Renal Services (UK) Limited

Renal Services (UK) Ltd -Poole

Inspection report

The Fulcrum Centre
Vantage Way
Poole
BH12 4NU
Tel:

Date of inspection visit: 24 March 2021
Date of publication: 08/06/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

This was our first inspection of this service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff were supported to complete training in key skills and understood how to protect patients from abuse. Staff assessed risks to patients, acted on the assessed risks and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients opportunity to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to suit patients' needs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders had skills and abilities to run the service. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. All staff were committed to improving services.

However:

- The service did not always operate an effective system to ensure they met duty of candour requirements after a notifiable incident.
- The control of systems and processes for governance was limited by the contractual arrangements with the commissioning NHS trust.
- Leaders and teams used systems to manage performance but actions for improvement were not clearly identified.
- Staff did not always follow systems and processes to safely prescribe, administer, and record medicines. Staff were observed preparing, checking and administering the medicine at the same time, increasing the risk of error. Storage for medicines was not well organised and we found expired medicines.
- Staff compliance with mandatory training had been delayed due to the COVID-19 pandemic and was below target levels. However, the service had a strategy to improve training compliance.
- The service did not always control infection risks well. There had been some potential infection control risks during COVID-19. The service had learnt from the incident and practices had been improved as a result.
- Staff did not use a standardised tool to identify when a patient's general condition was deteriorating. They did not record and manage patient risks from deteriorating conditions other than sepsis. Actions staff took relied upon their knowledge and experience. However, the service had a plan to introduce a standardised tool to assess general deterioration.
- Not all staff followed the policies of the service in some clinical procedures. We saw examples of staff carrying out an aseptic non touch technique and insertion of a vascular access device which did not follow the standard operating procedure of the service.
- There had been reduced patient feedback options for over 12 months because of the COVID-19 pandemic and there was no evidence actions had been identified based on patient feedback surveys.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis services	Good 	This was our first inspection of this service. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff were supported to complete training in key skills and understood how to protect patients from abuse. Staff assessed risks to patients, acted on the assessed risks and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. • Staff provided good care and treatment, gave patients opportunity to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to suit patients' needs. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders had skills and abilities to run the service. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. All staff were committed to improving services. However:

Summary of findings

- The service did not always operate an effective system to ensure they met duty of candour requirements after a notifiable incident.
- The control of systems and processes for governance was limited by the contractual arrangements with the commissioning NHS trust.
- Leaders and teams used systems to manage performance but actions for improvement were not clearly identified.
- Staff did not always follow systems and processes to safely prescribe, administer, and record medicines. Staff were observed preparing, checking and administering the medicine at the same time, increasing the risk of error. Storage for medicines was not well organised and we found expired medicines.
- Staff compliance with mandatory training had been delayed due to the COVID-19 pandemic and was below target levels. However, the service had a strategy to improve training compliance.
- The service did not always control infection risks well. There had been some potential infection control risks during COVID-19. The service had learnt from the incident and practices had been improved as a result.
- Staff did not use a standardised tool to identify when a patient's general condition was deteriorating. They did not record and manage patient risks from deteriorating conditions other than sepsis. Actions staff took relied upon their knowledge and experience. However, the service had a plan to introduce a standardised tool to assess general deterioration.
- Not all staff followed the policies of the service in some clinical procedures. We saw examples of staff carrying out an aseptic non touch technique and insertion of a vascular access device which did not follow the standard operating procedure of the service.
- There had been reduced patient feedback options for over 12 months because of the COVID-19 pandemic and there was no evidence actions had been identified based on patient feedback surveys.

Summary of findings

Contents

Summary of this inspection

Background to Renal Services (UK) Ltd -Poole

Renal Services (UK) Ltd – Poole provide regular dialysis to patients living in Poole and the surrounding area. Renal Services (UK) Limited, an independent healthcare provider, has operated Poole dialysis centre since October 2019. This was the first inspection of the service since its registration with the CQC.

The location has a waiting area, clinic rooms, 24 treatment stations including three side rooms with bathroom facilities and two self-care stations for use in the future. It offers each patient three dialysis treatments in each week and can treat up to 120 patients a week. The unit is open Monday, Wednesday and Friday from 7am to 12 midnight and Tuesday, Thursday and Saturday from 7am to 6.30pm. The local NHS trust commissions the dialysis service for patients who are established on regular dialysis. Consultants from the NHS trust lead the care and treatment for their patients and use the dialysis service at Poole. The consultants prescribe treatments and there is a contract of what the trust commissions from the dialysis service.

The service is registered to provide the regulated activity of treatment of disease, disorder and injury.

The service has had a registered manager since its registration.

There was an outbreak in January 2021 of COVID-19 in the Dorset region which affected 40 dialysis patients and four staff. This caused concern about safe management of infection and potential risks to patients who used the service. This prompted an inspection of the service.

How we carried out this inspection

We visited the service on 24 March 2021. We spoke with staff on the unit, patients who were receiving dialysis, reviewed patient care records and observed clinical practice. Over the following two weeks we spoke with staff from a partner organisation and reviewed a range of documents including staff personnel files, policy documents and a variety of information about governance and complaints management.

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

Areas for improvement

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with one legal requirement.

- The service must ensure medicines are stored in a way that reduces risk of staff error and out of date medicines are disposed of. (Regulaton12(1)(2)(g))
- The service must ensure all staff follow safe practices when administering medicines to patients and medicines are prepared at the time they are to be administered. (Regulaton12(1)(2)(g))
- The service must provide staff with a standardised tool for early identification and management for when a patient's condition is deteriorating. (Regulaton12(1)(2)(a))

Summary of this inspection

- The service must take responsibility, as the registered persons carrying on the regulated activity, for informing patients of incidents that may affect patient well-being and offering an apology. This must be in line with duty of candour regulations and be completed at the earliest opportunity, even if the reasons are not fully known. (Regulation 20(2)(3))

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

- The service should continue supporting staff to complete mandatory training.
- The service should consider documenting risks to patients of thromboembolism (clotting) or bleeding on patient records for staff to review.
- The service should consider how to ensure all staff follow their policies and that policies are relevant to current best practice. This includes techniques for infection prevention and control and techniques for vascular access.
- The service should consider how it demonstrates improvements have been made with a clear audit trail of improvement actions, reviews and completion dates.
- The service should consider how it gains patient feedback and involves patients in designing service delivery and improvement.
- The service should operate systems and processes for good governance. These systems should allow the service to assess, monitor and improve the quality and safety of the services provided when carrying out the regulated activity, and mitigate the risks relating to health, safety and welfare of service users which arise from carrying on of the regulated activity. Renal Services UK Limited and their Poole location should be responsible and accountable for the governance for the regulated activity.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dialysis services	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Dialysis services

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are Dialysis services safe?

Requires Improvement

This was the first inspection of this service. We rated it as requires improvement because:

Mandatory Training

Staff were not all up to date with mandatory training. However, the service were supporting staff to improve their mandatory training compliance in key skills required for their role. Managers monitored staff attendance at training using a tool which identified individual modules such as basic life support, fire safety and incident reporting. Staff compliance had reduced due the increased demands on time during the COVID-19 pandemic. Managers were monitoring this and there was 50% compliance at the time of our visit. Managers had created an action plan which included a trajectory showing 100% of staff would be up to date with mandatory training by the middle of April 2021. Staff were supported to attend modules with time and equipment allocated.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Safeguarding was included in mandatory training modules, which met national guidance. Staff compliance was above the provider's target of 85%. Staff described occasions they had identified concerns about patient safety and risk of abuse, and appropriately referred patients to the local authority safeguarding team. They had received information on the outcomes of concerns they had raised. The service worked with other agencies such as the local police if they had concerns about patient welfare. The location's provider followed recruitment policy when employing new staff which included disclosure and barring service checks and following up of references. Equal opportunity and diversity training was a mandatory requirement for staff to attend to prevent discrimination.

Cleanliness, infection control and hygiene

The service did not always control infection risks well. There had been an outbreak of COVID-19 amongst patients who attended the dialysis unit in January 2021 when 40 dialysis patients tested positive between 2 January and 2 February 2021. The service worked closely with the commissioning NHS trust and sought advice from them about infection prevention and control practices. Routine practices to prevent cross contamination between patients before

the COVID-19 outbreak included; assessing any COVID-19 symptoms before each treatment, encouraging patients to maintain two metre distancing in treatment areas and waiting areas and cleaning of all equipment used between patients. Following this outbreak, new infection prevention control systems had been introduced to control any further transmission between patients and staff. Actions taken were to introduce a one-way route through the unit for patients, organising patients into cohorts by attending the same weekly sessions and COVID-19 testing of patients and staff. Cleaning audit frequency was increased and we saw staff followed the new protocols and were reminded where compliance fell below expected standards. Following our visit managers told us how they tracked patients when in the unit. The electronic patient record showed which location patients used for their treatment. There had been no further incidences of COVID-19 positive patients since 2 February 2021.

Staff used learning from the COVID-19 outbreak to improve practice in controlling infection risks. We saw staff used equipment and control measures to protect patients, themselves and others from infection in most cases. Equipment was readily available for staff to use. There were adequate supplies of personal protective equipment (PPE) which staff used appropriately when in contact with patients. Managers observed staff compliance with using PPE according to national guidance in preventing transmission of COVID-19. Observations were documented on audit tables and fed back to staff individually and at team meetings. Managers reminded staff about correct use of PPE and of being bare below the elbow to ensure infection prevention and control procedures were complied with.

Environment and Equipment

Equipment was used in a way that reduced the risk of infection most of the time. However, not all staff followed standard operating procedures all the time. Staff were trained in procedures used for dialysis patients and were assessed for competency in specific activities. Managers audited staff compliance and informed staff of results. We observed one occasion when staff did not follow the service policy when using aseptic non touch technique. This created a risk of staff using contaminated equipment for what should have been a sterile procedure.

Staff kept equipment and the premises visibly clean. We visited all areas of the unit and observed them to be clean. Audits were undertaken of cleaning standards. Results were fed back to staff immediately for any areas they needed to improve on. These audit results were not collated into formal improvement plans, but actions managers took included increasing audit frequency which demonstrated improved staff compliance. For example; cleaning of chairs needed to be improved and audits, which had been increased in frequency, showed improvement in cleaning standards.

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use facilities and equipment and managed clinical waste well. The premises had undergone a major refurbishment programme which had been completed in January 2021 and had increased the number of dialysis stations available to 28. Facilities were designed to support patients while they were undergoing dialysis. This included space between dialysis stations, three side rooms with bathrooms for patients who needed them, spacious waiting area and clinical areas which were inaccessible for patients. Staff used the facilities to maintain patient safety. Waste and clinical specimens were segregated and stored safely away from patient access until they were collected. A clean treatment room was used by staff and was inaccessible to patients. Emergency equipment was easily accessible for staff and was checked daily when the unit was open. There was a schedule of maintenance for equipment and staff could access additional maintenance and equipment if equipment malfunctioned. We saw equipment had been safety checked within recommended time scales. Staff commented the response from the external provider who maintained equipment was prompt. There was a documented schedule of water testing in the unit. Dialysis sets were single use and disposed of once used. Staff received training with each piece of equipment they used, and their practice was observed and audited. Where compliance fell below the expected standard staff were informed of improvement needed.

Good

Dialysis services

Assessing and responding to patient risk

Staff completed and updated most risk assessments for each patient and removed or minimised risks. Risk assessments were completed for each patient when they first accessed the service and were updated regularly. These included risks of falling, pressure ulcers, sepsis, blood borne viruses, COVID-19 and mental health. Risks for patients of venous thromboembolism (clotting) or bleeding were assessed by trust clinicians who prescribed anticoagulation therapy. Staff followed the standard operating procedure to screen patients for ongoing bleeding or clotting risks before and after each therapy session. This was documented on the patient record**.** If risks of continuing with treatment were too great, further advice would be sought from the consultant overseeing the patient's care. However, records we reviewed showed staff did not document risks and actions taken for patients regarding thromboembolism (clotting) or bleeding on individual patient records. We raised this with managers who confirmed they did not record this risk and would review their processes.

Staff identified and acted upon patients who were at risk of deterioration, and used a tool to identify suspected risk of sepsis. **However, staff did not use a standardised tool to identify when a patient's general condition was deteriorating.** Patients' conditions were monitored before, during and after dialysis, which followed the service's policy. Actions staff needed to take to prevent further deterioration relied upon staff recognition based on their knowledge and experience. We saw senior nurses supporting more junior nursing staff to recognise when a patient needed more support. Staff followed the service's protocol to call an ambulance for further clinical support and treatment for the patient. These events were reported as incidents for investigation and learning. The corporate provider managers were in the process of introducing a national early warning scoring system (NEWS2) to their units. This was a tool which would support staff in identifying and managing patients whose condition was deteriorating. This was planned for the Poole unit in May 2021.

Staffing

The dialysis unit was nurse led and had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. Staff numbers were planned to meet the needs of patients booked into the unit and were in line with national guidance. Each shift was staffed with four registered nurses who were trained in dialysis, with two health care assistants and two assistant practitioners for 24 patients. At times of unexpected absence staff used a bank of nursing staff who were familiar with the unit. Twice daily staff handovers were comprehensive and updated staff on risks and specific patient needs. Medical oversight and advice was available by contacting the commissioning trust renal service.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. Staff used a combination of paper and electronic patient records. The electronic record was comprehensive and available for staff who needed access, including relevant staff at the local NHS trust. The shorter paper record was kept and updated at the patient dialysis station. We reviewed three patient records and found they were comprehensive and regularly updated by staff.

Medicines

Staff did not always follow systems and processes to safely prescribe, administer, and record medicines. Medical staff from the local NHS trust who had oversight for patient treatments, prescribed medicines using an

electronic system. We saw staff did not always follow the service's policy. The policy states medicines should be checked at time of administration and by the nurse who would administer it. We saw staff following the electronic patient prescription record and two staff checking each prescription. Two nursing staff checked two patient medicines with the prescription but then stored the medicine in the patient notes until it was due for administration. One nurse transported the medicine from the nursing station to the patient paper records, in their pocket. There was no assurance the same nurse who checked the medicine, administered it to the patient. This practice increased the risk of error. Senior staff took immediate action when we informed them of our observations.

Medicines were stored securely. However, they were not well organised, and we found expired medicines. Medicines were stored securely in a locked cupboard and within a locked room. However, we found a variety of medicines stored in two baskets within the cupboard. This storage method increased the risk of staff picking up the incorrect medicine. Staff checked the room and fridge temperatures daily when the unit was open and were aware of action needed if outside of acceptable ranges. Medicines were also stored in the emergency trolley. Staff checked the emergency trolley daily and logged checks had been completed. We found a box of medicines held on the emergency trolley, which had expired by nearly one month and were beyond their expiry date of 28 February 2021. The lead nurse took immediate action to replace the medicines when informed of the discrepancy and added expiry dates to the check list. Staff followed the service's policy and prior to administration of medicines checked patient identity verbally, using three forms of identification such as date of birth, name and address. Monthly medicines' audits we saw, included storage and staff administration. However, these audits had not identified the risks of disorganised storage. The service had no dedicated pharmacy support but could access the local NHS trust for advice if they needed it.

Incidents

The service used a system to report, investigate and learn from patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. The service had an electronic system to record incidents which notified relevant managers, gave guidance on next steps and kept a record of actions taken with due dates for completion of actions identified. Learning from incidents was shared at unit and service level meetings. Information was shared at these meetings from incidents at other locations the provider managed. Incidents reported included near misses. The dialysis unit had not informed and apologised to patients and relatives for any infection which had been potentially acquired at the unit. However, staff at the dialysis unit were supporting the NHS trust who were investigating the source of the COVID-19 outbreak, which occurred during a COVID-19 surge in the community. This included occasions when patients shared transport, attended during twilight sessions and patient route through the unit. We saw an action plan to reduce risks of transmitting COVID-19 between anyone attending the dialysis unit following the outbreak in January 2021.

Managers ensured actions from patient safety alerts were implemented and monitored. The provider disseminated National Patient Safety Alerts to managers of dialysis units. These alerts were assessed for actions needed at each clinic and cascaded to staff where relevant to the clinic.

The service monitored results to improve safety. Staff collected safety information and shared it with staff. Variances during treatment were monitored and shared with staff and used to identify where improvements could be made for patient safety. These were reported and reviewed at clinical governance meetings and cascaded to staff in the unit. There was a theme of more frequent patients not attending for treatment. Actions staff needed to take were reinforced to maintain patient safety. This included staff contacting patients, investigating possible reasons for non-attendance and ensuring patients were aware of the consequences of missing a dialysis treatment.

Good

Dialysis services

Are Dialysis services effective?

Good

This was the first inspection of the service. We rated it as good because:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers monitored patients' clinical outcomes in line with the Renal Association Standards and National Institute for Health and Care Excellence guidelines (NG107). Staff followed procedures for ensuring arterio-vascular fistulas remained patent. Managers reviewed incidences when deviation from prescribed treatments was required. For example, if a patient was hypotensive on arrival and needed to have treatment adjusted and patients that did not attend for planned treatment. This information was collated and reviewed every three months to identify trends. Staff discussed patient variances with clinicians from the local NHS trust each month. Managers checked to make sure staff followed guidance. Managers carried out a programme of audits and fed this back to staff.

Patient Outcomes

Staff monitored the effectiveness of care and treatment. Clinical discussions took place each month between staff from the host trust and the unit at Poole, regarding patient treatments which were based on individual patient blood results. The NHS trust used audit data from the dialysis unit as part of their contribution to the UK Renal Registry. They used the findings to make improvements and achieve good outcomes for patients. The clinic manager monitored the number of patient variances to assess where improvements could be made. Patient variances are where treatments provided have been altered from the prescribed treatments. Staff monitored the reasons for the variances such as patient did not attend or clinical need, discussed them with the clinicians and took action to reduce any further variances where possible. Between May 2020 and February 2021, variances ranged from 3.72% to 8.71% for their patient group, which was similar to other dialysis units in the region but had no national target.

Staff protected the rights of patients subject to the Mental Health Act 1983. Staff received training on the rights of patients and knew where to access support for patients and their relatives. If their mental health made it inappropriate for treatment at the unit in Poole, patients would be referred to the host trust for more support.

Nutrition and hydration

Patients had access to food and drink. Patients were advised to bring food and drink with them if they needed it. This was a new process during COVID-19. Before this time staff were able to provide snacks and drinks if needed. Providing food and drinks was considered to increase the risk of transmitting COVID-19. Patients could access specialist dietary advice and support from dietitian services at the local NHS trust. Before COVID-19 a dietitian visited the unit regularly. This had become a remote advice service during the pandemic and patients could access the service face to face, if they attended the NHS renal service.

Pain relief

Good

Dialysis services

Staff assessed and monitored patients regularly to see if they were in pain and took action to relieve discomfort in a timely way. Patients who attended the unit were able to communicate and we saw staff monitored non-verbal signs of discomfort for each patient.

Competent Staff

The service made sure staff were competent for their roles. Managers appraised staff work performance and held supervision meetings with them to provide support and development. Records of induction and training in renal dialysis nursing were kept in staff personnel files. These showed detailed modules of training, which staff had completed, observation of practice and assessment of their competence by a senior staff member, annually. There was good compliance with attendance at the dialysis modules, reaching over 86%. Standard operating procedures and competency documents were in line with recommendations from the British Renal Society and with the host NHS trust using their service. Staff who wanted to broaden their skills were encouraged to apply to the service to attend university led training in renal care. At least five staff had achieved university accreditation and rotas included one of these staff for each shift where possible. However, we observed one example where the standard operating procedure was not followed completely by staff. This was during the commencement of treatment when accessing the blood vessel. National guidance from the British Renal Society describes processes for two methods of vascular access: dry needling (no flushing needed) and wet needling (0.9% saline flush). The training and assessment documents and standard operating procedure used by the service followed the wet needling technique. Staff had used the dry needling technique which was not in line with the standard operating procedure for the service. Staff had not clamped the device to prevent air entering the blood vessel which was not in line with national guidance. Managers were aware of variations in practice used by staff but had not taken action to ensure all staff followed their standard operating procedures. All other practice we saw followed the service's policies.

Multidisciplinary working

Renal Service (UK) Poole nursing staff worked together as a team, and with doctors and other healthcare professionals from external providers, to benefit patients. They supported each other to provide good care. Staff investigated reasons that patients did not attend their appointments. Staff analysed patients' blood results and liaised with clinical staff about patients' risk factors and provided patients with advice on their best care options. Staff had link roles in other areas, such as infection prevention and control and acted as a resource for staff at the unit by sharing knowledge between trust, provider and renal specialty organisations.

Health promotion

Staff gave patients practical support and advice to lead healthier lives. Staff discussed healthy lifestyle options with patients during their dialysis. Leaflets were available for patients to read and take away with them. Patients were advised to monitor their own weight and fluid intake outside of the dialysis sessions.

Consent, Mental Capacity Act and DOLs

Staff supported patients to make informed decisions about their care and treatment. **They followed national guidance to gain patients' consent**. We saw staff ensuring they had current consent for the dialysis session and associated procedures. They knew how to support patients who lacked capacity to make their own decisions or were

experiencing mental ill health. Staff were trained in the Mental Capacity Act and understanding of patients living with dementia. Staff described scenarios when patients could make unwise decisions and supported them with being fully aware of consequences while respecting the decision. Patients who needed additional support for mental well-being, were referred to the host NHS trust.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system they could all update. This was accessible by the trust and the dialysis unit, contemporaneously.

Are Dialysis services caring?

Good

This was the first inspection of this service. We rated it as good because:

Compassionate Care Quality Commission

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. We saw patients being greeted by staff with respect. Staff listened to patients and gave them time to settle down for their treatment. The unit had a calm atmosphere and TVs and music were available to relieve any boredom. There was enough space between treatment chairs, curtains were individual for each chair and there was enough background noise to create privacy in conversation between staff and patients. If patients needed privacy there were three side rooms which could be used and other private areas suitable for confidential conversations. During COVID-19 patients were discouraged from changing their sessions. This was to reduce risks of disease transmission. However, staff supported patients to feel comfortable and listened to their concerns.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. We saw staff spending time with patients and discussed their needs. Patients who expressed concerns were able to discuss them with staff. We heard how treatments had been adjusted to support patient choice. Patients could bring items into the unit for their comfort. We saw this included their choice of refreshment and blankets/throws from their home. Staff were empathetic towards patients who were emotionally challenged when attending regular dialysis sessions. Staff put patient care before themselves and remained responsible for their care during the session. Psychological support was available from the NHS trust renal service.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff recognised when patients were finding it difficult to attend dialysis sessions and supported patients and their relatives to understand their treatment options. Some patients decided to reduce or withdraw from treatment. They

made these decisions with support from staff who could offer further referrals for ongoing care. Patients felt informed of their treatment choices and how to get more information. Patients attended appointments at the NHS trust for consultations with the clinician overseeing their treatment. Staff developed information leaflets for patients, to support discussions and to raise awareness of risks if they missed dialysis.

Are Dialysis services responsive?

Good

This was the first inspection of this service. We rated it as good because:

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The service was commissioned on behalf of patients who attended the local NHS trust. Patient numbers were set out in an agreement with the local NHS trust and further patients were not accepted by the service unless staff were available to care for them. The refurbishment of the unit had increased the number of dialysis stations by three and incorporated space for use as a minimal care unit (an area where patients received training and support to promote self-care). Trust staff were not using it at the time of our visit, but plans were for this to progress. Office spaces and clinic rooms were available for trust staff to use and see patients. The trust organised transport for patients to and from dialysis sessions. Taxis were able to drop patients close to the unit entrance and patients in cars could park near the unit. Staff said they had not experienced any issues with patients being delayed due to transport issues. The design of the unit allowed patients to access the unit through a level entrance and automatically opening doors, remain two metres distance from other patients and to use toilet facilities before and after dialysis. The nursing station was always staffed, and its location provided good overview of patients in the unit. Dialysis chairs were adjustable for patient comfort and staff supported patients to maintain their comfort.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. Dialysis sessions were usually of four hours duration. The same staff stayed with the patient during their session. Staff discussed patient care with renal clinicians and explored how to provide treatment in collaboration with patients and taking into account patient preferences. This was sometimes to increase or decrease the number or length or dialysis sessions. If patients' needs were complex, they would be discussed with clinicians who oversaw their care and referred to the NHS trust if needed. Before COVID-19 the service supported patients to find dialysis services in their holiday location. However, this had not been needed since the national travel restrictions in response to COVID-19. Language support was available from systems used at the NHS trust which commissioned the service and leaflets were available at the Poole dialysis unit.

Access and flow

People could access the service when they needed it and received the right care promptly. The service did not have any patients waiting for dialysis. During the COVID-19 pandemic, sessions were reorganised to ensure patient needs were managed safely. NHS trust clinicians identified patients who could manage on reduced hours or sessions of

dialysis in order that the service could continue and maintain physical distancing of patients. Patients were seen quickly after their arrival at the unit and were greeted by staff in the waiting area before moving to the dialysis station. Staff liaised directly with patients regarding any delays to treatment and reorganised sessions if this was needed. Patients could reorganise sessions if they needed to, but this was discouraged due to COVID-19. This was to keep patients in a cohort of patients and minimise contact with other patients.

The dialysis unit was open six days a week at varying times to meet the needs of patients who attend after daytime commitments. The unit was operational from 7am until 6.30pm, six days a week and they operated additional evening dialysis for three evenings until midnight. Key services were available to patients mainly through the NHS trust hosting their care. Staff at the dialysis unit were in daily contact with the trust and could refer patients for further support. Dietitian advice was available remotely and psychological support through the NHS trust.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. All complaints or concerns patients raised were documented using an electronic system. This identified timings for response to patients and actions needed to manage any improvements. The four complaints we reviewed had responses in line with the service's policy. Patients had been informed of investigation outcomes and consulted about any further involvement they would like. Some of the complaints had been expressed verbally to staff who had escalated them for action. All complaints were reviewed at integrated governance meetings for themes and trends and to share learning across locations. Information was cascaded at unit meetings.

Are Dialysis services well-led?

Good

This was the first inspection of this service. We rated it as good because:

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. The CQC registered manager, who was also the unit manager, led the Poole unit on behalf of the corporate provider, Renal Services UK limited. They were experienced and knowledgeable about the dialysis specialty and were clear about their responsibilities and who they reported to. The unit manager worked closely with staff from the NHS renal service and deferred to them for clinical leadership and advice on general practices. This promoted good partnership working which reduced barriers between NHS and the independent dialysis service. However, there was a risk the Poole dialysis unit would defer to the NHS service instead of making their own decisions.

The unit manager was visible and approachable in the service for patients and staff most of the time. However, the unit manager was also managing other locations which meant they were not able to spend each day physically at the Poole unit. Senior staff were always available at the unit the nurse in charge was not always easily identified. They had daily contact with staff at the unit and staff found them supportive. They supported staff to develop their skills and take on

more senior roles. A senior nurse led the unit when the registered manager was not available and was being trained to take the role of registered manager for the Poole location. The senior nurse had the clinical skills to lead and was able to seek additional support from the corporate provider when it was needed and while their management skills were being further developed.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. The corporate provider had engaged with local NHS services to assess the needs of local patients who needed dialysis. The refurbishment of the location had improved facilities by increasing the number of dialysis stations and quality of the premises. They had created provision for services to be offered to patients who wanted increased independence and for greater partnership working with NHS services. This was due to the additional space for patients to attend using the minimal care chairs and office space for NHS staff. The managers designed how it delivered its service to promote dialysis treatment for local patients. We saw no documented evidence of patients having been involved in planning the new unit. Staff at the location were focused on providing services for patients safely and with compassion.

Culture

Staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. Staff demonstrated how they cared for patients and delayed taking breaks in order to continue caring for their patients. Staff found managers approachable and we saw how they engaged in respectful conversations. Appraisal processes supported staff to identify where they would benefit from further training and considered individual circumstances. Managers offered support and advice when staff requested it and we saw how staff were comfortable to raise issues with managers. The service promoted equality and diversity in daily work and provided opportunities for career development to all staff. We heard how staff were supported to alter working hours to manage personal commitments. Staff attended equality and diversity training and training was provided for all staff in the unit. The service had an open culture where patients, their families and staff could raise concerns without fear. We saw issues had been raised by patients and responded to by the service. There was a whistleblowing policy which staff could access, and this was included in the staff handbook. It provided information on how staff could raise concerns with one of the provider's directors. It promised confidentiality but no detail on further processes or alternative contacts. Staff told us they could raise concerns if they needed to. There was a newly provided hotline for staff to raise concerns anonymously if they wanted to.

Governance

The service did not always accept accountability for meeting duty of candour regulations at the earliest opportunity, even when reasons were not fully known. Staff were able to tell us how they would apologise and give patients honest information and suitable support following incidents. However, we saw no documentation that staff from the Poole dialysis unit had offered an apology or explanation to patients or their families, where patients may have contracted COVID-19 from the unit in January 2021. Investigations into the source of the outbreak were still in progress and being led by the commissioning trust. We were told consultants from the NHS trust had discussed the outbreak with patients. There was no evidence duty of candour regulations had been followed by the Poole dialysis unit, who were the registered persons providing the regulated activity in relation to the care and treatment provided to

service users. There was no evidence patients had received written notification of the events including an apology. Staff followed the Being Open and Honest policy produced by the corporate provider. We saw documented actions taken by staff following concerns raised and comments made by patients. This had included patient discomfort and how to use the adjustable chairs. Staff had apologised to patients and provided suitable support.

The control of systems and processes for governance was limited by the contractual arrangements with the commissioning NHS trust. Although there were suitable links and reporting to the commissioning NHS trust by Poole dialysis unit, the unit was restricted in the actions and processes they were able to follow in line with their contract. However, Poole dialysis are responsible and accountable as the registered provider to provide the regulated activity to service users. The COVID-19 outbreak linked to the unit evidenced where governance had not been effective to ensure safety and quality and the appropriate mitigation of risks.

Managers from the Poole dialysis unit received information shared by the trust following mortality reviews. Clinicians from the trust monitored and investigated patient mortality, which included hospital acquired COVID-19 related deaths. Deaths which had resulted from the COVID-19 outbreak in January 2021 were part of the NHS trust's review of deaths from COVID-19. Following this outbreak staff from the Poole dialysis unit attended weekly outbreak meetings with the trust to identify areas for improvement. Clinicians from the NHS trust spoke with patients at the dialysis unit about the circumstances of the outbreak. process.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Oversight and governance processes were set by the corporate provider and followed by the Poole dialysis unit. Meetings followed a standard agenda. Monthly governance meetings were held at corporate level and information was cascaded to dialysis units through unit meetings and at daily handover meetings. These included changes at corporate level, risks, patient outcomes and incidents. The contract with the NHS trust defined how the trust would maintain oversight of services to their patients. The unit manager attended weekly meetings with the commissioning NHS trust. They were able to share information on performance against trust standards and plans for further improving clinical practice. Clinicians from the trust reported there were no barriers to improvement plans and the Poole dialysis unit responded proactively to improve practice.

Managing risks, issues and performance

Leaders and teams used systems to manage performance but actions for improvement were not clearly identified. There was a systematic plan of audits to monitor performance although we did not see evidence actions for improvement and learning were identified. Audits were aligned with key performance indicators agreed with the commissioner or host trust, at the contract commencement. Performance was reported to the trust and discussed at monthly meetings. Improvements were shown through repeat audits, but improvement actions were not identified or documented in action plans. Improvements were measured using audit results. For example, staff compliance with hand hygiene audits had fallen below expected standards. Hand hygiene and equipment cleaning audit frequency was increased, and staff compliance improved. However, there was no documentation to show what actions had brought about the improvement to support future actions and sustainability of the improvement.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff raised issues to the managers. If they could not be resolved immediately, they were escalated to more senior managers in the form of a risk register. These risks were reviewed monthly and mitigating actions were actions assigned to an individual. There was a detailed risk register dedicated to COVID-19. This gave detail of actions needed to reduce transmission and if any further infections were identified in staff or patients. It demonstrated learning and actions taken following the COVID-19 outbreak and included additional risks due to these changes. For example, implementing the

one-way system created a risk of injury for patients leaving the unit. Temporary barriers were put in place to reduce the risk to patients. Risks were reviewed monthly, as a minimum frequency, information governance meetings held at corporate provider level. Information was shared with staff at team and unit meetings. They had plans to cope with unexpected events. There was a plan of action in the case of a power outage to reduce risks to patients and in cases of extreme weather conditions. Staff were confident in the processes for maintaining equipment and services and had found no compromise in quality of care due to financial constraints. Staff in the Poole unit and from the NHS trust had contributed to plans during the refurbishment. This had created greater capacity to treat more patients in the unit.

Managing information

The service collected reliable data and analysed it and used it to make improvements. Data was shared with clinicians from the NHS trust in addition to the corporate provider. The NHS trust found the dialysis unit to be open and honest in their reporting. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information was shared with managers and staff at team meetings. Progress against actions was clearly identified in a table format. This included items identified as risks and audit outcomes. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff actively and openly engaged with staff to plan and manage services. Patient feedback was gathered improvement actions, relating to patient feedback, were not always documented. We saw staff greeting patients and engaging in conversation during the dialysis session. Concerns had been raised from these conversations to managers who had acted on the information. For example, noise during the refurbishment works. Before COVID-19 patients were able to provide feedback using comments boxes in the waiting area. However, changes to IPC processes meant these boxes were removed. Feedback was gathered at monthly staff meetings and an additional meeting for band 6 staff had been initiated the previous month. This was to provide staff with time to contribute their concerns or ideas. Renal Services (UK) Limited carried out staff and patient surveys annually and results were discussed at unit meetings. The staff survey for 2020 showed most staff were positive about support they received personally and in their professional roles. The most recent patient survey was in 2019 and showed 100% of patients would recommend the Poole dialysis unit to other patients. Patients also contributed to Patient Reported Experience Measures, which was a survey held nationally. This had been held in November 2020 and publication of results was awaited. Managers took time to speak with patients and gather verbal feedback. Leads collaborated with partner organisations to help improve services for patients. The NHS trust provided positive feedback about partnership working and how the dialysis unit engaged and worked collaboratively with the trust in any changes to the premises or services. The trust was consulted on the design of the refurbishment plans and provision was made to house a small team of staff employed by the trust. Clinic rooms were provided with air conditioning to improve the patient experience.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Staff were open in identifying areas for improvement. Feedback from the NHS trust and other dialysis units was shared with the unit in Poole and cascaded at unit and staff meetings. Actions were taken to improve practice, but these were not always formally documented. Managers identified and supported areas of improvement for patient care and used their skills to improve care. The unit manager created learning packages for the corporate provider to use in all its

dialysis units. Leaders supported research projects. The Poole dialysis unit did not state it had a purpose to undertake its own research projects but would actively support research which was undertaken by its partners. Staff were encouraged to attend national conferences for renal dialysis and undertake additional renal courses with external organisations.

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 20 HSCA (RA) Regulations 2014 Duty of candour **The service did not always operate an effective system to ensure they met duty of candour requirements after a notifiable incident.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Staff did not always follow systems and processes to safely prescribe, administer, and record medicines. Staff were observed preparing, checking and administering the medicine at the same time, increasing the risk of error. Storage for medicines was not well organised and we found expired medicines. • Staff did not use a standardised tool to identify when a patient's general condition was deteriorating. They did not record and manage patient risks from deteriorating conditions outside of risk assessing sepsis. Actions staff took relied upon their knowledge and experience. However, the service had a plan to introduce a standardised tool.