

Scunthorpe NHS Dialysis Unit

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Since 2008 Fresenius Medical Care Renal Services Ltd has provided haemodialysis for stable patients with end stage renal disease or failure at Scunthorpe NHS Dialysis Unit. The dialysis unit is located on the Scunthorpe General Hospital site. The service is a satellite service of Hull NHS Dialysis Unit and patients are referred from this hub and the local NHS trust. It is a 16-station dialysis unit, comprising of four side isolation rooms and a 12 station main bay.

We inspected this service using our comprehensive inspection methodology. We carried out an announced comprehensive inspection on 23 May 2017 and an unannounced inspection on 12 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 said to us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we do not rate

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

We found the following areas of good practice:

- We found that the unit was visibly clean, arrangements for infection prevention and control were in place and there was no incidence of infection. The environment met standards for dialysis units and equipment maintenance arrangements were robust. Staff were aware of their responsibilities in keeping the patient safe from harm and record keeping was thorough. Mandatory training was completed by all staff.
- Effective arrangements and support from a dietitian and social worker were in place and the individual need of dialysis patients was a priority. There was effective multidisciplinary working and good collaboration with the unit consultant and the NHS trust renal team which helped support patients' treatment and positive outcomes.
- There was a good range of comprehensive policies in place to support staff; these were accessible and understood by staff we spoke with. Policies were based on national guidance and an audit programme was in place to monitor compliance. Key performance indicators for 2016/17 showed comparable performance against other Fresenius units nationally.
- Staff described the Fresenius incident reporting system and were aware of changes being made to transfer from a paper to an electronic system. Staff reported incidents as clinical, non-clinical and treatment variance reports (TVR's).
- We observed staff working with competence and confidence and the training available in the unit supported all staff to perform their role well. Nursing staff were experienced and qualified in renal dialysis. Over 50% of nursing staff had over 10 years renal experience and one had a specialist renal qualification. One hundred percent of staff had received induction and appraisal.
- We observed that consent processes were in place and documentation was accurate. Easy access to complex patient information in the unit and across the NHS trust supported treatment and care of patients in the unit.
- Effective processes were in place for the provision of medicines. These were stored and administered in line with guidance and staff completed competencies annually to ensure they continued to administer medicines correctly.

Summary of findings

- We observed a caring and compassionate approach taken by the nursing staff and named nurses during inspection. The detail in written individualised care plans was thorough and updated.
- Nurse staffing levels were maintained in line with national guidance to ensure patient safety. There was use of a specialist nurse agency when required. Staff provided additional cover during peaks in activity or during staff shortage. Nursing staff had direct access to the consultant responsible for patients care.
- Patients were supported with self-care opportunities and a comprehensive patient education process was in place. Holiday dialysis for patients was arranged to provide continuity of treatment and support the wellbeing of patients.
- The unit provided a satellite local service, with flexible appointment system for patients requiring dialysis and the service contract obligations were clear to senior staff. We observed a responsive approach to arranging appointments with the needs of the patient at the centre. Arrangements for contingency for appointments in an emergency was in place.
- The unit had detailed local risk assessments in place and we observed a new operational risk register; this was being developed by the national senior team and would be reviewed through the governance committee structure prior to implementation and training for unit staff.
- Activity was monitored closely for non-attendances of patients. The team worked flexibly to accommodate patients individual appointment needs to avoid non-attendance. Any unavoidable or emergency transfers to the NHS trust renal unit were appropriately managed by the nursing team.
- The unit monitored waiting and travel times for patients and they did not have long waits pre and post treatment.
- Staff had introduced a formal process for identification (ID) of patients as action from previous inspection feedback. A signed document with photograph in the patient record had been introduced. We observed nurses asking patients for ID prior to treatment and administration of medicines on both visits. This process needed embedding to ensure safe identification of patients, with particular regard to safe administration of medicines and treatment by staff.
- Team meetings gave evidence of local leadership sharing lessons learnt from incidents and audit findings. Nursing staff we spoke were very positive about the clinic managers open approach to leadership and governance.
- Employee surveys were performed annually and action plans supported the team to address any issues where required. Staff morale was good in the unit at the time of inspection.
- Patient satisfaction surveys showed consistent positive results and we spoke with patients who expressed high regard for the care and treatment they received from the team in the unit.

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

- The grading of harm from incidents was not clearly described by staff. It was also not clear on the reporting forms or in the unit policy. This would not support a clear trigger for the requirements of the duty of candour regulation.
- The classification of clinical and non-clinical incidents did not reflect the reported events, for example patients falling in the unit were reported under 'non-clinical' incidents, to the health and safety manager, rather than the chief nurse.
- Observations were recorded regularly to assess the patient's condition, before during and after dialysis. We noted however that the unit did not use a recognised national early warning score (NEWS) system to support the recognition of the deteriorating patient.
- We did not observe a system for reporting of pain assessment for patients in the unit who receive dialysis treatment.

Summary of findings

- The unit did not have processes or policy in place to ensure staff could identify and manage patients at risk of developing sepsis.
- Unit staff did not have access to a designated member of Fresenius staff who had appropriate level 4 safeguarding training for advice. This training requirement was also not included in the Fresenius policy.
- We looked at a range of policies, these all had included a date they became effective, but did not have a date to indicate when the policy expired or would be revised.
- The arrangements for the workforce race equality standards (WRES) were not embedded in the unit.

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, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service

Dialysis Services

Rating

Summary of each main service

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

Summary of findings

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Scunthorpe NHS Dialysis Unit

Services we looked at:

Dialysis Services

Summary of this inspection

Background to Scunthorpe NHS Dialysis Unit

The service provides haemodialysis treatment to adults. Scunthorpe NHS Dialysis Unit opened in 2008 and is operated by Fresenius Medical Care Renal Services Ltd and primarily serves the communities of Northern Lincolnshire, with occasional access to services for people who are referred for holiday dialysis.

The unit has had a registered manager in post since February 2008 who was available on the days of

inspection. Fresenius Medical Care Renal Services Ltd UK has a nominated individual for this location. The unit is registered for the following activities; Treatment of disease disorder or injury.

The CQC have inspected the location previously and there were no outstanding requirement notices or enforcement associated with this service at the time of the comprehensive inspection in May 2017.

Our inspection team

The inspection was carried out by two CQC inspectors. The inspection team included a specialist advisor with expertise in dialysis services. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspection.

Information about Scunthorpe NHS Dialysis Unit

The Fresenius Dialysis unit in Scunthorpe is located on the site of Scunthorpe General Hospital. It provides treatment and care to adults only and the service runs over six days, Monday to Saturday. There are no overnight facilities. There are two to three dialysis treatment sessions a day. Sixteen patients receive dialysis at each session. On Tuesday, Thursday and Saturday there are two daytime sessions. An additional twilight treatment session is provided for patients on Monday, Wednesday and Friday which ends at 23.00hrs.

The unit has 16 stations in total with 12 stations in a main treatment area and four isolation rooms. The building is modern in design with ample storage, office space and treatment rooms. Access to the unit is on the ground floor and there is a secure car park directly outside.

The main referring or 'hub' unit is the Hull Royal Infirmary, which are part of the Hull and East Yorkshire NHS Trust. This trust provides the renal multidisciplinary team (MDT), with a consultant nephrologist visiting the dialysis unit once a week on a Tuesday, and more often if required. MDT meetings are held monthly where patient outcomes and blood results are reviewed.

There are 840 dialysis treatment sessions delivered a month. The service delivered 10,773 haemodialysis sessions in 2016/17. There were 71 people in total using the service. The unit does not provide peritoneal dialysis or services to children.

During the inspection of Scunthorpe NHS Dialysis unit we spoke with 12 staff including, registered nurses, dialysis assistants, the clinic manager, consultant nephrologist and reception staff. We spoke with six patients. We also received 28 'Tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed five sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital/service has been inspected previously which found that the hospital/service was meeting all standards of quality and safety it was inspected against.

Activity (April 2016 to April 2017)

Summary of this inspection

- In the reporting period April 2016 to April 2017, There were on average of 840 dialysis sessions delivered every month.
- The service delivered 10,773 sessions in the same reporting period, with 4,180 sessions delivered to adults aged 18-65 and 6,593 sessions to adults aged over 65.
- Previous to the inspection visit 66 people were using the service, 24 aged 18-65 and 42 above 65. Staff told us of a recent increase to 71 patients during inspection.
- Three clinical incidents and three non-clinical incidents were reported. We did not see a breakdown of the incidents for severity of harm i.e. no harm, low harm, moderate harm, severe harm or death.
- There were no serious incidents in the reporting period 2016/17.
- Nil in-service patient deaths had occurred in the reporting period.
- There were no reported incidences of healthcare acquired Methicillin-resistant Staphylococcus Aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), or Escherichia-Coli infections.
- There was one written complaint received during the reporting period by the unit.

Staffing

The unit employed 10.1 Whole Time Equivalent (WTE) registered nurses, 3.4 WTE dialysis assistants and one receptionist. As part of the contract dietitians, clinicians and specialist nurses were available to support patients. A renal social worker is employed By Fresenius Medical Care Renal Services Ltd. The unit did not employ any medical staff. Consultant nephrologist staff attend the unit weekly on Tuesdays and monthly for MDT meetings.

Track record on safety (April 2016 to April 2017)

- There had been no reported never events.

Services accredited by a national body:

- The unit is accredited against ISO 9001 and ISO 14001 quality management systems and are therefore subject to regular audit and review.

Services provided at the hospital under service level agreement:

- Counselling service.
- Clinical and non-clinical domestic waste removal.
- Cleaning and domestic services
- Catering service for patient refreshments

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We found the following areas of good practice:

- We found that the unit was visibly clean, arrangements for infection prevention and control were in place and there was no incidence of serious infection.
- The environment met standards for dialysis clinics and equipment maintenance arrangements were robust.
- Staff were aware of their responsibilities in keeping patients safe from harm and record keeping was thorough. Staff could describe the incident reporting system.
- ID processes had been recently introduced to support the safe identification of patients prior to treatment and administration of medication.
- Nurse staffing levels were maintained in line with national guidance.
- Mandatory training was completed by all staff.
- Risk assessments were carried out for patients and staff were aware of escalation policies and processes for transfer of patients to NHS hospitals.
- Arrangements for contingency in an emergency were in place.

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

- The grading of harm from incidents was not clearly described by staff. It was also not clear on the reporting forms or in unit policy. This would not support a clear trigger for the requirements of the duty of candour regulation.
- The classification of clinical and non-clinical incidents did not reflect the reported events, for example patients falling in the clinic were reported under 'non-clinical' incidents, to the health and safety manager, rather than the chief nurse.
- Unit staff did not have access to a designated member of Fresenius staff who had appropriate level 4 safeguarding training for advice.
- We noted that the unit did not use a recognised national early warning score (NEWS) system to support the recognition of the deteriorating patient. There was inconsistent recording of temperature and no recording of respiratory rate as directed by the care plan.

Summary of this inspection

- Staff did not use a recognised sepsis assessment tool and had not received any training or guidance on the management of patients with sepsis.

Are services effective?

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

We found the following areas of good practice:

- There was effective multidisciplinary working and collaboration with the NHS trust renal team to help support patients treatment and positive outcomes.
- Activity was monitored closely for non-attendances of patients and the team worked flexibly to accommodate patients individual appointment needs. Any unavoidable transfers to the NHS trust renal unit were appropriately managed.
- We observed staff working with competence and confidence and the training available in the unit supported all staff to perform their role well. Nursing staff were experienced and qualified in renal dialysis.
- Consent processes were in place, policy was robust and documentation was accurate.

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

- We did not observe a system for reporting of pain assessment for patients in the unit who receive dialysis treatment.
- We looked at a range of policies, these all had included a date they became effective, but did not have a date to indicate when the policy expired or would be revised.

Are services caring?

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

We found the following areas of good practice:

- We observed a caring and compassionate approach taken by the nursing staff, MDT and named nurses during inspection.
- We spoke with patients who told us that 'staff were fantastic', and 'would go out of their way to help with anything.' Of 28 'tell us about your care' cards, there were 22 positive responses with detailed comments from patients praising the care and treatment they received in the unit.
- During inspection we observed nurses make arrangements to help celebrate a patient's birthday with friends and family. A

Summary of this inspection

birthday cake had been ordered and other patients in the unit were involved in celebrations. We observed nursing staff supporting a patient with sight impairment to listen to the radio during treatment.

- Patients spoke highly of the team overall with specific references to individual named nurses, the clinic manager and the renal social worker.

Are services responsive?

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

We found the following areas of good practice:

- The unit provided a satellite local service, with a flexible appointment system for patients requiring dialysis. We observed a responsive approach to arranging appointments. These were arranged with the needs of the patient at the centre, taking into account their work and social commitments. Nurses took into account the complex care needs for vulnerable and elderly patients.
- Senior staff were committed to attending business and clinical meetings at the NHS trust to manage the achievement of contract obligations and key performance indicators.
- The unit staff had a good understanding of patient travel and waiting times. Patient transport was organised to reduce waiting times for patients before and after treatment.

Are services well-led?

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

We found the following areas of good practice:

- There was a clear leadership structure in the Fresenius Medical Care organisation and that was applied regionally to the Scunthorpe NHS Dialysis Unit. The clinic manager was highly regarded by the team and staff morale was good at the time of inspection.
- Leadership was reflected in a nominated lead consultant from local NHS renal services, a regional business manager, area head nurse and clinic manager, who was based in the unit for 100% of the job role. The clinic manager liaised closely with the local NHS trust.
- We observed positive support in the unit team and nursing staff spoke highly of one another. This was reflected in our observations of their teamwork and communication and in the employee survey responses.
- The Fresenius governance framework was detailed and supported with a range of comprehensive policies, a structured

Summary of this inspection

committee and meeting system, a strategy and vision that directed the team to deliver ‘the right care to the right patient at the right time’. Senior staff were conversant with these elements of their service and senior business and governance meetings were consistently attended.

- The implementation of the new local risk register was making good progress at the time of inspection. This work should continue to be embedded in practice.
- The clinic manager held regular team meetings that were well attended, minutes were recorded and demonstrated examples of sharing of learning and good practice.

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

- The unit was not meeting the Workforce Race Equality Standard (WRES) (2015) at the time of our inspection.

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Never events should not happen if healthcare providers follow national guidance on how to prevent them. During the reporting period, April 2016 to April 2017 there had been no never events reported.
- Serious incidents are incidents that require further investigation and reporting. There were no serious incidents in the unit during the reporting period April 2016 to April 2017. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology in cases of serious and moderate harm.
- The unit had a policy for the reporting of incidents, near misses and adverse events. Staff we spoke with could explain the process for reporting incidents on the electronic clinical incident report form. However, we spoke with staff who did not have a clear understanding of the grading of moderate and serious harm incidents and subsequently there was mixed understanding of the application of the duty of candour regulation. We were therefore not assured that all themes and trends from incidents could be identified to trigger the duty of candour.
- The duty of candour is a regulatory duty; Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) introduced in November 2014. This regulation requires the healthcare provider to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology in cases of serious and moderate harm.
- Staff reported that the incident reporting culture was open and reporting was encouraged. Staff described, and we observed, examples of clinical and non-clinical incidents, and patient variance reports. Clinic managers reviewed each incident and treatment variance reports (TVR's) and shared with staff any themes or lessons in bulletins and unit meetings and used as learning tools to improve patient outcomes at the time of inspection.
- The service was implementing a new electronic incident reporting system in pilot sites to support on-going improvement and data analyses of incidents. We did not observe this at the time of inspection.
- The unit monitored performance against patient harms, they reported against the number of falls that occurred on the unit. In the reporting period, April 2016 to April 2017 there had been one reported patient fall on the unit. This was recorded in the care record and shared at staff meetings. Falls however were reported as non clinical incidents which is not an accurate assessment.
- We were told by senior staff that clinical incidents are monitored nationally with unit updates and learning bulletins distributed by the chief nurse to support lessons learned across the organisation. We saw evidence of sharing of incidents in the unit displays of information, minutes of meetings and in discussions with staff.

Dialysis Services

Mandatory training

- All new staff undergo induction which includes some core elements of mandatory training in safety systems, processes and practices linked to the care and management of patients. Preceptors train new recruits and record training in their integrated competence document. This document is designed to follow key stages; Induction, fundamental skills, advancing skills and management skills. Mandatory training was delivered as both face-to-face training sessions or via e-learning programmes.
- We observed ten staff records that gave evidence of up to date training records for registered nurses and dialysis assistants, attendance and sign off by senior nursing staff and mentors was evident.
- We observed the electronic management system for training that was being upgraded and improved, it was well organised and senior staff could review and monitor individual staff training needs and were given prompts around the time for mandatory update. The tool included all aspects of training and competence sign off including medical devices.
- Staff in the unit were reported as 100% updated with mandatory training for 2016/17. Staff we spoke with told us access and quality of training was very good. We reviewed unit training reports and individual training records as evidence of 100% compliance.
- The mandatory training programme had a safety emphasis and included eLearning and classroom based training sessions. The programme included prevention of healthcare associated infections, waste, medicines and records management, and reporting of incidents. Senior staff attended training for root cause analysis and management of emergencies.
- All staff attended basic life support training and nursing rotas would indicate each shift where a member of the team had life support qualifications and training. Emergency scenario training was carried out every 6 months.
- Mandatory training records for agency nursing staff are monitored by the Flexibank administrators to ensure training is up to date. Staff we spoke with told us if training lapses the member of staff is suspended from

shift allocation until evidence of completion is received. Flexibank training records are retained centrally and we were not able to review at the time of inspection.

- Staff we spoke with told us that the training available was very good. They had good access and felt supported to attend or access mandatory updates.

Safeguarding

- There were systems and processes in place to keep vulnerable patients safe. All staff we spoke with were aware of their roles and responsibilities for escalation of any safeguarding concerns. We observed contacts for safeguarding leads and points of contact at the nurses station.
- The clinic manager was the designated safeguarding co-ordinator and they acted as the safeguarding lead for the unit. There was no local designated staff who had appropriate level 4 child safeguarding training. This training requirement was not included in the policy. The policy directed staff to report any safeguarding issues to the chief nurse and also into the NHS trust safeguarding team. There had been no concerns raised in 2016/17. Staff we spoke with could not give us examples of escalation of any safeguarding concerns.
- Staff received training in the safeguarding of vulnerable people. We reviewed staff training records and saw that 100% of staff had received safeguarding adults training. The clinic manager had also trained to level 2 safeguarding for children. Unit staff did not have access to a designated member of Fresenius staff who had appropriate level 4 safeguarding training for advice as detailed in the safeguarding children and young people: roles and competences for healthcare staff Intercollegiate document March 2014.
- The unit had a policy for safeguarding adults and children, which detailed training requirements and areas when to raise a safeguarding concern. This document did not make reference to female genital mutilation but we noted that staff had attended e-learning training in 2017 for increasing knowledge and awareness of radicalisation, which also included the principles of PREVENT training programmes for staff to safeguard people and communities.

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Cleanliness, infection control and hygiene

- There were comprehensive Fresenius infection prevention and control (IPC) policies in place with standards audited on an on-going basis both at unit, central and external level. Cleaning, decontamination of equipment and clinical practice was observed to be compliant with policy during inspection, to include the technique for connecting and disconnecting patients to dialysis machines.
- The Fresenius chief nurse was the lead for IPC and had overall responsibility for providing infection prevention and control advice. On site there were link nurses, these staff received training to enable them to carry out the role.
- We observed aseptic non touch technique (ANTT) processes that were in line with policy and good practice when staff were connecting or disconnecting patients to dialysis machines. (Aseptic techniques are methods designed to prevent contamination from microorganisms. They involve actions to minimise the risks of infections).
- Infection prevention and control audits and hand hygiene audit data we reviewed, which was on display, met unit compliance targets and showed 87-100% compliance for the reporting period January 2017 to March 2017. Alcohol hand sanitiser was available at every dialysis station. We observed staff perform hand hygiene at appropriate times and all staff wore personal protective equipment (PPE) whilst performing clinical duties.
- Protocols were in place to screen patients returning from holiday in regions identified as high risk of infection for blood borne viruses. Screening for MRSA and MSSA was also carried out.
- Procedures were in place to assess carriers of blood borne virus (BBV) such as hepatitis B and C, staff were able to describe the correct isolation requirements and actions required to mitigate the risk of BBV cross infection.
- Staff had access to four isolation rooms for nursing patients with a known or suspected infection.
- Staff were knowledgeable about the surveillance of water systems for presence of bacteria, and were able to explain the procedures required to test water samples. Staff were able to explain the procedure if a water sample came back as contaminated.
- Records we reviewed showed that staff carried out the correct procedures in regards to flushing of water outlets to prevent contamination of the water supply.
- Staff had access to clinical and non-clinical waste facilities; staff were able to dispose of waste including sharps, at the point of use. Staff were observed to use appropriate segregation of waste and the unit had targets for waste management, which were being met. The five sharps disposal bins inspected were assembled correctly, not overfilled and used as per policy.
- Staff received training on infection, prevention and control through a range of methods, face to face and through e-Learning. IPC training compliance rates for the unit were 100%. Staff are assessed annually by the IPC coordinator, this was the clinic manager at Scunthorpe NHS Dialysis Unit. We observed staff competence documents to be up to date.
- The senior nurse had overall responsibility for cleaning by contracted domestic staff. We observed the cleaning schedules and there was a good system in place. Domestic staff cleaned the unit and there was a communication system to inform the domestic of any increased infection risk or need for deep cleans to isolation rooms. We noted that the unit had disposable curtains around each bed space. These were all dated and replacement dates were clearly written on the curtain label.

Environment and equipment

- The unit was accessed via a single entrance and via an intercom system to reception as a security measure. Entrance to the main treatment area from the main waiting area was via a digital lock and all unit and storerooms were kept locked. There was good access, parking just outside the premises and disabled bays near to the entrance.
- The unit was spacious, had natural light and appeared warm and welcoming for patients and visitors on the day of inspection. The unit had 16 dialysis stations

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with four of these being single isolation rooms. There was more than the recommended space of 900mm between station chairs. There was a central nurses station which afforded staff easy observation of patients.

- Maintenance of dialysis machines and chairs are scheduled and monitored using a maintenance and calibration plan, this detailed the dialysis machines by model type, serial number along with the scheduled date of maintenance. A similar plan existed for dialysis chairs and other clinical equipment for example; patient thermometers, blood pressure monitors and patient scales.
- Technicians maintain the dialysis machines, chairs, beds and water treatment plant with support from dialysis assistants. Records are maintained relating to the maintenance and calibration of all equipment used at the unit, from records we reviewed this provided assurance that equipment used was calibrated and maintained appropriately.
- Staff we spoke with knew how to log a call with the help desk regarding any facilities issues. The help desk allocated a job number and priority level to the call and requested a contractor to attend the unit. We saw evidence of this system in the communication diary where staff had documented minor faults for logging in the system and updated progress against any issues.
- The resuscitation trolley and equipment we checked was stocked as per checklist, there was a consistent system for checking in place and evidence of staff sign off for the previous three months. This included audit checks from the NHS trust resuscitation officer. All necessary equipment was available and easy to access in the main unit. The suction system and defibrillator was in working order and had been checked on a maintenance programme. Oxygen was available both on the trolley, and stored safely in a locked area directly outside of the unit. All single use items were found to be in date and stock levels were good.
- Staff we spoke with said there were adequate stocks of equipment and we saw evidence of appropriate stock rotation. The system for segregating supplies of fluids

for treatment was very good as learning from an incident in 2015 had prompted sustained improvement. There had been nil incidences reported of using the incorrect fluid concentrates for treatment.

- We observed that all the patients had pressure relieving additional mattresses that they could have for comfort if they chose to or if they were assessed as being at greater risk of developing a pressure ulcer. The mattresses were checked regularly and this was evident on the cleaning checklist and in our observations.
- We observed appropriate management of alarm systems on equipment to alert staff of any potential risk, disconnection from dialysis or deterioration of patient condition. Use of alarms in the unit was understood by nursing staff and all staff had achieved competencies around understanding parameters and use of equipment. We observed nurses respond to alarms promptly. We reviewed sign off for competency and found reports to be up to date and as per policy

Medicines

- The unit did not store any controlled drugs. Lead responsibility for the safe and secure handling and control of medicines was the clinic manager.
- The nurse in charge, usually the team leader or more senior nursing staff would be allocated duties as key holder for the medicines cabinet on a day to day basis. Medicines were stored securely in a locked cupboard.
- Medicines requiring refrigeration were stored in a fridge, which was locked and the temperatures of the fridges and room were checked daily. Staff were aware of the action to take if the temperature recorded was not within the appropriate minimum and maximum range.
- The nurses liaised with the local NHS pharmacy for additional advice relating to dialysis drugs. In addition, Fresenius staff had access to a pharmacist at head office should this be required.
- There were a small number of medications routinely used for dialysis, such as anti-coagulation and intravenous fluids. The unit also had a small stock of

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regular medications such as EPO (erythropoietin – a subcutaneous injection required by renal patients to help with red blood cell production). Stock medication was ordered from Fresenius and the local NHS trust.

- The patients NHS consultant nephrologist prescribed all medication required for dialysis. Staff we spoke with said that there was regular review and good access to the consultant for prescription changes. Therefore, there was minimal need to access out of hours support; however, the nursing staff could contact the local NHS trust doctor on call for any urgent prescription changes or advice.
- Emergency medicines were readily available and they were found to be in date in a sealed box on the bottom shelf of the resuscitation trolley. This was agreed locally and in line with Fresenius policy.
- We looked at the prescription and medicine administration records for five patients on the unit. These records were fully completed and were clear and legible.
- We observed a new system and process being introduced to identify patients safely prior to administration of treatment and medicines. Staff had begun to develop a system of photographs in the care records. We also observed staff asking patients to confirm identity prior to treatment in the unit. We noted that this issue and the associated risks had been included in the risk register. We acknowledge that most patients were well known to the clinical team, however nursing staff must always adhere to Nursing and Midwifery Council (NMC) standards for medicines management; this includes being certain of the patients identity, checking allergy status and expiry date.
- Medication changes were discussed at the patient's multidisciplinary meeting and shared with the patient and the patients GP.
- There was an organisational medicines management policy; however, this did not include identification of patients or arrangements for medicines audit.
- The Fresenius Medical Care patient treatment database automatically transferred patient data into the clinical data base of the NHS trust where the patient is under a renal consultant. Staff we spoke with described this process as working well.
- We reviewed five sets of patient records and saw entries made pre, middle and post dialysis as well as entries made for any variances during the period of dialysis. These entries were made at appropriate times in relation to the patient pathway. We also reviewed electronic and patient paper records including care plans and pathways and saw that these had been regularly reviewed, signed, dated and updated. Records were maintained in line with the NMC Code of Professional Conduct in relation to record keeping. All entries were legible.
- We observed patient records to be stored securely with respect for patient confidentiality during inspection. There were no information governance breaches.
- Named nurses can contact the GP services by telephone if they feel the patients' needs to be referred for extra care i.e. chiropody, or wound dressing clinics and this was documented in the care record.
- Documentation audits were carried out on a monthly basis. Twenty-seven aspects of documentation were looked at each time; (for example legibility, signature, clear prescription, care plan in place). Results we reviewed over a three month period in 2017 showed 100% compliance. These results were shared with staff at team meetings.
- Each registered nurse held a caseload of dialysis patients, records we reviewed showed that each registered nurse had approximately ten patients on their caseload as named nurses. Staff updated patient records and care plans for patients on their caseload.
- Patient's needs were assessed and treatment was planned and delivered in line with their individual care plans. There was a comprehensive care pathway in the five care plans we reviewed. Records contained a current dialysis prescription, dialysis summary charts and risk assessments, i.e. moving and handling and Waterlow pressure ulcer risk scores.

Records

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Assessing and responding to patient risk

- Only stable patients were dialysed on the unit; if someone was acutely ill with renal problems, they were treated at a main NHS hospital. This was to ensure that patients who required additional support received their treatment at the local NHS trust where medical staff were available 24 hours a day.
- Patients weighed themselves before treatment began. They inserted an electronic card, which identified them, into the electronic walk-on weighing scales. This was to establish any excessive fluid, which had built up in between treatments.
- Observations of vital signs such as blood pressure and pulse were recorded before, during and after dialysis treatment. There was no regular record of respiratory rate on the observation chart, although the care plan did direct the recording of this physiological parameter. Temperature was recorded routinely when patients received dialysis through an intravenous line, pre and post treatment.
- The unit did not use a modified early warning score system to identify the deteriorating patient. Nursing staff we spoke with were experienced and able to articulate the clinical condition of a deteriorating patient. Staff we spoke with had not had any training in national early warning score (NEWS) and could therefore not describe the recognition of the patient deteriorating in the same context.
- Staff could describe how they would recognise a patient that was unwell and how they would get support and escalate concerns in the absence of a NEWS system. There was a detailed policy document, 'complications, reactions, and other clinical event pathway' but no system was in place to ensure that care was delivered in line with national guidance from the Department of Health or the National Patient Safety Agency. This meant there was a risk that deteriorating patients may not be managed appropriately.
- There was no sepsis toolkit or pathway in use at the unit. This was not in line with the National Institute for Health and Care Excellence (NICE) guideline (NG51) for recognition, diagnosis, or early management of sepsis. (Sepsis is a life-threatening illness caused by the body's response to an infection). Staff we spoke with

were not knowledgeable about sepsis pathways. Staff however could describe what would happen if a patient deteriorated and could describe signs and symptoms of infection. .

- There was an agreement with the local NHS trust that patients who became ill would be transferred to the hospital. There were 23 patient transfers to another healthcare provider in the 12-month reporting period. There was no benchmark used within the organisation to inform whether this was a high or low number of patient transfers or whether these were appropriate planned transfers or unplanned emergency transfers. We observed a log of details of transfers and did not have any concerns about the types or reasons for transfer of patients to the local NHS trust.
- Patients were referred from the parent NHS trust with a full medical history, personal details and blood results. Staff in the unit then contacted the person initially by phone to prepare them for their first visit. The clinic manager said that there were specific appointments available for pre-dialysis patients to visit the unit.
- Staff recorded variances during the period of dialysis in the electronic patient records for example, falls risks, mobility post dialysis and changes in vital signs measurements. Staff used this information to help plan the next dialysis session and to identify any themes occurring during dialysis.
- Staff we spoke with had a good awareness of the process for escalation of concerns with renal medics on call at the parent trust.

Staffing

- Scunthorpe NHS Dialysis unit worked to a predetermined one nurse to four patient ratio and skill mix was defined by contract and policy agreements with the local NHS trust Hospital.
- There were 10.1 whole time equivalent (WTE) registered nurses (RN's). There were 3.4 WTE dialysis assistants (DA's) in post (12 RN's and 4 DA's). The unit at Scunthorpe has a 1:4 patient to registered nurse ratio with an additional DA per shift (with skill mix 67%:33%). This equates to five members of staff per shift with a minimum of 2 RN's and 1 Dialysis Assistant per shift.

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- At the time of inspection the unit had 1.0 WTE dialysis RN vacancies. The turnover in the 12 months prior to inspection was reported as two staff having left the service and two staff recruited. There had also been a one WTE increase in registered nurse establishment in 2016 to cover increases in activity.
- The unit senior team ensures compliance with staffing ratios through the application of an e-rostering system. The clinic manager completed these eight weeks in advance and forwarded to the Regional Business Manager for approval. Staff we spoke with did not raise any concerns over their duty rotas.
- The clinic manager reviewed duty rotas on a daily basis to assess staffing levels based on the actual number of patients attending for dialysis and also for unexpected staff shortages caused for example by sickness.
- When staff shortages are identified action was taken including rearranging shifts with the cooperation of unit staff. Where staffing levels cannot be maintained the unit used staff from the organisation renal flexi bank. Where the flexi bank cannot cover shifts, these were covered by external nursing agencies. The unit had used 34 registered nurse agency shifts in the three-month period prior to inspection visit.
- We reviewed three duty rotas over a three-month period, we noted that staffing numbers were in line with expected levels and consistent across shifts. Skill mix of staff was also good with a balance of experienced nurses with long service and newer staff.
- The team had introduced an electronic handover sheet, staff we spoke with said that they used this prior to patients arriving for morning dialysis. Staff also had a communication book.
- The unit did not employ directly any medical staff. Consultants were contactable via telephone, e-mail, through the consultant's secretary or hospital pager. Out of hours, the on call Consultant covering Scunthorpe NHS Dialysis unit was contacted via the hospital switchboard. All unit staff we spoke with were aware of how to contact a patient's consultant, and spoke of good access to consultant support.
- Consultant staff reviewed patients on a monthly basis at the multidisciplinary team meetings and ad-hoc as

required. Staff confirmed the consultant staff were visible and accessible. Patients we spoke with also confirmed that the consultant was available outside of unit appointments and would visit the unit to review patients.

Major incident awareness and training

- Appropriate clinical emergency equipment was available.
- An Emergency Preparedness Plan (EPP) was in place for the unit detailing the plans for the prevention and management of potential emergency situations. This outlined the roles and responsibilities of individuals in the case of identified emergencies including loss of water supply, electrical failure, fire or flood, bad weather and pandemic illness. There were established links with other units to enable transfer of patients in order to receive their treatment.
- Patients records we reviewed had personnel emergency evacuation plans (PEEP) applicable to patients whilst on and off dialysis. This included specific reference to their mobility needs during evacuation. Staff on a regular basis updated these plans.
- The unit was reported as having had no disruption as a result of a recent 'cyber-attack' across NHS systems. There had been a prompt response and systems were updated.

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

Evidence-based care and treatment

- We saw that policies and procedures were developed in line with guidance and standards from the UK Renal Association and had been incorporated into the organisations 'NephroCare standard for good dialysis care'. Clinical care and outcomes were monitored in line with National Institute for Health and Care Excellence (NICE) and the referring NHS trusts requirements. The Renal Association is the professional body for the United Kingdom (UK) nephrologists (renal physicians, or kidney doctors) and renal scientists in the UK.

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- Clinical care was led by NHS consultant nephrologists. The unit was nurse led based on plans and pathways individual to the patients. The team spoke with us about the expectations to work in line with the UK Renal Association Standards to dialysis quality outcomes.
 - The unit used an International standards organisation ISO accredited Integrated Management System (9001 and 14001) to ensure all policies and procedures supported best practice evidence. An annual review was completed to ensure that the evidence remained current. However, we looked at a range of policies, these all had included a date they became effective, but did not have a date to indicate when the policy expired or would be revised. Policies were stored on the shared drive and staff we spoke with said they were able to access them.
 - Individual care pathways and treatment prescriptions were available for dialysis patients. These were based on relevant national guidance. We saw evidence of a range of standardised, documented pathways and agreed care plans that had been individualised for patients by named nursing staff, examples of these included pressure care and falls care plans.
 - The local NHS trust was responsible for the creation of fistulas; staff at the unit were responsible for monitoring them. A fistula is a special blood vessel created in a patients arm, called an arteriovenous fistula (AV fistula). The blood vessel is created in an operation by connecting an artery to a vein, which makes the blood vessel larger and stronger. This makes it easier to transfer the patients' blood into the dialysis machine and back again. AV fistulas are regarded as the best form of vascular access for adults receiving haemodialysis. This is because they last longer, and have less risk of complications than other types of vascular access. The unit monitored the AV fistulas, which forms part of the NICE quality standard. At the time of inspection 76% of patients had an arteriovenous fistula which was in line with the Renal Association standards of over 70%.
 - Each patients weight and observations were checked and recorded pre, during and post dialysis treatment. This was in addition to constant monitoring throughout the dialysis treatment.
 - All staff monitor patients vascular access as part of their pre-dialysis assessment and following treatment. We saw assessment of vascular access in the care records we reviewed. This followed NICE Quality Standards (QS72): Renal replacement therapy services for adults.
 - The unit had a local audit programme; the audit programme was discussed during governance meetings and was reviewed by the area head nurse on a regular basis. The unit took part in nursing audits for example; infection prevention and control practices, medication and pressure area care. Results of audits were displayed in the unit.
- ## Pain relief
- Individual pain control needs of patients were informally assessed by nursing staff and paracetamol was routinely prescribed by consultants for patients, however there was no formal assessment of patients pain control needs at the unit.
 - Patients we spoke with did not report any pain or discomfort on the day of inspection.
- ## Nutrition and hydration
- Patients were supplied with regular hot and cold drinks, in reach, at their bedside. Patients were offered biscuits and sandwiches and were able to bring in snacks and food from home if they required. Patients we spoke with were aware of the dietary restriction of their illness and appreciated the support of the team and dietitian.
 - We saw evidence of nutritional assessment in the care plans as the malnutrition universal screening tool (MUST) was completed in notes we reviewed. Patients were weighed pre and post dialysis treatment. This procedure contributed to assessment and the overall treatment prescription.
 - A dietitian worked flexibly around the needs of patients in the unit as per contract arrangements with Hull NHS trust. We spoke with staff during the unannounced inspection, who told us that they worked flexibly to meet the dietary and nutritional needs of individual patients in the unit.
- ## Patient outcomes

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- Results and treatment data were captured in the unit database with blood results feeding into the trust electronic system. Unit 'live' data was available to the unit manager and consultant who monitor and audit individual patient performance month on month to identify where improvements and maintenance in achievement of national standards could be made.
- The unit data management system provided customised reports and trend analysis to monitor and audit patient outcomes and treatment parameters. This highlighted the opportunity to improve outcomes and in turn quality of life. The following outcomes were audited; achievement of quality standards (Renal Association Guidelines), patient observations, dialysis access specific data, treatment variances, infection control interventions and body composition monitoring.
- In addition, each month a report summary for each dialysis unit was produced for all clinics by the head office as part of a 'balanced scorecard'. The data collected, as part of the Treatment Variance Report (TVR) was monitored and reviewed by unit staff. This included monitoring or prescribed and delivered treatment times, fistulae and catheter care, admission to hospital and quality standards for monitoring of patients' blood results. Within Fresenius, the dataset was shared monthly with the area head nurse who worked with the clinic manager to address any improvement areas.
- A new 'clinic review' process further captured overall month on month clinical effectiveness and improvement areas. As part of the Fresenius 'Clinical Governance Review' and reporting, a report defining the units achievement of the Renal Association standards is sent to the NHS trust consultants.
- As the UK Renal Registry data is representative of all 'parent' NHS trust patients this does not permit the review of patients and outcome trends specifically treated within Scunthorpe NHS Dialysis unit. Therefore data, specific to the unit, is available through the clinic database. Senior staff told us that this is used to benchmark patient outcomes both as an individual unit and nationally against all Fresenius Medical Care UK clinics. We did not have opportunity to review national benchmarked data, unit staff could not describe the benchmarked position against other similar dialysis units.
- It was reported to us that there was a small percentage of patients who refused the prescribed four hours treatment durations. There was also a small percentage of patients who were prescribed less than four hours for example in May 2017, 86% of patients achieved the full 720 minutes of dialysis treatment time, and this included the patients prescribed less than four hours.
- The clinic manager informally monitored travel or waiting times for patients to be assured that they did not wait for treatment after arrival and for transport home after treatment. There were no issues reported from staff and we were told by senior unit staff that there were very few delays.
- There had been 27 non attendances in the unit in 2015/16. These were for a variety of reasons; some patients chose not to attend, also some numbers may have been attributed to hospital in-patient stay, but the unit was not informed. When patients persistently did not attend staff described that they had changed their appointment times to support appointment attendance.
- Monthly multidisciplinary meetings were held, staff we spoke with said that all patients' blood results were reviewed; progress and general condition was discussed. The named nurses and dietitian discussed outcomes and changes with all patients. Staff we spoke with were very clear about the changes for patients in their care. Written information was also provided as standard to ensure the patient has an on-going record of their treatment outcomes. Patients we spoke with were very clear about their treatment and care plans.
- Clinical outcomes for renal patients on dialysis can be measured by the results of their blood tests. The blood results were monitored on a monthly basis as directed by the NHS trust. Results were collated on the electronic patient database used at the unit. The data was available for the unit manager and consultant to review so they could see individual patient outcomes. Changes in treatment were planned as a required.

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- Monthly blood sampling was carried out and results were checked by the nursing staff. Urea reduction ratios (URR's) were calculated, and these are one measure of how effectively dialysis treatment removes waste products from the body. For the three months prior to inspection and average of 90% of patients achieved a URR of greater than 65% as indicated by RA guidelines.
- On reviewing the unit review reports we saw that overall performance was better than expected for certain performance criteria. The report showed performance against 13 criteria including adequacy of dialysis management, nutrition management and other patient outcomes in March 2017.
- Staff we spoke with told us that they had experience of end of life care, they would liaise with GP and Macmillan services to facilitate preferred place of death for patients nearing the end of life. The clinic manager kept a local record of the number of expected deaths of patients who received care and treatment in the unit at Scunthorpe. It was reported that often patients would be admitted to the local NHS trust at the end of life.

Competent staff

- We observed a clinically competent and confident team on the day of inspection. Staff we spoke with were experienced dialysis nurses and we observed care and treatment being delivered by a caring and knowledgeable team of nurses and dialysis assistants.
- In the 12 month reporting period prior to inspection 100% of dialysis nurses had received an appraisal and had their professional Nursing and Midwifery Council (NMC) registration checked by the clinic manager. Nurses were supported with revalidation processes.
- We reviewed a consistent level of detail in staff appraisal documentation in the five appraisal records we checked. We noted nurse appraisal documentation was detailed with a range of objectives.
- Staff we spoke with described good access and support for training. We reviewed ten personnel files that gave evidence of a thorough induction program which included emergency procedures, training and supervision of clinical practice and sign off of competence. Each member of staff had training &

education files, staff we spoke with told us that there was good access to internal and external study days, and access to the Fresenius learning centre. We reviewed evidence of full competence assessment during staff probationary period for RN's and DA's.

- We noted a 'Training and Education Progression Plan' which outlined a commitment to induction for new staff, it provided an overview of the first year of employment within the unit defining objectives for the following phases; supernumerary, probation, supervised practice, consolidation of knowledge and skills and then onto consolidation of managerial practice where appropriate. Staff we spoke with confirmed this arrangement.
- For existing staff the unit offered ample on-going professional development opportunities for on-going assessment and maintenance of competence which is pivotal to the Nursing and Midwifery Council (NMC) revalidation approach, for example; annual appraisal of competence, appraisal, mandatory and statutory training, access to external training such as accredited renal courses, dialysis specific study days, E-learning and virtual classroom training. There was one registered nurses with a recognised renal qualification, with one planned to commence the course in 2017. Over 50% of nurses had more than ten years renal experience.
- Staff working on the unit received six weeks supernumerary period during induction and a six-month preceptorship period allowing time to achieve all the required competencies. Nurses we spoke with told us that supernumerary periods could be increased if the member of staff or mentor felt that this period needed to be longer.

Multidisciplinary working

- Staff we spoke with told us the renal consultant had overall responsibility for patient care and visited the unit every month to carry out a clinical review of patients.
- There were established multi-disciplinary team (MDT) meetings for discussions of patients on dialysis pathways. MDT meetings included attendance from a dietitian, the renal social worker and vascular specialist nurse as well as members of the medical and nursing teams.

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- Clinical nurse specialists from the parent NHS hospital attended the unit to provide clinical expertise and review patients if needed.
- Whilst on the unit we observed good communication and support between members of the team, nursing staff and patients we spoke with described good working relationships amongst all staff involved in care and treatment, including clinical and ancillary staff and transport services.
- The neighbouring trust vascular access and pre dialysis nurses attended the unit to review patients and ran pre-assessment clinics at the unit to enable patients requiring new vascular access to be seen at the clinic rather than attending the referring hospital.

Access to information

- The Fresenius Medical Care patient treatment database EuCliD automatically transferred patient data into the NHS trust clinical database system PROTON. Staff we spoke with described this process as working well.
- The service was able to offer dialysis to patients from out of area who may be on holiday. Arrangements for referrals are through Fresenius head office or through the patient's own unit to the dialysis unit. The clinic manager provisionally allocates dialysis availability subject to receiving completed documentation and medical approval and acceptance. An Incoming Holiday Patient Form (UK-CR-03-40) is used to ensure all relevant information is gathered relating to the holiday patient, to reduce risks to all patients e.g. isolation requirements.
- We spoke with the dietitian and social worker who told us that paper records were stored securely. The team used a consistent document template across the unit and NHS trust. They had access to EuCliD and PROTON.
- The clinic manager ensured all unit letters were signed by named nurses and the dietitian. Staff we spoke with told us that named nurses would contact the GP services by telephone if they felt the patient needed to be referred for extra care such as, chiropody, or wound dressing clinics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing and this was clear in the Fresenius consent policy.
- We reviewed eight patient consent to dialysis forms and noted all to be accurate. There was policy and systems in place to gain consent and review consent from people using the service. We observed staff asking for informal consent prior to giving care and treatment.
- One hundred percent of staff had received Mental Capacity Act (2005) training, and Deprivation of Liberty (DoLS) training (both attended 3 yearly). At the time of inspection all patients attending the unit for dialysis had capacity to make decisions in relation to treatment and care. Staff we spoke with did not describe clearly the application of the MCA or DoLS in practice as they had not had much experience in view of the admission criteria of low risk patients.

Are dialysis services caring?

Compassionate care

- We observed a caring and compassionate approach by the nursing staff during inspection.
- Patients had access to a nurse call system and staff were careful to place the handset to the side not connected to the dialysis machine, this ensured patients were able to call for help if they required. During the inspection, we saw that staff answered patients' needs promptly, including alarms on dialysis machines. The staff assisted patients with warmth and compassion and gave reassurance where needed.
- The privacy and dignity of patients was prioritised. The curtain and screen system and space around the bed spaces was more than was needed to ensure conversations were not overheard and patients had privacy.
- We spoke with patients who told us that 'staff were fantastic', and 'would go out of their way to help with anything.' Of 28 'tell us about your care' cards, there

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were 22 wholly positive responses with comments, 'since my arrival I have been treated with exquisite care and understanding especially in regards to my younger age being slightly isolating throughout my illness. The staff have shown no limit in empathy and I owe them much of the credit regarding my optimism and recovery', 'The nurses are caring and treat me with just the right balance of dignity and respect and a cheerful friendship. Important as I will spend over 5 hours, three times a week.' 'their proficiency as dialysis practitioners is amazing, their time management is superb – but invisible. 'clinical and hygiene standards 10/10 – not one adverse criticism.' The six mixed responses highlighted issues with temperature of the unit, transport delays and one report about staff attitude that we escalated to the unit manager.

- The unit had consultation rooms where patients could have confidential discussions about their care with any members of the multidisciplinary team should they so wish.

Understanding and involvement of patients and those close to them

- We observed the use of a named nurse approach and nurses had a caseload of patients and built relationships over a long period of time. This fostered familiar yet professional communication between patients and staff in the unit. The named nurse was responsible for ensuring patients had updates about their treatment plans and blood results after the monthly MDT meeting or at any other review by consultant staff.
- Staff told us that patients were encouraged to be as involved in treatment as possible. There was a comprehensive Fresenius Medical Care, 'patient and carer shared and self-care training checklist' which guided three supervised assessments by a nurse with the patient of each step of treatment. It included clear consent and sign off of understanding in the document. We did not review any patients using the shared care process during the inspection but observed patients being offered opportunities to be involved in their care such as, removing needles after treatment and self-weighing prior to treatment
- We spoke with a patient who had been supported to take holidays and receive dialysis treatment in other

units and they described this as being organised very well. During inspection we observed arrangements being made to help celebrate a patients birthday with friends and family. A birthday cake had been ordered and other patients in the unit were involved in celebrations. We observed nursing staff supporting a patient with sight impairment to listen to the radio during treatment.

- The unit collected feedback through a 'Tell us what you think' anonymous leaflet system which allowed patients to comment on the service using freepost direct to Fresenius Head Office. Results or actions from this feedback were not available in the unit.

Emotional support

- Staff we spoke with were aware of how to access additional support for patients and liaised in partnership with the consultant nephrologist and a social worker allocated to the renal unit NHS trust. We spoke with patients who described the social worker role as valuable and based on a flexible appointment system. One patient told us that if you had any issues "she would sort everything out."
- Care plans, and care pathways were individualised in detail with assessment of patient's emotional, social, cultural, spiritual, psychological and physical needs. It was clear that nurses took opportunity to keep patients informed about their care, involving them and their families in decisions and ensuring that they have the opportunity to participate in their own care.
- The renal consultant was able to refer patients to the renal counselling service based at Hull and East Yorkshire hospitals.

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 provided dialysis treatment for the patients of the Lincolnshire area, The unit had 16 dialysis stations.
- Patients were referred to the unit for their haemodialysis treatment from the parent NHS trust

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renal unit. The unit had eligibility criteria to ensure that patients were physically well enough for satellite treatment and lived in the local area. The unit provided a flexible service to local patients. Patient treatment was established at the NHS trust renal unit and they then referred to the local satellite unit.

- The unit was commissioned by the local clinical commissioning group (CCG) and contracted by the parent NHS organisation to provide satellite dialysis as part of a defined specification. Senior unit staff attended business meetings at the parent NHS trust to manage the service and ensure that key performance indicators were being met.

Access and flow

- The unit used an appointment system which staff we spoke with said ensured structure, timeliness and minimises delays as far as possible. The unit offered a flexible approach to the patient's dialysis sessions changing dialysis days and or times as far as possible to accommodate external commitments, appointments or social events the patients may have. Sometimes this may necessitated a dialysis session being relocated to the referring hospital.
- Referrals for admission were directed by the consultant nephrologist team at the NHS trust renal unit, who would contact the unit, usually the unit manager, to inform the team that they had a new patient for admission
- There was no waiting list for treatment at the unit and staff we spoke with said that this was consistent.
- The utilisation of capacity in the unit in the 3-month reporting period was as follows: November 85%, December 89% and January 86% and so had spaces to accommodate for holiday treatment sessions for people stating in the local area, provided this had been medically approved and there was session availability and all relevant information was available.
- The unit had not cancelled or delayed any dialysis sessions for non-clinical reasons in the 12 months prior to the inspection.
- There had been 23 patient transfers to the NHS in the reporting period April 2016 to April 2017. Staff we

spoke with said that all the transfers were necessary and we reviewed an informal log kept by the clinic manager, however there was no detailed analysis or benchmarking of this information.

- Access to the unit was good, and patients could park directly outside the unit.
- Transport of patients was via a specific contract and patients we spoke with did not have any issues with transportation at this unit. We observed patients waiting for short amounts of time before and after dialysis treatment on both the announced and unannounced inspection.

Meeting people's individual needs

- Staff encouraged and supported patients to arrange dialysis away from base and welcomed patients to the unit for temporary holiday treatment providing medical approval was given and all pre-assessment checks had been made, in addition to having dialysis session availability.
- We observed good access to facilities in the unit, which was spacious and modern in design with good provision for people with individual needs. We observed wheelchair users being supported with access to treatment and facilities. We observed the use of pressure relieving mattresses and the unit had access to a bed for patients who were not comfortable in the reclining chairs.
- Patients had access to Wi-Fi, personal televisions in each bed space and reading materials of their choice. Patients were supported to bring anything in from home to alleviate any boredom during their dialysis treatment session.
- Scunthorpe NHS Dialysis unit provided haemodialysis treatment to patients by following an individualised treatment prescription. Changes to prescriptions were made during multi-disciplinary meetings. The outcome of the meetings and changes to care were discussed with the patients and provide a responsive approach.
- Patient information was available in four main languages but staff we spoke with said they were able

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to obtain information in other languages or larger print if required. Access to interpreter services was made through the NHS trust switchboard and staff we spoke with knew how to access when needed.

- The unit had an acceptance criteria and policy which was designed to be open and inclusive, accepting patients over 18 years, had functioning haemodialysis vascular access, were clinically stable for satellite treatment and had medical approval. Staff requested these details as part of pre-transfer assessment to ensure all care needs could be met and transfer to the unit was safe with full communication with the patient and carer or family.
- Patients did visit the unit as part of the pre-assessment clinic prior to commencement of treatment to familiarise themselves with facilities, staff and routine.
- Senior and junior nursing staff we spoke with told us that the patient would be allocated a dedicated dialysis appointment time which considers: Social care and work commitments, day appointment availability for the elderly, vulnerable or those with more complex care needs, length of journey to the unit and number of hours or days of dialysis the patient was prescribed as part of their care plan.

Learning from complaints and concerns

- The unit had a process and complaints policy that addressed both formal and informal complaints that were raised via the clinic manager. The Fresenius complaints process was displayed in the waiting area. The patient advice and liaison service (PALS) at the NHS trust had produced leaflets and posters to guide patients about the complaint process and these were visible in the reception area.
- In the reporting period, April 2016 to April 2017 the unit had received one formal complaint which was managed under the organisational formal complaint procedure and ten written compliments. 'Tell us what you think' leaflets were available for patients and these encouraged patients to make comments, raise concerns or compliments to be shared.
- It was the responsibility of the clinic manager or deputy clinic manager to ensure all complaints were sympathetically dealt with within maximum 20

working days. The clinic manager spoke in detail of the one formal complaint with the steps taken, including the involvement of the consultant to ensure a good outcome for a patient receiving treatment in the unit. The example given to inspectors demonstrated a patient centred approach.

- Staff we spoke with could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required.
- Staff we spoke with recognised that lessons for continuous quality improvement for people using the service might develop as a direct result of concerns or complaints. The approach was said to mirror the NHS approach.

Are dialysis services well-led?

Leadership and culture of service

- Nursing staff we spoke with told us that senior leadership was consistent with good levels of visibility and support; this included the support given from the regional and national team. All staff we spoke with told us that the clinic manager was caring and listened to staff concerns. There was clearly a high level of professional respect and regard for the clinic manager amongst all levels of staff in the team at Scunthorpe NHS Dialysis Unit.
- Consultant staff we spoke with corroborated the team approach and strength of the local leadership in the unit. There was a culture of patient centred care and continuity for patients was a priority.
- The unit team told us they held regular team meetings, staff we spoke with said these were planned and fairly well attended. Meeting minutes we reviewed which spanned 2016/17 confirmed good discussion and consistent agendas.
- There was a clear leadership structure in the Fresenius Medical Care organisation and that was applied regionally to the Scunthorpe NHS Dialysis unit. Local leadership was reflected in a regional business manager position and area head nurse, who would be unit based approximately once or twice a week.

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The clinic manager was based in the unit for 100% of the nursing job role. There was a deputy clinic manager and one team leader in senior positions in the unit. Senior staff were present during inspection. The clinic manager was also present during the unannounced inspection.

- Morale amongst nurses was described as good. A positive working culture was evident from staff interviews, observations and survey information.
- Staff described their peers in a positive way and spoke about them supporting each other. The senior management team said they were proud of the staff working within the unit.
- The culture and leadership within the unit represented the vision and values of the organisation, encourage openness, transparency, and promote quality care. At ward and department level, staff we spoke with described the culture as open and supportive.

Vision and strategy for this this core service

- Fresenius Medical UK in partnership with the NHS trust renal unit had a clear vision and strategy with quality and safety at the top of its priority. It was expected that this was cascaded to the local team through business and clinical meetings, and staff training and updates. The Fresenius Clinical Governance strategy document described a framework that the team used to deliver 'the right care to the right patient at the right time.'
- The senior team at regional and local level were aware of the strategy and values for achieving priorities and delivering good quality care, however staff we spoke with in the unit did not have a clear understanding on the day of inspection. There was a consistent approach to display of the values and strategy and they were included in induction and appraisal.
- The unit had a corporate vision for the service to improve the quality of life for nephrology patients. The unit also had a culture and quality statement. This was displayed on the walls of the waiting area.

Governance, risk management and quality measurement

- The unit had a newly developed electronic national and local risk register, which appeared comprehensive

and a much improved approach. This was part of a process that was being developed at a corporate level in Fresenius Medical Care UK. We reviewed comprehensive risk assessments that were complete and in date and thorough. The risk assessments reflected most risks and issues at the unit. Senior staff we spoke with did not have a full understanding of the risk register as it was still under development. Local and emerging risks were being included, for example, identification of patients.

- The clinical risk management policy was also under review to reflect the changes being made across the organisation to reflect local risk comprehensively in locations. It had previously included detail about risk management principles and risk assessment processes, however there was no evidence in the current policy to suggest that there was a corporate or local risk register.
- The business strategy meeting was well attended at the NHS trust and the clinic manager was involved in monitoring progress in delivering the strategy. The use of dashboards had been recently introduced for monitoring of performance and had not been embedded into practice or cascaded to all staff.
- The unit local meeting was consistent and the agenda and content supported governance of risk and quality at a local level with the nursing team. The meeting focussed on business around infection control, health and safety and environmental issues.
- There was a nominated NHS consultant nephrologist clinical lead for the unit. The team met quarterly to review unit performance against key performance indicators (KPI's), we reviewed one set of KPI's from November 2016 which gave good detail of both achievements and areas of underperformance. The meeting was attended by the regional business manager, area head nurse and clinic manager, along with key trust staff.
- There was a clinical governance committee as part of the Fresenius Medical Care group strategy. The clinic manager was responsible for monitoring and leading on delivering effective governance and quality monitoring in the dialysis unit, supported by the wider Fresenius management team. Data was collected by

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the clinic manager and reported monthly to the trust team where it was input to the UK renal registry. It was through this process and shared meetings that validation of audit results and benchmarking occurred

- The Workforce Race Equality Standard (WRES) is a requirement for organisations which provide care to NHS patients. This is to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
- WRES has been part of the NHS standard contract, since 2015. NHS England indicates independent healthcare locations whose annual income for the year is at least £200,000 should have a WRES report. This means the unit should publish data to show they monitor and assure staff equality by having an action plan to address any data gaps in the future.

Patient and staff engagement

- The unit participated in the Fresenius employee satisfaction survey November 2016 that measured the staff's satisfaction at Scunthorpe NHS Dialysis Unit. The unit compared the results against the average NHS staff satisfaction data. A greater number of staff at 80% would recommend the unit to friends and family requiring dialysis, against a 69% NHS response. A smaller number of staff would recommend their dialysis unit as a place to work at 30% than the NHS 52% score for the same question.

- The unit participated in the Fresenius national patient survey 2016 that measured the patient's experience of care. The response rate was 58% better than the national average of 55%. The survey also asked, did the patient have complete confidence in the nurses and 88% said that they did. The survey asked whether patients thought the unit was friendly and happy and 95% patients responded that it was.
- Within the unit, no patient representative was available on groups or committees despite attempts from staff to recruit patients to this role. However, the clinic manager worked closely with local renal groups and representatives from the unit were members of these groups.
- We received 28 comment cards from patients with 22 overall positive responses to include personal comments about staff and the individual care given. Of six responses that were not wholly positive, patients expressed concern around parking, and transport issues.

Innovation, improvement and sustainability

- The team had taken feedback from early inspection findings and begun to implement a plan for improvement around, ID of patients and local risk registers.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- Ensure that incident reporting is clearly graded for severity of harm, and staff understand the moderate harm trigger to support the application of the duty of candour regulation.
- Ensure unit staff have access to a nominated safeguarding children lead with level 4 training.

Action the provider **SHOULD** take to improve

- The provider should ensure that all risks relevant to the hospital are recorded on the risk register.
- The provider should ensure that performance information is collected is used for benchmarking.
- The provider should ensure that the system in place to allow staff to identify patients receiving care and treatment is embedded into practice for all staff to include the requirements for administration of medications.

- The provider should ensure that the workforce and race equality standards (WRES) are implemented in full.
- The provider should ensure that a recognised early warning score reflecting the risks of the dialysis patient is implemented to prompt recognition of the deteriorating patient.
- The provider should consider the value and implementation of sepsis toolkits and specific pathways.
- The provider should add and revise the review dates for policies and procedures.

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	<p>Regulation 20 HSCA (RA) Regulations 2014 Duty of candour</p> <p>20 (1) A health service body must act in an open and transparent way with service users in carrying on a regulated activity. (7)</p> <p>How the regulation was not being met:</p> <p>There was no grading of 'moderate' harm in incident reporting policy. Staff we spoke with did not have a clear understanding of moderate harm triggers for duty of candour. This means that the duty of candour would not be triggered for moderate harm that requires (a) a moderate increase in treatment, and (b) significant but not permanent harm.</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>13 (2): Systems and processes must be established and operated effectively to prevent abuse of service users.</p> <p>How the regulation was not being met</p> <p>There was not a member of staff who had received training in safeguarding at level 4 for the team to contact for advice and escalation of safeguarding concerns within the organisation.</p>