide separate male and female toilets. Records showed patients were made aware of this before they consented to treatment at the unit.

- The water treatment plant was located in a small, locked room, which was in need of refurbishment. There was no floor drain, which meant there was a risk of flooding. The water tank was mounted on a metal platform; however, this was showing evidence of rust. There was paint peeling from the walls and ceiling, and very little space (about 30cm) between the water tank and the water treatment plant, which hindered access. The risk assessment for the water treatment room identified the lack of space, and the hazard relating to electrical equipment close to water, however the control measures in the assessment did not provide adequate mitigation.
- There was a sharps bin attached to patient tables at each station. These were correctly assembled and dated, and not overfilled.
- Staff separated and disposed of waste appropriately, including clinical waste.
- There were two clinical waste bins, located outside the dirty utility room, in a locked compound. The waste bins were not locked when we visited for the announced inspection, but were locked when we returned for the unannounced visit. Although the compound gate was locked with a padlock, the gates would be relatively easy to break, and people could easily climb into the compound making it insecure. We asked if this had been risk assessed but it had not.
- Staff checked the water supply in line with Renal Association best practice guidelines. They carried out daily and monthly checks and submitted monthly water samples for bacterial analysis. The unit also checked the water for contaminants. The water treatment plant was equipped with a warning system to alert staff of any disruption to the water supply. There had been one incident relating to the water supply in 2017. Staff had contacted maintenance contractors, who had resolved the issue and the unit was able resume dialysis services the following day.
- The unit had one spare dialysis machine, which was available if, for example, a machine developed a fault. Staff were aware of the process for reporting faulty equipment to ensure patients did not experience delays or sessions were cancelled.
- The manager said the unit had needed to delay treatment sessions in the past, due to an issue with the water plant. They had followed the unit's contingency plans and had redirected patients to another unit, and opened up alternative sessions on the subsequent day. These actions had minimised any delay to patient dialysis.
- The unit did not have a dedicated, spare machine to use for patients with blood borne viruses, however, this was in line with the Renal Services (UK) Limited equipment policy.
- The dialysis machines had built-in alarms, which went off when patient treatments or vital signs went outside normal parameters. Alarms rang for different reasons, and staff understood what actions to take to support the patients.
- We saw service records for the dialysis machines and they had all been annually serviced under contract, in line with the Renal Services (UK) Limited policy. The unit was due to receive new machines in July 2017, as the ones in use had completed between 20,000 and 35,000 hours. Renal Services complied with Renal Association guidance, to replace machines before they had completed 40,000 hours.
- We reviewed records and the unit's electronic chair weighing scales and blood pressure monitors had been serviced in the past year. The manager said the unit could borrow a chair scale, if needed at short notice, from the adjacent NHS clinic.
- The unit had emergency resuscitation equipment including an automated defibrillator, which staff were trained to use. All staff completed annual training in basic life support. Staff signed to record they had checked the resuscitation trolley each day they were on site, and we found that all stocks were in date.
- Staff received training in the use of equipment as part of their induction and competency assessment.
- The unit stored consumables in a locked garage in the car park. The registered manager ensured stock levels were monitored and there was a system for stock rotation. Staff monitored the temperature of the store and checked that items were stored within acceptable temperature parameters. The store was well organised

and clean. Staff monitored the batch numbers of consumables in case of any patient safety alerts or batch problems. Dialysis sets were single use and disposed of after use in clinical waste bins.

**Medicine Management**

- Nurses at the unit followed the Renal Services (UK) Limited medicine management policy (reviewed March 2017). The registered manager ordered medicines approximately monthly and stock checked medicines every fortnight, monitoring their expiry dates. All medicines we saw in stock were in date.
- Nurses monitored the storage temperature for all medicines. During our announced inspection visit, we observed the thermometer in the medicine fridge was not one designed for monitoring medical fridges. The registered manager ordered a replacement once we pointed this out, and a medical fridge thermometer, with a maximum and minimum recording, was in place when we returned for our unannounced inspection. Staff were monitoring and recording room and fridge temperatures and knew what to do if the temperatures fell outside the acceptable range.
- Nurses checked the medicines before administering them to patients; however they did not ask patients to confirm all the identity checks as listed in the policy (i.e. their name, date of birth and postcode). One nurse, not two checked and signed for the administration of intravenous medicines. This meant staff were not following their own medicines management policy or the Nursing and Midwifery Council (NMC) Standards for Medicine Management (2007). There had been no medicine administration errors however at this location in the previous 12 months.
- Nurses recorded the batch number of medicines, dialysis tubing and dialysers on each patient's daily monitoring chart. This was so they could carry out a trace if there was a safety alert associated with the medicine or equipment.
- Consultant nephrologists at the NHS trust prescribed each patient's dialysis medicines, including sodium chloride for different purposes, using patient specific directions (PSDs). A PSD is a written instruction, signed by the doctor to supply and/or administer medicines to a named patient after the doctor has assessed the patient. The PSD booklets covered medicines used in dialysis. Doctors supplied separate prescriptions for intravenous iron and erythropoietin.
- Staff administered anticoagulants, against parameters set in a Patient Group Direction (PGD). PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified for treatment. The nurses had signed to show they understood how to administer the medicine.
- There were no controlled drugs used by nurses at the clinic. Controlled drugs require extra security of storage and administration.
- The nurses stored medicines in a locked cupboard or locked fridge, depending on the recommended storage temperature. The medicines cupboard and fridge were in the clean utility room. Only authorised staff had access to the room, as entry was controlled by a keypad lock. Staff kept the fridge unlocked during the dialysis sessions, as the risk of patients accessing the room was controlled.
- When patients attended the unit for holiday dialysis their medicine prescriptions were organised in advance, by their own doctors.
- The nurses had completed medicines training and this was part of their renal competency induction training. They had access to the consultant nephrologists, or the renal team, to raise any concerns relating to medicines. The registered manager said they also had good access to patients' GPs, as for most patients, their GPs were at the practice on the same premises.

**Records**

- Nurses created legible, written patient records. They also had access to the commissioning NHS trust's electronic patient records, so they could update them after each dialysis session. This meant patient information was available to staff at the NHS trust.
- Consultant nephrologists had access to the day-to-day patient treatment records. They also submitted results of monthly blood tests to the UK Renal Registry.

- Nurses kept secure records. Patient files were kept in the locked clinic room after the dialysis session, until the nurses were able to input data into the trust's electronic patient record. Staff kept patient files in a locked filing cabinet overnight.
- Nurses recorded patient observation on daily dialysis prescription charts created by the NHS trust's renal unit. They used the charts to record the dialysis time, blood pressure, temperature, patient weight pre and post dialysis and the treatment protocol. Nurses also noted any observations and patient feedback, and typed information from each dialysis session into the NHS trust patient record. They attached the labels from medicines and disposable devices, used for the patient's dialysis session, onto the daily prescription charts and signed for the medicines administered.
- The registered manager audited five patient records per month, and results showed 100% compliance each month from February 2017 to May 2017. The audit checked records included patients' next of kin, religious belief, allergies, past medical history and consultant. In addition, they checked staff initialled entries, completed monthly blood reviews and calculated the efficiency of the dialysis treatment.
- Staff kept dialysis summaries in patient files for reference and comparison. Patient files included clinic letters, records of monthly discussions with patients about their blood results, results of any blood borne virus tests, and notes of consultant meetings and multi-disciplinary meetings. In addition, they recorded patients' consent to treatment and consent to have photographs taken of their vascular access. Files were indexed and clearly laid out.

**Assessing and responding to patient risk**

- Consultant nephrologists at the commissioning NHS trust referred patients to this unit who they assessed as stable on dialysis and suitable for treatment at a satellite unit.
- The unit's medical emergency policy (reviewed March 2017) instructed staff call an ambulance, administer oxygen and commence CPR if required.
- Patient records showed nursing staff assessed patients before, during and after dialysis. Nurses asked patients about their wellbeing and took account of their comments. They noted if patients said they felt unwell or had experienced changes since their last dialysis. Staff could contact the renal team at the local NHS trust if they had any concerns.
- As part of their competency training assessment, nurses learnt how to identify patients showing signs of deterioration. These included hypotension, nausea, clotting and sepsis. They did not use a recognised tool for this, such as an early warning score system. The dialysis-trained nurses used their knowledge of individual dialysis patients to assess deterioration.
- The unit did not use a specific tool for assessing sepsis but staff had training in identifying and responding to symptoms of sepsis.
- Nurses carried out clinical observations, including monitoring patients' blood pressure and temperature. Patients weighed themselves and discussed this information, and the dialysis treatment with the nurses. Patients and nurses had monthly reviews of the treatment outcomes and the nurses escalated any concerns to the renal team as appropriate.
- The unit carried out risk assessment on admission, using a combination of assessment forms provided both by the provider and by the trust. These included assessing and evaluating vascular access, fluid removal, manual handling/mobility, falls risk, pressure ulcer risk and pain. Records showed staff reviewed these at the monthly meetings with patients. Some of the tools were new, such as the falls risk assessment and the pain risk assessment. One record we reviewed showed the patient did not have a management plan in response to their falls risk assessment, to guide staff on how to minimise the risk of the person falling. For one person, who was partially sighted, there was no individual emergency evacuation plan to advise staff on how best to support them in an emergency. Risk assessments were not consistently linked to individual care plans.
- The unit treated patients attending for holiday dialysis if they had been assessed as fit and stable for dialysis treatment by their referring doctor. We were told that prospective holiday dialysis patients needed to be

tested negative for blood borne viruses. We saw these results were included in the notes for two holiday dialysis patients attending the unit at the time of the inspection.

- The nurses set up the dialysis machines for each individual patient, and programmed the machines to trigger an alarm when a patient's clinical recordings moved out of a set range. We observed that nurses responded promptly to any alarms and took appropriate action to stabilise the patient. For example, they supported one patient with low blood pressure and monitored them closely until the patient stabilised.
- Staff used the machine alarms to monitor if a patient's condition deteriorated. The service did not use an early warning system to alert staff if a patient was deteriorating, but staff monitored patients at risk more frequently.
- We observed the unit did not have a formal system for checking patient identity. In some cases staff asked patients for their date of birth, but this was not done consistently. Although the unit used bank staff, most of these were also familiar with the unit and the patients. However, the unit also took holiday dialysis patients, and we observed that staff did not formally check the identity of these patients. This meant there was risk that patients could receive the wrong treatment or medicines and this was also against NMC standards.

**Staffing**

- The provider employed only trained renal nurses at this unit. The staffing levels were based on the Renal Workforce Planning Group 2002 guidance, which recommends a ratio of nurses to patients of 1:4. At this unit, there were two nurses on duty for up to seven dialysis patients, which presented a slightly higher (better) ratio. Staffing levels were also agreed with the commissioning NHS trust. The provider had not risk assessed the implications of having only two staff on site, for example on staff wellbeing or on the safe operation of the unit.
- Renal Services employed the registered manager and two part–time renal nurses at this nurse-led unit. The provider had recently recruited a deputy manager, due to start in July 2017, who had previous experience working in the unit.
- There was a regular reliance on bank staff, with 14 shifts covered by bank staff between January 2017 and March 2017. The unit employed regular bank staff who also worked in nearby renal units and knew the Milford on Sea unit well. Bank staff completed an induction and competency assessment during their first shift.
- The level of staff sickness was low, at 2% in the three months January 2017 to March 2017.
- Staff tended to work long shifts, 11 to 14 hour days. They worked their contracted hours and also often chose to work additional hours. The registered manager worked extra-long days if there was a twilight shift for holiday dialysis patients, and also worked additional days to complete management tasks. They had their breaks within the unit, to maintain staff coverage. Staff had signed to opt out of the working time directive.
- All patients were under the care of a consultant nephrologist at their local NHS trust. Nurses said they could contact specific consultants or members of the renal team with questions by telephone or email and they were prompt to respond.

**Major incident awareness and training**

- The unit maintained emergency equipment on site, and staff had received training in basic life support and what action to take in medical emergencies and cardiac arrests.
- The staff had access to the provider's business continuity plans, policies and procedures. These covered power failure, disruption to the water supply and fire. The policy had a section with specific instructions for staff at the Milford-on-Sea unit, with contact details of services to call in the event of an emergency.

- The unit did not have personal emergency evacuation plans for each patient, to reflect their own mobility and support needs. This meant there was a risk that staff might not know how best to support individual patients in an emergency evacuation procedure.
- Due to the essential requirement for the supply of water and electricity in order to treat patients, the unit was in the critical/priority list of the local water authority and electricity board.
- Any disruption to the water system created an alarm to alert staff, and an emergency tank enabled staff to disconnect patients.
- The dialysis units had battery packs, should the mains electricity fail. The chairs also had batteries but service reports showed that these were not working and had not been replaced in some of the chairs.
- Staff created paper records and these provided a backup if IT systems failed.

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

**Evidence-based care and treatment**

- Renal Services (UK) had created competency frameworks and policies based on the Renal Association standards, National Institute for Health and Care Excellence (NICE) standards and guidelines set out by the commissioning NHS trust. The unit maintained a file of printed policies for reference, and these reflected the most recent ones produced by the provider.
- The unit offered all patients a type of dialysis called haemodiafiltration, which promotes the efficient removal of large as well as small molecular weight solutes from blood. There is some clinical evidence that haemodiafiltration achieves better outcomes for patients than haemodialysis.
- All patients received dialysis three times a week, which is line with the Renal Association Guidelines.
- The referring NHS trust did not refer patients to this clinic who needed support with home dialysis. As part of their assessment however, patients were assessed for suitability for inclusion on the kidney transplant list.
- Nurses assessed each patient's vascular access in line with the National Service Framework for Renal Services and the NICE quality standards 72 statement 8. They took photographs to help assess any changes to the vascular access and monitored access problems, such as poor blood flow and infections. They recorded notes on patient vascular access on the NHS patient records, for review by the patient's nephrologist. If they had serious concerns, they contacted the renal department directly.
- Staff carried out observations on all patients before and during dialysis, and submitted performance results to the commissioning trust. These showed, for example, if there had been access problems, access infections, any adverse incidents or early terminations of treatment. This gave an indication of how the unit was complying with national guidelines in providing effective care and treatment. For example between January 2017 and May 2017, the unit had reported 12 treatment variances, and these related primarily to hypotension (nine incidents). During this period, it reported three incidents of poor blood flow and no access infections.
- Nurses also assessed patients for their mobility, falls risk and risk of pressure ulcer development, nutrition and fluid management. This was in line with NICE guidance and the National Service Framework for Renal Services.
- A dietitian reviewed patients' nutritional status every quarter, or more frequently as risk assessed, which was in line with the Renal Association guidelines, of 4-6 monthly for stable patients on haemodialysis. When undergoing dialysis, nurses offered patients a snack and a hot drink, in line with the National Service Framework for Renal Services.
- Staff did not follow specific guidelines for identifying and responding to sepsis, however if a patient

appeared unwell or showed signs of deterioration staff monitored more closely and either continued monitoring, or discontinued the dialysis as per guidelines.

**Pain relief**

- Patients brought their own pain relief medicines to the unit, for self-administration.
- Nurses asked patients about their pain and recorded pain responses in their notes. They used a new pain score tool for this purpose. We observed that staff asked patients about their pain and took account of their responses in how they set up the dialysis procedures.

**Nutrition and hydration**

- Patients brought their own meals or snacks to the dialysis unit but the unit also provided toast, biscuits and hot drinks, which patients appreciated.
- Patients said they received good advice and support from the renal dietitian based at the commissioning NHS hospital. They had regular quarterly meetings and could obtain information and support in between these appointments if needed.
- Most patients were fully aware of the weight of fluid the dialysis process needed to remove and they discussed and agreed it before starting dialysis with nurses.

**Patient Outcomes**

- The unit monitored and reported on patient outcomes each month. These outcomes consisted of blood results, vital signs, target weights and nutritional status. It reported on key performance indicators each month, as agreed with the trust and in line with the Renal Association Haemodialysis Guidelines (2009). These related to problems with vascular access, such as poor blood flow and clots, vascular access infections, water quality and adverse incidents. These measures reflected whether nurses carried out safe and effective practices.
- In the five-month period January 2017 to May 2017, the unit reported between zero and three access problems each month. They also shared this information directly with nephrologists when patients experienced problems, to help minimise failure and avoid emergency access.
- Nurses monitored each patient's blood results and submitted monthly samples for analysis. This helped nephrologists assess the efficiency of the haemodialysis treatment and support decision making to make improvements. Nurses checked the monthly blood tests for urea removal, as recommended in the Renal Association guidelines, to measure how effective the dialysis treatment had been in removing waste products. The unit also measured dialysis adequacy and urea reduction using the Kt/V measurement. This is calculated from the volume of fluid cleared of urea as a proportion of the total volume of water in the patient. (URR). The monthly urea reduction ratio (URR) results between January 2017 and May 2017 showed all patients had higher rates of URR than recommended. This showed that dialysis treatments were effective and promoted improved patient outcomes.
- The unit monitored patients' blood for the Kidney Disease Outcomes Quality Initiative (KDOQI) group's measure of urea reduction. Results provided further evidence of effective urea removal, showing effective patient outcomes.
- The unit uploaded photographs of each patient's vascular access onto the trust's database, for the access team and consultant to review and monitor any changes to patients over time, and make necessary interventions to support long term haemodialysis.
- The Renal Association Guidelines recommend that arteriovenous fistulas (AVF) should be the preferred type of access, with 65% of patients starting with an AVF. Most patients at this unit had AVFs, 60%, and those with other types of access had these because they were unsuitable for AVFs.
- Staff carried out ongoing monitoring of patient wellbeing at each dialysis session. The registered manager described how they had helped one patient who had a painful fistula. The registered manager had raised this with the patient's doctor and the doctor had changed the prescription, which had relieved their symptoms.

- The Renal Association recommends that waiting times for dialysis and for transport home are minimised to improve patient attendance, co-operation with the treatment and patient quality of life. Results at this unit showed patients were consistently treated within 30 minutes of their appointment time. The unit reported any delays to the commissioning trust each fortnight, in order for them to liaise with the contracted patient transport service.
- The host trust incorporated patient outcome data from the unit into their submission to the UK Renal Registry. The Renal Registry is part of the Renal Association that collects, analyses and reports on data from renal centres in the UK, as mandated by the NHS National Service Specification. The registry also provided access to a clinical database, which could be used in renal research. The data submitted included blood results, the frequency of patients experiencing hypotension, vascular access infections and microbial counts in the water used for dialysis.

**Competent staff**

- There were three trained nurses employed at the unit, with one nurse working mainly Saturdays. The unit was not operating on Saturdays at the time of the inspection and so this nurse also worked other shifts on an ad hoc basis. We observed that staff demonstrated competency in their roles and were familiar with how the unit operated.
- The unit also employed bank staff, who had to demonstrated competency in the unit's procedures. The provider had an 'induction and assessed competency package' for bank and agency staff during their first shift which the registered manager signed off. This included dialysis and vascular access, orientation and medicine competencies.
- The unit employed experienced renal nurses and they were required to complete an induction period, including a period of being supernumerary to observe and learn corporate and local procedures. Staff records showed they had mentors when they started.
- Staff at Renal Services (UK) head office managed staff recruitment and ensured prospective new staff were suitable for interview. They checked applicants' identity, criminal records, medical declaration, references and qualifications. Unit managers interviewed applicants, for both substantive staff and those wishing to join the Renal Services bank staff.
- The head office had completed the recruitment checks for a new deputy manager. The manager had interviewed the applicant, however the provider had not issued a formal confirmation to the registered manager that the full recruitment checks had been completed, to provide them with the necessary assurance.
- All staff had completed reassessments of their aseptic non-touch techniques within the past year. They had also completed practical assessments of their intravenous techniques. One staff member was being supported to develop their skills and complete the advance renal course.
- There was no formal staff supervision of practice, but this was a small team where the manager had oversight of all activities. All staff had participated in annual appraisals and we saw these were structured and promoted two way discussions. Records showed that when staff requested specific training, this was arranged for them.
- Unit managers attended quarterly away days where they had presentations relevant to the running of the unit, for example on incident reporting, clinical governance and finance. The service provided copies of the presentations.
- The head of nursing supported the nurses with their professional revalidation (to renew registration with the Nursing and Midwifery Council (NMC)). Evidence of revalidation was kept at head office.

**Multidisciplinary working**

- Nurses sent monthly blood samples from each patient to the commissioning trust for analysis. The lead consultant or their colleagues monitored blood results and viewed observations and results on line and liaised with the unit's nurses when necessary to make recommendations or changes. The consultants visited the unit each quarter to meet with patients at booked appointments.

- Patients reported this approach worked well, with effective communication and cooperation in sharing treatment observations and promoting timely interventions. Patients also saw the trust's dietitian every three months, which they found useful.
- The nurses communicated with the trust renal team in between these formal meetings if they had specific queries or concerns about a patient's diet or weight changes.
- Nurses at the unit said the trust renal team organised appointments for patients to see renal psychologists, and they encouraged referrals if they considered patients would benefit for their care.
- We observed effective communication between staff on the unit, about people's specific care and treatment needs.
- The registered manager said they had good access to patient GPs, most of whom were based in the practice on the same site. The unit filed letters between GPs and consultants within patient files for easy access and reference.

**Access to information**

- There was an effective system for sharing patient information between the unit and the commissioning NHS hospital. Staff at the unit recorded daily observations and results and entered them onto the trust's patient records where they could be reviewed by members of the renal team. They also uploaded the information needed to deliver effective care and treatment in a timely way, so this was available to all staff involved in patient care. The unit had access to the most recent clinic letters following a patient's appointment with the consultant. This enabled all professionals involved in patient care to keep up to date with the patients' condition and wellbeing.
- Staff at the unit and the patient's lead consultant had access to the most recent blood results for the patients. Following review of the blood results, the consultant and registered manager discussed any changes required to treatment for patients. The named nurse explained the results to the patients and implemented any changes at their next dialysis session. They also provided patients with a print out of the analysis results for reference.
- There was a file of corporate policies available for staff to refer to in the unit. The file contained the most up to date versions of the policies, and staff signed to show when they had read them.

**Equality and human rights**

- The service had an equal opportunities policy within the employee handbook, aimed to prevent discrimination towards job applicants or employees, either directly or indirectly on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation.
- Workforce race equality standards (WRES) have been part of the NHS standard contracts since 2015. NHS and independent healthcare locations are required to have a WRES report. At the time of the inspection, Renal Services (UK) Limited were discussing how they would publish their data in support of these standards, with reference to the Milford-on-Sea unit, on their website.
- From August 2016, all organisations are legally required to follow the Accessible Information Standard. There was no process to ensure that people who have a disability, impairment, or sensory loss were provided with information that they can easily read or understand and with support so they could communicate effectively with staff.

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

- Patients gave consent for treatment at their initial appointment, prior to treatment. We saw completed consent forms in all the patient files we reviewed. These included signatures from a nurse admitting the patient, declaring they had discussed dialysis treatment and the risks with the patient. Staff did not ask for verbal consent each time prior to receiving care and treatment at the unit. Staff respected patient views if they wished to shorten their treatment session. This as in line with the units consent policy. In this instance, staff had held a conversation with the patient about the risks associated with this and recorded it in the patient's notes.

- The provider's consent policy made reference to the Mental Capacity Act 2005, Mental Health Act 1983 and the Department of Health guidance documents on consent. The policy was available to staff in the unit's policy file.
- Staff had completed training on the Mental Capacity Act 2005. The registered manager said if they considered a patient did not have capacity to understand their treatment and make decisions about their care, they would raise concerns with the patient's consultant. The lead consultant was responsible for overall care and treatment of the patient.
- Patients were asked for their consent to having photographs taken of their fistula and for those pictures to be stored. Patient records contained completed consent forms specifically about photographs which contained clear guidance about how the photographs would be used and stored.

## Are dialysis services caring?

### Compassionate care

- We observed staff interacted with patients in a caring and compassionate manner. Staff put patients at ease and engaged them in conversation.
- We spoke with 11 patients during the announced and unannounced visits. All the patients we spoke with were very positive about the quality of care they received at the clinic. Patients made comments such as: "Perfect service, [staff] always happy and helpful", "10/10 for care", "Caring and thoughtful nurses" and "Nurses are marvellous".
- We received 15 completed comments cards from patients who attended the unit. The comments reflected what we heard during the inspection. The most common descriptions of the service were, 'friendly,' 'caring', 'a happy environment,' 'professional staff' and 'respectful staff'.
- We saw staff offer compassionate care at all times. When a patient's blood pressure was low, staff were caring and reassured the patient and continued to observe and monitor them after the episode.
- The 2016 annual patient satisfaction results showed 100% of patients (less than 20 patients) said the staff were helpful and 92% said they were always treated with dignity and respect, with 8% rating the unit 4/5 for dignity and respect.

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

- Patients said they understood the treatment they were receiving and felt they had enough information. They said they were prepared for dialysis before they attended this clinic, whilst in hospital, and they found the routines easier at this satellite clinic, with more personalised care. They were aware they had been allocated a named nurse to support them with their care reviews.
- We observed that patients were encouraged to be fully involved in their care. They weighed themselves and reported their weight to staff before and after dialysis. They told staff if there had been any changes to their health and commented on any changes. The nurses discussed observations and vital signs with patients, involving them in their dialysis treatment. They also had monthly discussions about their blood results and what they meant. Patients asked questions and staff answered them clearly and professionally.
- We observed that some patients chose to record their results on a personalised National Kidney Foundation booklet provided by the unit. This enabled them to track their treatment and also provided a handy guide to some of the data that nurses monitored.
- Patients knew that nursing staff reviewed their care each session, and they were confident that the nurses provided the care, treatment and support they needed.
- We observed the nursing staff enabled a holiday dialysis patient to continue with self-care when attending this unit and offered assistance in an unobtrusive way.
- The clinic had set up the named nurse approach to encourage patients and staff to develop a supportive relationship. The unit also held 'patient days' for

friends and family of existing patients and potential patients. The staff organised social events involving patients and family at Christmas for both patients and staff.

**Emotional support**

- Patients said they appreciated the calm approach and emotional support provided by staff. They particularly welcomed the help in arranging dialysis holidays. We received feedback from patients with comments such as; 'The staff always great me with a smile,' 'The staff are friendly, helpful and totally competent' and '[The staff's] sense of humour helps to calm my nerves'.
- We observed that staff provided reassurance and calm explanations when a new patient required support.
- Most of the patients had attended the clinic for dialysis for a long period, and staff and patients got to know each other well and enjoyed a joke together. Patients commented that staff made them feel comfortable and at ease and they liked the way the unit had a small, stable team of nurses.
- Patients said the NHS consultants coordinated support from renal psychologists or a social worker when staff recognised a need with individual patients.

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

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

- The unit was originally set up in 2008 to provide local dialysis services for NHS patients living in south west Hampshire but under the care of nephrologists at the host hospital to the east of the county. The provider had refurbished and adapted part of the small, NHS war memorial hospital in the coastal town of Milford-on-Sea. The unit shared the site with the local centre for primary care services. As a result, many of the renal patients lived within 10-30 minutes' drive from the unit. Not having to travel long distances has been shown to help improve a dialysis patient's quality of life.
- The unit was designed for easy access. There was parking on site for dialysis patients and there was a contract for patient transport provider for those who could not drive to the unit independently. The unit was located on the ground floor with a ramp from the car park/drop off point to the main entrance.
- Because the unit was small, it did not have all the facilities recommended by the NHS Estates guidance (Health Building Note 07-01). Patients had no complaints about the lack of space and the guidance was written for larger units, those with 12 or more dialysis stations. There was a lack of space for storage of wheelchairs and there were no lockers for personal belongings.
- Between January 2017 and March 2017, the unit was operating at 33% capacity. The commissioners had referred sufficient patients to open the unit on only three days out of six. As the unit had a surplus of available capacity, it was able to accept all referred admissions for patients meeting the admission criteria. At maximum capacity, the unit could treat up to 42 patients, and at the time of the inspection, the unit was treating 15 patients, including two holiday dialysis patients. The service generally operated with two day-time shifts and added in further shifts, usually in the evenings, to accommodate holiday dialysis patients.

**Meeting the needs of individual people**

- The provider had a dedicated holiday dialysis co-ordinator to liaise with NHS trust holiday coordinators, patients, consultant nephrologists and the units to arrange treatment bookings. The co-ordinator forwarded patient information to the unit and requested any outstanding information. The coordinated requested information four weeks prior to the holiday dates and the nursing staff checked the details before accepting the patients.
- The host NHS hospital only referred patients to this satellite unit who were stable on dialysis and suitable for treatment away from the main renal hospital. The NHS hospital did not refer patients to the service who they assessed as needing additional support, for example because they lived with dementia or a learning disability that meant they did not understand

the treatment they received. The unit could support patients with a learning disability, if staff assessed they understood and consented to the treatment and care the satellite unit offered.

- The referral and admission policy stated the unit could only treat people who could receive treatment safely and comfortably in electronic renal chairs. This was because the small satellite unit did not have space or equipment for beds. The unit could however make some adjustments for individual patients, by offering pressure relieving equipment.
- The staff supported patients to participate in their own care, in as much as they wished. Most patients weighed themselves independently, and told the nurses their pre and post dialysis weights. We observed one patient who chose to self-needle, however this was a holiday dialysis patient, and most patients said they preferred the nurses to do this for them.
- There was a TV for each dialysis station and patients could access Wi-Fi for personal entertainment.
- The unit had a patient guide, which included contact details, including for out of normal working hours, opening times and terms and conditions.
- The registered manager said if staff recognised people needed additional psychological support, they sought help from their GP or consultant in making the necessary referrals.
- The unit did not have privacy curtains to provide privacy for patients during dialysis. Patients did not overlook each other, as the stations were aligned, facing the windows. The unit had a metal screen, which we saw staff use when a patient felt uncomfortable. The metal screen was not easy to use and did not provide a high degree of privacy.
- Staff did not make adverse comments about the lack of privacy curtains, and staff said they could have private meetings with patients in the office or in a room in the main hospital if this was needed. We observed that most patients wore headphones during their dialysis and these meant staff and patients could have some privacy when having discussions on the ward.
- Patients said the registered manager was able to offer some flexibility for their dialysis treatments, which they appreciated. On our visit, one patient wanted to change their appointment time for their next session, and the manager was able to offer them different options, which they found helpful. One patient reported in their feedback card that staff were helpful in rearranging dialysis times to suit their other appointments.
- The commissioning, host NHS trust managed referrals to the unit and between April 2016 and March 2017, the unit provided 2431 dialysis sessions. The unit had not cancelled any sessions during this period.
- Patients were given staggered appointment times to minimise waiting time and we observed this worked well. The 2016 annual patient survey reported that all patients were satisfied with their appointment times.
- The unit monitored delays in patient transport and reported results to the commissioning NHS Trust. The unit reported that over 75% of patients were treated within 30 minutes of their appointment time in January 2017, February 2017, March 2017 and April 2017. The reports did not provide further details, for example, how many patients this affected or the actual length of delay patients experienced.
- The patient survey also showed 85% of patients (approximately 12 patients) said their dialysis always commenced in a timely manner, and they arrived for their appointment at the right time. Survey results showed the remaining 15% of patients rated timeliness 4/5. All patients reported they were dropped off and picked up at the right time or within 30 minutes of the appointed time. For patient transport, over half the patients rated the service excellent and all patients rated the service adequate/good/excellent. Transport services often provided one main driver for most of the drop offs, which meant they knew the patients and could accommodate their needs.
- Although patient feedback to CQC was overwhelmingly positive, we received one comment that a patient sometimes waited 25 minutes to get connected for dialysis and another that the quality of patient transport could be variable.

**Access and flow**

- Patients reported good liaison with their consultants and dietitians, with quarterly meetings at the unit at a time that suited them.

**Learning from complaints and concerns**

- People said they could raise any concerns with the manager, and they would feel confident that a complaint would be taken seriously.
- All patients who provided feedback to us said they had no complaints about the service, and were overwhelmingly positive.
- The unit had received no complaints between April 2016 and March 2017 and had received 25 compliments from patients and their relatives.
- The complaints policy for the unit outlined how a complaint would be handled, the timescales for a response and the different stages of complaints management. This was also summarised in the patient guide.
- The patient guide provided incorrect information about how to escalate complaints if they were not satisfied with the response they had received from Renal Services. It advised complainants, who were dissatisfied with the way their complaint had been handled, to write to an organisation that no longer existed.

## Are dialysis services well-led?

**Leadership and culture of service**

- The staff liked working at the unit and the three nurses we spoke with said they were supported by the registered manager and said the unit was well organised. We observed there was a cooperative, cheerful culture, where staff supported each other
- The registered manager worked shifts, with mostly one other staff member. When the unit had additional patients, for example for holiday dialysis, the manager chose to work 14-hour shifts to cover the twilight shifts, with a second nurse, often from the bank staff. The manager also elected to work shifts on non-dialysis days to carry out management tasks. A deputy manager had was due to start in July 2017, to help support the manager and provide additional management capacity.
- The registered manager had a good understanding of the needs of the unit and its staff. The manager was a nurse with over 14-years of experience in renal nursing and qualifications in teaching and assessment in clinical practice. They met with other clinic managers for monthly meetings and also attended quarterly development days. The manager development days provided opportunities for learning and reflection in areas such as clinical practice and governance, workforce training and business development.
- Patients reported a high degree of confidence in the skills of the manager. They said the unit was friendly, clean, and run in a professional way. They also commented on the relaxed and caring atmosphere that the staff team created, which was a reflection on the style of leadership.
- The manager said they had good support from the senior team, with daily catch-up calls and prompt responses to any queries.

**Vision and strategy for this core service**

- The provider's stated aim was to provide 'inspired patient care', supported by a set of seven values. These values related to providing highest quality, safe patient care, striving for excellence, valuing people, promoting open communication, being accountable and encouraging new ideas and creativity. The Renal Services' values were on display in the waiting area. Staff had a broad understanding of these values.
- Senior managers said the organisation aimed to improve patient quality of life, by providing local haemodialysis services and promoting increased patient freedom.
- At Milford-on-Sea, a key objective was to increase the number of patients at the unit, whilst maintaining a patient-focused, shared-care culture. The unit was staffed for delivering services three days a week. As recruitment of skilled renal staff was difficult, the provider had set up a training plan specifically for

nurses new to dialysis to learn renal skills, with a view to future expansion. The Milford-on-Sea unit did not have any junior staff in the development pipeline. There was no specific, written strategy for this service.

- The registered manager attended the clinic manager away days and conferences, for in-house professional development and to support them in their roles.

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

- Senior staff explained the provider had an overarching risk register that was included in the business continuity plan. It was maintained by the regulatory and quality manager. Although the overarching risk register applied to all units, it did not identify specific, local risks relevant to this individual clinic. As a result, the clinic staff did not have an oversight or ownership of risks relating to this unit, such as the condition of the water treatment plant, some chair batteries not working and the management of controlled access forpatients.
- The provider's risk register had been added to the business continuity policy when it had been reviewed in June 2017. The identified risks related to recruitment, utilities failure, natural events preventing access to premises, adverse weather, pandemic illness and failure of the air conditioning. The risk register rated the likelihood and impact of these risks and included mitigation. The register did not include a date when the risk was identified, or timescales for implementing mitigating actions. It did not identify risks specific to Milford-on-Sea. For example, the provider had not risk assessed having only two members of staff on duty at one time.
- The clinical governance strategy 2017-2019 (February 2017) stated that Renal Services will work towards;
- 'demonstrating outcomes of care,
- monitoring and improving practices against national and European standards,
- ensuring staff are skilled and trained,
- a commitment to sharing information with and having supervision from NHS trusts
- auditing outcomes for patients'.
- The governance structure was described to the inspection team in terms of clinical governance and corporate governance streams. The clinical governance lead took responsibility for ensuring the organisation followed Renal Association guidance, and was also responsible for reviewing incidents, complaints, infection control, audits, patient satisfaction, policies and procedures. Corporate governance covered quality management in terms or health and safety, risk assessments and CQC compliance, as well as contingency planning, environment, human resources and finance. All governance matters were discussed at the quarterly clinical governance meetings.
- The management structure showed the clinic's registered manager reported to the regional clinical manager, who in turn reported to the head of nursing. The clinical governance manager reported to the head of nursing. The heads of nursing and of contracts (quality and regulatory) reported to the chief operating officer.
- The chief operating officer chaired the quarterly clinical governance meetings, with the medical director, the head of contracts, the regional clinical manager and the head of nursing in attendance. Minutes of meetings showed they were used for discussing incidents and variances, staffing, complaints, policies as well as tender updates. The minutes showed items for further action were not consistently captured in an action plan and monitored.
- The registered manager reported clinical performance to the clinical governance committee each month. These reports were supported by documents detailing any variances by patient, and the actions staff had taken to support the patient. For example, we saw examples of variances relating to a patient who called the unit for advice when they were at home, and a patient whose transport had not been arranged. The head of nursing reviewed the variance reports and discussed the actions taken with the manager.
- The clinic managers had monthly telephone meetings, which were used to discuss topics such as appraisals, staffing, recruitment and rosters, tenders for new business, incidents and variances. The registered

manager said these were useful opportunities for sharing information and learning from incidents at other clinics. The minutes showed specific actions were allocated to staff to complete.

- The clinic held its own meetings, and these were also minuted. The minutes showed the meetings were used to discuss key issues relating to the unit, such as transport updates and audit results as well as corporate messages relating to infection control and new assessment tools. Staff signed to show they had read the minutes.
- Most of the operating policies had been reviewed in the previous six months. However, the policies did not always provide comprehensive, clear guidance. Renal Services had a risk management and incident reporting policy (reviewed and revised March 2017) and a summary incident-reporting flowchart, which outlined responsibilities and actions to take when incidents occurred. The flowchart clarified what incidents needed to be reported to external bodies, such as the Care Quality Commission as well as when to contact the commissioning NHS trust. However, this level of detail was not included in the policy. These two documents did not clearly describe clinical and non-clinical incidents, near misses and variances. This meant the corporate policies and procedures lacked clear, detailed guidance for staff.
- The infection control policy (reviewed April 2017) did not make reference to the Health and Social Care Act 2008, code of practice on the prevention and control of infection and related guidance (2015), which sets out the systems and criteria for good infection control and prevention practices. hpolicyM, did not include details relating to the storage of different types of dialysis medicines stored on site, or guidelines for medicine audits. In general, the policies were often quite brief which meant they did not provide staff with operational guidance on how to implement the policy
- There had been a health and safety audit of the unit in March 2017 by an external body. This showed the unit carried out the necessary checks of equipment and had completed a fire risk assessment. There was one action, to check staff driving licences, and the registered manager had completed this.
- The trust's lead nurses visited the unit on an ad hoc basis to discuss developments and meet with the team. The commissioning trust last carried out a formal audit in June 2016, and results showed 100% compliance.
- The registered manager had set up a schedule for undertaking the audits on behalf of the trust. These included hand hygiene audits and observations, where the unit had scored 99% -100%. Staff were advised of any non-compliances so they could make improvements. The unit audited five patient records a month, and scored 100% against all parameters in February 2017, March 2017, April 2017 and May 2017. We observed the audit tool had not been updated, for example to check the new falls risk assessment had been completed/updated. These findings indicated the audit objectives had not been reviewed and did not fully reflect current processes to drive improvement.
- The provider had not carried out formal audits of the quality and safety of the unit, as part of their own internal governance and scrutiny procedures. The audit programme was not used to check compliance against regulations, for example in relation to medicine management.
- There were processes for reviewing and reflecting on incidents and these were discussed at team meetings, managers meetings and clinical governance meetings. The clinic manager could escalate any issues or queries via daily catch-up calls with a senior manager.

**Public and staff engagement**

- The clinic sought patient views through the annual patient survey and took action in response to the results. The last survey was reported in December 2016. Results showed a high level of satisfaction and confidence in the service, with almost all patients giving the service the highest ratings. The questions had been designed to provide useful data for improving the service. For example, although the unit was small and there were no curtains around the stations, when asked if they had enough privacy to discuss their condition or treatment, 77% of patients gave this the highest rating (always) and none were critical of privacy. Patients gave poorer ratings for the questions about who to contact after leaving the unit,

and engagement with the Kidney Patients Association. As a result, the registered manager reissued all patients with another patient guide and reminded them how to contact staff if they had concerns. They also prompted patients to view the literature about the KPA and gave out leaflets and newsletters.

- Patients reported they knew about the results of the patient survey although they couldn't recall the detail.
- There had not been a recent staff survey and senior managers said a new style staff survey was planned for 2017. Staff and managers felt the organisation was open and transparent.
- The employees handbook included guidance on how to raise concerns, including who to contact for whistle-blowing.

**Innovation, improvement and sustainability**

- Renal Services' technicians monitored the usage of the dialysis machines, and the ones at this unit were due to be replaced soon after our inspection, in July 2017. This was because they had completed between 20,000 and 35,000 machine hours. The asset register for this equipment was held at head office, and the registered manager had been informed of the schedule for replacing the machines and staff training.
- The unit prided itself on the cooperative approach to care and the mutual agreement for staff to 'go the extra mile' for patients. This meant being proactive in monitoring patient outcomes, maintaining the infection control standards and responding promptly to any machine alerts to support the patients.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that systems are in place to ensure risks relating to the unit are identified, assessed, monitored and mitigated. For example, relating to security procedures, the water plant, failed chair batteries.

### Action the provider SHOULD take to improve

- The provider should develop a clear, accurate policy and procedure for incident management.
- The provider should ensure the clinical waste compound is secure, to minimise the risk that unauthorised people can access the waste and the compound.
- The provider should check that patients are formally identified at the start of each session and before administration of medicines, in line with the policy.
- The provider should ensure the audit programme is designed to improve quality standards and check compliance with regulations. For example, to audit medicines management, and to check records reflect agreed processes and practices.
- The provider should ensure the registered manager receives confirmation that new staff have complied with all the recruitment checks, as they are accountable for the unit's workforce.
- The provider should review and revise the patient guide to ensure it is accurate and informative.
- The provider should carry out a survey of staff views to identify areas for improvement.
- The provider should create a service strategy for the unit, so staff and patients understand and can participate in forward planning.
- The provider should check policies and procedures are aligned to best practice and are sufficiently comprehensive to guide staff. For example, the risk management and incident policy, the medicines management policy and the infection, prevention and control policy.

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 17 HSCA (RA) Regulations 2014 Good governance<br><br>The service did not have a local risk management system. The provider must ensure that systems are in place to ensure risks relating to the unit are identified, assessed, monitored and mitigated.<br><br>Regulation 17(1)(2)(a)(b)(f) |