Darlington Dialysis Clinic

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

Darlington Dialysis Clinic is operated by Diaverum UK Limited. The unit has 18 stations comprised of 16 stations in the main area and two side rooms (which can be used for isolation purposes). It is contracted by South Tees Hospitals NHS Foundation Trusts, to provide haemodialysis for stable NHS patients with end stage renal disease/failure. Patients are referred to the unit by local NHS trusts.

The service is situated as a 'standalone' dialysis unit on the site of Darlington Memorial hospital.

The service originally commenced in 1994, but was taken over by Diaverum in 2011.

The provider does not treat children at the unit.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 14 June 2017, along with an unannounced visit to the unit on 23 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.

Summary of findings

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

Services we do not rate

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

We found the following areas of good practice;

- Incident reporting and investigating processes were robust and staff were clear in relation to their roles and responsibilities.
- We found that the clinic was visibly clean, arrangements for infection prevention and control were in place and there was no incidence of infection.
- The unit was compliant with the NHS Estates guidance (Health Building Note 07-01) and equipment maintenance arrangements were robust.
- There was a good range of comprehensive policies in place to support staff; these were accessible and understood by staff we spoke with.
- We observed a caring and compassionate approach taken by the nursing staff during inspection.
- Nurse staffing levels were maintained in line with national guidance to ensure patient safety.
- We saw 100% compliance in relation to mandatory training completion.
- The clinic provided opportunity for patients to visit prior to starting dialysis treatment, as part of pre-assessment.
- 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 to support the wellbeing of patients.
- The unit took a proactive approach to risk management, the risk assessments we reviewed were appropriate to the environment and had been reviewed regularly.
- The unit manager was visible to both patients, staff, and maintained a supportive and positive culture on the unit.

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

- Nursing staff were not trained to safeguarding children level two in accordance with national guidance and the safeguard policy did not include children.
- Comprehensive patient assessments were not routinely updated and care plans were not developed for specific health conditions such as diabetes.
- The service did not fully follow patient identification procedures for checking medicines before administration, which increased the risk to patients of medicine errors, and audits were not completed to ensure maintenance against national standards.
- Policies were not reviewed regularly and we were not assured that they were reflective of best practice.
- The service did not have sufficient arrangements for appropriate information and interpreting services for patients who cannot communicate in English, in line with the Accessible Information Standard.
- The service had not implemented the Workforce Race Equality Standards 2015 (WRES).
- Arrival and pick up times for patients were not monitored in accordance with NICE quality standards.

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. We issued the provider with three requirement notices, which are at the end of the report.

Ellen Armistead.

Deputy Chief Inspector of Hospitals (North region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis Services		The unit provided only dialysis treatment for adults. We did not rate the service but found that most patients were happy with the care and treatment they received and felt the unit was friendly with competent staff available to provide haemodialysis treatment.

Summary of findings

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Background to Darlington Dialysis Clinic

Darlington dialysis Clinic is operated by Diaverum UK. The service was taken over by Diaverum in 1996. It is a private medical dialysis unit, situated in the grounds of Darlington Memorial hospital. The unit primarily serves the communities of Tees Valley. It also accepts patient referrals from outside this area.

The unit has had a registered manager in post since 2000 (Service contracted out to a different provider at that time).

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, one other CQC inspector and a specialist advisor with expertise in renal dialysis. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspections.

Information about Darlington Dialysis Clinic

The dialysis unit has one main ward area and two isolation rooms and is registered to provide the following regulated activities:

- Treatment of disease, disorder, or injury.

There are three treatment sessions for patients who have dialysis on Monday, Wednesday, and Friday, with a maximum 18 patients in the morning, 18 in the afternoon and 11 patients during the evening session. There are two treatment sessions for patients who have dialysis on Tuesday, Thursday, and Saturday mornings when around 15 patients are dialysed.

The usual times for dialysing patients are 7.45am, 1.00pm and 6.00pm. The dialysis unit opens at 7.30am and closes at the latest at 11.30pm.

Patients were referred to the unit by South Tees Hospitals NHS Foundation Trust. The trust provided the renal multidisciplinary team, which included consultants, dieticians and specialist nursing staff.

The unit had 77 active patients and delivers average of 800 treatments sessions each month. Both male and female patients are treated at the unit in a mixed sex area.

During the inspection, we visited the three treatment areas where dialysis took place, and the other non-clinical areas of the unit, such as the maintenance room, and water storage area. We spoke with eight staff including the area head nurse, unit manager, deputy manager, registered nurses, and dialysis assistants. We also spoke with twelve patients and reviewed five sets of patient records.

There were no special reviews or investigations of the unit ongoing by the CQC at any time during the 12 months before this inspection. The last CQC inspection took place in February 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity

- In the reporting period April 2016 to March 2017, there were 4566 dialysis sessions carried out for 18-65 year olds and 7170 sessions for people over 65 years of age.
- At the time of the inspection, 30 patients aged 18-65 and 47 patients over 65 years of age were being treated at the unit.
- All patients receiving care were NHS funded.

The unit did not employ any doctors. Doctors were employed by the local NHS trust and provided cover to

Summary of this inspection

the unit on an agreed basis. The unit employed 8.7 whole time equivalent (WTE) registered nurses (seven full time and two part time). There were 2 WTE healthcare assistants.

Track record on safety (April 2016 to March 2017)

- There were no reported never events.
- One serious incident was reported and 80 treatment variations. No clinical incidents were reported.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus Aureus (MRSA), were reported.
- No incidences of hospital acquired Methicillin-sensitive Staphylococcus Aureus (MSSA) were reported.
- No complaints were received by the CQC or referred to the Parliamentary Health Services Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service. The unit had received two written compliments from patients.

Services accredited by a national body:

The unit was accredited against ISO 9001 quality management system and is therefore subject to regular audit and review.

- The ISO 9001 quality management system is a standard based on a number of quality management principles including a customer focus and continual improvement

Services provided under service level agreement:

- Renal counsellor
- Clinical and domestic waste
- Laundry and linen
- Cleaning
- Patient refreshments
- Security services

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.

During our inspection we found the following areas of good practice:

- Staff demonstrated a clear understanding of the clinical incident reporting processes and were able to provide examples of incidents reported under three categorisations.
- Safety bulletins were shared with staff and we found high levels of compliance in relation to staff understanding.
- All staff displayed appropriate aseptic technique when connecting or disconnecting dialysis lines.
- There was an open and transparent culture on the unit and staff were clear when to apply duty of candour when things went wrong.
- All staff were proactively supported with their training and development needs and mandatory training compliance was high.
- Staff were able to explain what they would do in situations where vulnerable adults needed safeguarding.
- Staff worked flexibly and the rota was planned to ensure safe numbers of staff were available to meet patient need.
- Clear escalation plans were in place, in regard to care of the deteriorating patient. Staff were clearly able to describe protocols and policies.

However, we also found the following areas of poor practice which the provider needs to improve:

- Initial assessment of patient needs was not routinely re-assessed, and care plans were not developed for patients with specific medical concerns.
- Patient identification checks were not fully completed prior to medicines administration and there were a lack of audits to provide assurance regarding medicines management.
- The provider must develop their children's safeguarding policy in line with current national guidance and ensure all staff are trained to an appropriate level, relevant to their role.

Are services effective?

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

We found the following areas of good practice:

- The provider had developed policies and procedures, which were developed in line with national guidance and standards.

Summary of this inspection

- The average Urea Reduction Ratio (URR), for the patients at the Darlington unit from March 2017 to May 2017 was 92%, which was above the recommended target levels.
- Plans were in place to offer patients a Haemodiafiltration treatment option.
- Patients who did not attend appointments were monitored as part of the treatment variance reporting system.
- The average number of patients attending three times a week and dialysed for the prescribed four hours treatment time was 98%. This was much better than the national average of 70%.
- In the 12 months leading up to our inspection, 100% of patients received high flux dialysis.
- All staff on the unit were proactively supported with competency and development needs.
- We saw 100% percent of staff had received an appraisal in the last 12 months.

However, we also found areas where the provider needs to improve:

- The average number of patients with an arteriovenous (AVF) fistula was 70%. This was lower and worse than the Renal Association standard of 80%.
- Policies were not reviewed regularly and we were not assured that they were reflective of best practice.
- The provider did not monitor arrival and pick up times for patients requiring transport who received dialysis.

Are services caring?

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

We found the following areas of good practice:

- We saw positive interaction between staff and patients. Staff communicated with patients in a respectful and considerate manner.
- Patients received treatment in shared areas; however, we saw sufficient space between each patient to maintain privacy and dignity.
- When patients first started treatment, they could come to visit the unit first with a family member or friend for a look around.
- All of the patients comment cards we received showed positive feedback about the care patients experienced.
- The most recent patient survey showed high satisfaction scores regarding the care and treatment from staff.
- Patients we spoke with said staff were friendly and had a caring approach.

Summary of this inspection

Are services responsive?

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

We found the following areas of good practice:

- The unit was accessible by people who used wheelchairs. There was a hoist available, which staff used if patients were unable to transfer on to the dialysis chair.
- The unit operated at around 84% capacity and so had spaces to accommodate for holiday treatment sessions for people staying in the local area, provided this had been medically approved, there was session availability and all relevant information was available.
- There was no waiting list for referrals.
- Appointment sessions were offered to patients in accordance with their personal needs and circumstances.
- Patients were actively encouraged to be part of the self –care dialysis programme.
- We saw staff speaking with patients about their treatment and blood results in a way they could understand.
- There was a variety of information available to patients including dietary information, holiday provision and shared care.
- Staff we spoke with told us adjustments could be made for someone with learning disabilities or who were living with dementia; for example, they could have someone with them during treatment.

However, we also found areas where the provider needs to improve:

- There was no evidence the unit monitored against NICE quality standards about patients being collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis.
- There was no patient involvement group where patients could make suggestions about the service or care of patents on the unit, or where staff could share information about the service with patients.
- The unit was not meeting the 'Accessible Information Standard' (2016) at the time of our inspection.

Are services well-led?

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

We found the following areas of good practice:

- Morale in the unit was good and staff felt supported by local managers.

Summary of this inspection

- There was a friendly culture, and the manager was visible and approachable and took time to seek the views of patients during dialysis treatment.
- All staff placed patients at the forefront of everything they did and were aware of the vision of the company.
- The unit manager had developed a strategy to develop services and improve patient outcomes.
- The unit staff worked together and seemed to have supportive relationships.
- We saw views and experiences of patients had been sought through the national patient survey 2016 and 91% of patients said they had complete confidence in the nursing staff.
- Staff survey response rates were high and feedback regarding the culture and leadership was positive.
- Risks were assessed and monitored and action plans were put in place to drive improvement.
- An exercise to manage services following the failure of the Water Treatment Plant was recognised as being highly successful and demonstrated clear leadership by the unit manager.

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

- The unit's governance arrangements required strengthening. Policies were not consistently reviewed and were not always reflective of current best practice and national guidelines.
- Staff had not been provided with safeguarding two training as outlined in the intercollegiate guidance document "Safeguarding Children and Young People" (2014).

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are dialysis services safe?

Incidents

- There was a culture of reporting and learning from incidents amongst staff. Staff we spoke with understood their responsibility to report incidents and gave examples of incidents they had reported.
- We saw the provider had a policy for the reporting of incidents including near misses. We saw this policy was issued in 2013 but was not due to be reviewed until 2017. Nurses were able to input the details of incidents into the electronic database and the unit manager would review these. These would then be submitted to the area nurse and then the chief nurse to be reviewed and we saw documents, which supported this.
- During the reporting period, April 2016 to March 2017 there had been no never events. 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.
- The provider reported one serious incident in the last 12 months.
- We reviewed the data relating to this incident, which involved an incident in the grounds of the local NHS hospital in which the dialysis unit was located. We saw the incident was investigated thoroughly and application of duty of candour was evident.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Incidents were categorised as clinical and non-clinical and there was in addition to this a system of reporting any variance from the care pathways, such as shortened treatments. Staff were able to describe examples of events, which were reported under these headings.
- The provider reported no clinical incidents in the last 12 months. We saw 80 treatment variations were reported in the last six months prior to inspection. These included failures to attend for treatment, shortened or interrupted treatment (by patient), hypotension (lowered blood pressure) requiring more than 300 ml of fluid treatment and vascular access problems. Staff we spoke with told us that any treatment shortened by more than 15 minutes would be reported as an incident. There were no trends or re-occurring themes emerging from these reports.
- Some specific incidents were monitored. These included the number of falls and the number of pressure ulcers occurring under the care of staff in the unit. Between April 2016 and March 2017, no incidents were reported under these headings.
- The unit manager and deputy received an email alert to advise that an incident had been submitted onto the electronic database. The manager was responsible for analysis and investigation of all incidents in the unit and reviewed them as part of a quarterly management review process, with the lead nurse. The deputy unit manager held responsibility to review incidents in the manager's absence.
- The unit manager told us team meetings were held each week and incidents were discussed. Staff we spoke with told us the unit manager shared details of all incidents that had occurred on the unit. We reviewed minutes taken from a staff meeting in May 2017, which supported this.
- Nursing staff were able to identify clinical incident reporting procedures but were not able to give examples of learning following the incidents.

- Staff we spoke with told us they were encouraged to report incidents and there was a no blame culture when something went wrong.
- We saw patient safety alerts were routinely provided to staff and were held within a file at the nurse's desk area. For each alert, there was a staff signature page to confirm they have seen the alert and read it. We saw staff regularly read these alerts and had signed to say they understood them.
- The unit manager told us they had recently received an email regarding stopping the practice of dry needling however they told us they needed to discuss with staff and check competence before they all changed practice. Dry needling was not in line with current best practice as it carries the risk of introducing air into the patient's bloodstream. Although there was no commencement date, the unit manager considered this as high priority.

Mandatory training

- All staff were required to complete a programme of induction, which included mandatory training modules appropriate to their role.
- Mandatory training for staff included a range of subjects such as fire safety, medicine management, data protection and basic life support. Training was delivered through a mix of classroom and online training sessions.
- Training was delivered on an annual, two yearly or three yearly basis, dependent on the topic. For example, fire safety and basic life support were annual, safeguarding and anaphylaxis were two yearly and manual handling theory was three yearly with an annual practical training session. Sepsis training was offered in addition to this.
- We reviewed the annual training spreadsheet, which showed training for the staff working on the unit and when training was due. The sheet was colour coded, for example showing red where training was overdue, amber if the training was due soon, and green if the training was within date.
- Mandatory training was up to date in all areas we reviewed, showing 100% compliance.

Safeguarding

- There was a corporate safeguarding policy 'Safeguarding Adults with Care and Support needs'. The policy provided guidance and examples of when to raise a safeguarding concern and we saw a safeguarding adult's referral process flowchart in addition to this. All staff on the unit had completed PREVENT training. PREVENT provides recognition and protection of vulnerable individuals from risk of grooming and involvement in terrorist activities or supporting terrorism.
- The designated lead for safeguarding was the nursing director for the company. The unit manager told us the lead had completed level four safeguard training for both adults and children. All staff we spoke with were clear whom their safeguarding lead was and which local authorities they would need to contact to raise an alert.
- We saw 100% of staff had online safeguarding adults level two training. The unit manager had completed level three in addition to this.
- Intercollegiate guidance (2014) recommends that level two is the minimum level required for non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers. Although, children were not treated at the unit some patients may have been parents or carers. The service did not treat patients under the age of 18 years.
- None of the staff on the unit had completed safeguarding children training and we did not see a policy relating to children's safeguarding protocols.
- Staff underwent disclosure and barring checks just prior to appointment but there was no policy or process in place to revisit these.

Cleanliness, infection control, and hygiene

- There were clear infection prevention, control (IPC) policies and hygiene plans for staff to follow. All staff we spoke with told us they were aware of the procedures in place. There were two single rooms on the unit, which could be used for isolation purposes if patients had or were suspected to have an infectious condition.
- A link nurse had been allocated to take a responsibility for infection control and hygiene issues on the unit. They completed a quarterly infection control audit. We reviewed the last audit, which was completed in April 2017 and saw the unit complied with the checks completed. There were no actions to address, following the audit.
- Protocols were in place to screen patients returning from holiday to high risk of infection regions for blood borne viruses, methicillin resistant staphylococcus aureus (MRSA) and methicillin sensitive staphylococcus aureus (MSSA). The unit had reported zero cases of hospital acquired MRSA, MSSA, Clostridium difficile

(c.diff) or Escherichia-Coli infections in the reporting period April 2016 to March 2017. There were three cases of 'other bacteraemia', which were reported within the incident reporting process.
- The clinic did not have a policy for screening patients for Carbapenemase-producing Enterobacteriaceae (CPE) when patients returned from receiving healthcare treatment abroad or when they returned from being an inpatient in UK hospitals, known to have had problems with the spread of CPE.
- Monthly hand hygiene audits were carried out based on the World Health Organisation (WHO) 'Five moments for hand hygiene' guidelines. We reviewed the last three audits and saw the unit achieved 89% compliance in March, 100% in April and 95% May. The unit's internal target was 90%.
- We saw staff complied with bare below the elbow policy and they washed their hands at appropriate points of care. We observed aseptic technique when staff were attaching and removing lines.
- Staff wore personal protective equipment, such as aprons, gloves and visors when cleaning the equipment, and when undertaking the insertion and removal of dialysis needles. Each staff member had their own visor, which they wore when attaching patients to the dialysis machine.
- We inspected seven pieces of equipment including dialysis stations and suction pumps. We found all to be visibly clean.
- Staff we spoke with told us dialysis machines were cleaned between each patient and at the end of each day. These followed manufacturer and IPC guidance for routine disinfection. Single use consumables such as bloodlines were used and disposed of after each treatment. We saw staff followed the guidance.
- Staff carried out daily water tests to monitor the presence of chlorine and organisms in the water in line with the UK Renal Association clinical practice guidelines. We reviewed the water testing logs for the last three months and saw they were fully completed.
- Staff were able to describe the management of the water systems for the presence of bacteria and pH levels and were explain to explain the procedures that were required should a water sample test positive. We reviewed the daily checks carried out in the first five months of 2017 and saw there were no bacteriological organisms noted.
- Water filters were changed and serviced annually and records showed these were up to date.
- Records we reviewed showed staff carried out the correct procedures in regards to flushing of water outlets to prevent contamination of the water supply.
- Training compliance figures for infection prevention and control indicated 100% of staff had completed the training.
- The unit had a process for checking patients' vaccinations status with their GP. We reviewed four patient files and saw that the results were completed.

Environment and equipment

- The unit had 16 dialysis chairs/stations in the main area and two single isolation rooms. There was limited space around each station. The unit manager told us the unit had been built before the current building regulations (Department of Health renal care Health Building Note 07-01: satellite dialysis unit) came into force and any refurbishment plans would need to take into consideration how the unit would meet current requirements.
- The limited space meant that patients were close together and it was difficult to maintain privacy. There was one set of mobile privacy screens if patients needed them.
- Patients we asked about the limited space liked the proximity of the chairs as it meant they could talk to each other easily and they gained support from this. Patients were fully clothed and did not have any concerns about lack of privacy or dignity.
- Maintenance of the dialysis machines and chairs was scheduled and monitored using the dialysis machine maintenance/calibration plan; this detailed the dialysis machines by model type and serial number along with the scheduled date of maintenance by technicians. We reviewed the maintenance records, which were up to date.
- We saw all staff on the unit had received medical device training.
- A similar plan was present for dialysis chairs and other clinical equipment for example; patient thermometers, blood pressure monitors and patient weighing scales. There were three spare dialysis machines available and ready for use in case of breakdown or if machines needed to be kept for single patient use, for example if a patient had a blood borne virus.

- There was a mixture of older and newer chairs available. The unit manager told us they were in the middle of a replacement programme and all the old chairs would be replaced by the end of 2017.
- We saw there were generic pressure-relieving mattresses available on the dialysis chairs. The unit manager told us they would approach the referring trust if more specialised equipment was needed. There were no patients who required additional equipment at the time of inspection.
- Alarms on the machines would sound for a variety of reasons, including, sensitivity to patient's movement, blood flow changes, or leaks in the filters. We saw the alarms were used appropriately and not overridden; when alarms went off we saw nursing staff check the patients and the lines before cancelling the alarms. We checked the resuscitation trolley and found the equipment was correct and in date oxygen was available. Equipment checklists were available which showed the previous four weeks checks were up to date.
- We checked the stock held on two general dressings' trolleys and found all equipment to be in date and in good order. All staff we spoke with told us that there were adequate supplies of equipment and they received good support from the maintenance technicians.
- There were no spare patient weighing scales, however staff we spoke with told us if they could not get them repaired quickly, they would ask the local trust if they could loan some until repairs were made. This was an informal arrangement.
- We asked for evidence of the replacement programme for dialysis machines which should be replaced every seven to ten years or between 25,000 to 40,000 hours of use according to Renal Association guidelines. The unit manager told us the current machines were five and a half years old, with a life expectancy of seven years and were budgeted for replacement in 2018.
- We saw waste was handled and segregated appropriately.

Medicine Management

- There was a detailed medicines management policy. However, there was no audit of practice to provide assurance that standards of practice were monitored by pharmacy or senior staff. We spoke with senior staff who confirmed that currently no comprehensive medicines audits were performed but we saw a checklist used to check all medicines were in date and check prescriptions were accurate.
- The unit did not use or store any controlled drugs. The unit manager had lead responsibility for the safe and secure handling and control of medicines.
- Staff received annual medicines management training. During inspection, we saw evidence that 100% of staff had received this training.
- The nurse in charge varied depending on shift patterns but was always an experienced nurse. Staff we spoke with told us they were the key holder for the medicines cabinet on a day to day basis.
- There were a small number of medicines routinely used for dialysis, such as anti-coagulation and intravenous fluids. They did not use patient group directions (PGDs).
- Medicines requiring refrigeration were stored in a fridge, which was locked and the minimum and maximum temperatures were checked daily. Records we reviewed showed fridge temperatures were consistently recorded and were within an acceptable range. Staff were aware of the action to take if the temperature recorded was not within the appropriate range.
- Staff we spoke with told us they could access pharmacy support from the local NHS trust pharmacy for advice relating to dialysis drugs.
- No non-medical prescribing staff worked in the unit. The patient's consultant nephrologist prescribed any medication needed.
- Staff were clear about the process to follow if they required a prescription change or new prescription. The consultant or registrar would give a verbal instruction to a registered nurse who would transcribe onto a prescription form. The nurse faxed this to the doctor who would check and sign the prescription and fax back. The nurse stapled the temporary sheet to the full prescription card and used this until a doctor next visited the unit. At the next visit, the doctor would prescribe the required medicine onto the full chart and remove the temporary sheet. This process was covered within the medicines management policy.
- Patients we spoke with said they took their regular medicines at home prior to coming to the unit or when they went home.
- We observed two nurses checking a specific drug against patients' medicine prescription charts and observed the medicine was left at the patient's bedside.

This was done before the patients had entered the room. Nurses felt that this was safe practice because the patients always used the same bed space and a third member of staff would check the drug against the card and check the patient's name at the point of administration. We saw the same nurses checking the medication and dose out of the cupboard and the administering nurse all signed the drug chart. We did not see staff check the patient's identification at the point of administration, which is not in line with Nursing and Midwifery Council (NMC) medicine management standards.

- Nurses told us they asked patients to confirm their name before administering medicines. On another occasion, we observed a registered nurse checking a patient's date of birth but did not ask the patient's name of check any other details.
- Dialysis assistants could administer saline and anti-coagulants under the supervision of a registered nurse; they must have completed the appropriate competency document and have been deemed competent in all aspects of medication administration. We reviewed the training files and saw that training competencies were complete for these staff.
- We looked at the prescription and medicine administration records for five patients on the unit. These records were fully completed, clear and legible and were compliant with national standards.

Records

- The unit used a combination of paper and electronic records. Data was shared between the electronic database of the unit and the NHS hospital. This meant all appropriate health care professionals, had access to the patient records at all times.
- The paper records included the dialysis prescription, patient and next of kin contact information, and GP details. There were also nursing assessments, medicine charts, and patient consent forms. Records also contained standardised pathways for haemodialysis and management of Arteriovenous (AV) fistulas and grafts.
- Paper records were placed at the foot of each patient station and locked away in the staff office, when patients were not receiving treatment
- We looked at five sets of records and found that all were legible. Patients had regular observations recorded pre, during and post treatment with few gaps noted. Records contained a new patient admission assessment, which included a short review of 'activities of daily living'. Two of the five records we reviewed had gaps in the new patient assessment.
- We saw that the five patients entered the service between 2011 and 2015 but had not had a documented reassessment of their needs since their first admission. There was a risk that changes in patients overall health would not be identified.
- We saw risk assessment documentation, which was reviewed annually for manual handling, falls and needle dislodgement where applicable.
- There was a lack of specific care plans for patients with a medical need such as diabetes. Within the five files we reviewed, two patients were diabetic but did not have a care plan to support this. Staff were however able to appropriate describe the appropriate care required.
- We saw the provider had developed a policy specific to the care plans. The policy gave staff guidance as to when care plans should be developed. It was issued in 2015 and was due to be reviewed again later in 2015. The policy had not been reviewed at the time of inspection.
- All patients had a completed Waterlow assessment (to determine risk of developing a pressure ulcer) score in place; these had been introduced in the month prior to inspection.
- Documentation audits were carried out on a monthly basis. We reviewed the data of the last four audits completed prior to inspection. Ten patient records were audited on each occasion. We saw comments following each audit, which largely related to missing signatures and action plans to improve this.
- Each registered nurse held a case load of dialysis patients of approximately eight patients. Staff were expected to update patient records and care plans for patients on their caseload but we did not see any guidance for staff in relation to this.

Assessing and responding to patient risk

- Only clinically stable patients were dialysed on the unit; if someone was acutely ill with renal problems they were treated at a main NHS hospital.
- Staff undertook an assessment of patients prior to commencing their treatment at the unit. This included reviewing the patient's demographic details, their

clinical details including allergies, diagnoses and vascular access type, past medical history, their existing medicines and current dialysis prescriptions, virology results, and any special needs or mobility requirements.
- 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, and to determine the correct dialysis.
- Observations of vital signs such as blood pressure and pulse were recorded before, during and after dialysis treatment.
- Managers told us there were referral and escalation criteria in use for staff to follow should a patient's condition or results deteriorate. They told us that poorly patients were escalated to the renal consultant on-call and an email was sent to the patient's own consultant to ensure they were aware of any changes in condition.
- Staff on the unit had completed National Early Warning Score (NEWS) training. Nursing staff we spoke with were experienced and able to articulate the clinical condition of a deteriorating patient.
- We saw the unit had recently introduced a sepsis flow chart, which was 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).
- All staff were aware of the action required, to effectively identify sepsis and we saw staff had signed to say they have read the sepsis flow chart in May 2017.
- Staff we spoke with told us the service held emergency resuscitation simulations every six months. We saw the last simulation was in January 2017.
- We looked at five sets of patient records and saw all patients had personal emergency evacuation plans in place and these had been updated within the last three months.
- Staff recorded variances during the period of dialysis in the patient records for example, falls risks, mobility post dialysis, weight recording and changes in vital signs measurements. Staff used this information to help plan the next dialysis session and to identify any themes or risks occurring during dialysis.
- We saw pathways regarding management of hypotension and pyrexia (which included the acute management of symptoms) and an overview document in the patient record, which indicated the pathways relevant for that patient.
- If staff were concerned about a patient, they told us they could easily contact the renal registrar on call or speak to a consultant if needed. They told us they could easily arrange for a patient to be seen in outpatients or on the ward at the trust if necessary.
- In emergency situations, the staff would raise a crash call and the crash team would attend from the hospital where the unit was situated.
- Two of the renal consultants visited weekly and saw patients whom were receiving treatment that day. In addition, all patients were formally reviewed once a month. Treatment was reviewed and changes could be made.

Staffing

- The unit was staffed to a 1:4.5 staff to patient ratio; trained dialysis assistants were included in the ratio with registered nurses (RN). The unit manager told us there was always a minimum of two registered nurses on duty and the skill mix was usually around 67% registered nurses to 33% dialysis assistants. These numbers were in line with the Renal Workforce Planning Group 2012.
- Staff we spoke with felt they were able to provide individualised care but felt stretched and would like to see ratios improve to 1:4 in the future. The unit manager agreed with this and felt that patient acuity was generally rising and could foresee that ratios may need to be adjusted in the future.
- The manager was not included in the number of staff required to deliver patient care and was able to support staff delivering direct care.
- The unit employed 8.7 whole time equivalent (WTE) registered nurses (seven full time and two part time). There were 2.8 WTE dialysis assistants (two full time, and one part time) and two WTE health care assistants. (both full time).
- Prior to inspection, the provider told us they had one WTE dialysis RN vacancy. The unit manager told us that this vacancy was no longer required due to the reduction in referrals to the unit in recent months. The turnover in the 12 months prior to inspection was reported as four staff having left the service and four staff recruited.

- Staff were divided into two teams to ensure efficient delivery of care. We observed staff working in conjunction with each other and were supportive to each other's needs.
- The unit manager had considered reducing the number of chairs to 16 to address the ratio pressures but was unable to alter contract details until it was subject to a formal commissioning review.
- The unit manager acknowledged there had been staffing problems due to historical vacancies but staffing numbers were now consistent and there would be a full complement of staff soon due to recent successful recruitment. The unit had not used agency staff in the three months leading up to the inspection.
- If staffing levels could not be maintained by permanent staff, requests were made to the nursing bank, who arranged for cover. When the bank could not cover shifts, an approved external nursing agency was used. An agreed induction template was in place to ensure safe working practice.
- Staff worked longer hours on a Monday, Wednesday and Friday when the unit had three treatment sessions. If patients were delayed commencing treatment due to transport problems, the staff were flexible and worked over.
- The unit used a small number of regular bank staff, who were required to have renal experience. Evidence of bank staff qualifications and mandatory training was submitted to the provider's HR department prior to staff commencing working at the unit.
- The unit manager ensured compliance with staffing ratios through the application of an e-rostering system. This was completed eight weeks in advance. Annual leave was monitored and planned in advance.
- The unit did not employ any doctors. Four renal consultants provided cover to the unit. Managers told us two of the consultant staff visited the unit weekly and formally reviewed patients at monthly multi-disciplinary meetings. The remaining two consultants reviewed patients from the local NHS hospital site.
- Nurses told us consultants could be contacted at any time for advice or support regarding individual patients and that they would undertake individual reviews as necessary if a patient's condition or results changed.

Major incident awareness and training

- The unit had a corporate business continuity policy in place, which was supported by a procedure to support implementation of the policy. We viewed tailored business continuity plans for information technology, power supply, and water supply and water treatment plan failures. The unit also had plans in place for telephone systems failures, loss of heating and staff shortages.
- The emergency officer was the unit manager. An emergency preparedness plan (EPP) was in place. This detailed the plans for the prevention and management of potential emergency situations, such as fire, loss of electricity or water leaks. The plan included defined roles and responsibilities; contact details for emergency services, public services and utilities and key headquarter personnel.
- Patient's emergency evacuation plans we reviewed were appropriate to their needs.
- Evacuation simulations were conducted biannually and staff were aware of their responsibilities.

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

Evidence-based care and treatment

- The provider had developed policies and procedures, which were developed in line with guidance and standards from the UK Renal Association and National Institute for Health and Care Excellence (NICE) and had been incorporated into the organisations 'NephroCare standard for good dialysis care'.
- Treatment was led by an NHS consultant; staff we spoke with told us that treatment was prescribed to ensure best patient care outcomes.
- We saw the unit reviewed clinical outcome data on a monthly basis through the electronic database. The information was measured against the quality standards of the renal association guidelines. The unit manager told us this was used at multidisciplinary team (MDT) meetings to inform discussions regarding patients' treatment and medicine.
- We saw the unit followed some generic care pathways, which were appropriate to the individual's needs. Individual prescriptions were in each patient documentation file and all were reviewed within the last month.

- 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. We were told that fistula assessment forms were monitored monthly by the unit manager and we saw that these were completed on a monthly basis.
- In the 12 months before our inspection, the average number of patients with an AVF or AVG fistula was 70%. This was lower than the renal association standard of 80%.
- Assessment of patients' vascular access was carried out before and during treatment. Continuous monitoring by the dialysis machine meant that nurses were alerted by a machine alarm to any potential issues that could relate to poorly functioning fistula. Staff made notes detailing the nature of any problems identified.

Pain relief

- Staff we spoke with told us local anaesthetic was prescribed for patients who found the commencement of treatment particularly uncomfortable.
- Part of the patient's initial assessment on admission to the unit asked if the patient had any history of pain or discomfort whist on dialysis.
- Staff we spoke with told us they would give patients paracetamol if they complained of headache or other pain during their treatment. Two patients told us they had been given paracetamol for headaches.
- The five prescription charts we reviewed showed patients were prescribed 'as required' paracetamol. Nurses told us this was routinely prescribed for all patients and they would report excessive pain to the renal consultant on-call if necessary.

Nutrition and hydration

- Patients were offered hot and cold drinks and biscuits while they were having their treatment. Patients were also encouraged to bring their own food in if they wished.
- Patients who have renal failure require a strict diet and fluid restriction to maintain a healthy lifestyle .The renal dietitian visited the unit twice a week to give support and advice; staff we spoke with told us the dietitian was also available at the NHS hospital.
- Several magazines and leaflets were displayed in the reception area, which provided nutritional advice for patients.

Patient outcomes

- The unit did not directly submit data to the UK renal registry, as is normal practice. This was undertaken by the 'parent' NHS Trust. The data from the Darlington unit was combined with the NHS Trust data and submitted as one data set for South Tees NHS Foundation Trust. The data submitted included patients under the direct care and supervision of the Darlington unit; it did not include information on the unit's patients undergoing dialysis elsewhere during holiday periods. As the unit's data was combined with the trust's data, the unit was unable to benchmark its outcomes against other providers' clinics
- Due to the inclusion with the trust, the unit could not benchmark the effectiveness of its service to other dialysis providers. However, the unit manager told us that internal data could be accessed to provide a benchmark against other diaverum units within the clinic managers meeting.
- Data obtained through treatment, such as blood results were collated and held within the electronic recording database. Patient blood was tested for potassium, phosphate, calcium aluminium concentrations in-line with the renal association guidelines. Clinical outcomes for renal patients can be measured by the results of these blood tests. The data was available for the unit manager and consultant to review so they could see individual patient outcomes and results were fed into the trust system. This enabled the review of the effectiveness of treatment, and changes to be made to the patients' prescriptions, and care plans to improve outcomes.
- The unit's data management system provided customised reports and trend analysis to monitor and audit patient outcomes and treatment parameters. The

multidisciplinary team used this to improve outcomes and in turn quality of life. The report provided specific unit scores in areas such as infusion / volume, albumin, weekly treatment, vascular access, and haemoglobin. Best performance scores were discussed at the clinic managers meeting.

- The results of the data show how the unit performs in the achievement of quality standards based on UK Renal Association guidelines. We reviewed results of blood tests for three months from March to May 2017. These comprised of a number of outcomes, for example:
  - two standards we looked at show how much waste products are removed from the patient and how effective the dialysis is;
  - the rate blood passes through the dialyzer over time, related to the volume of water in the patient's body (expressed as a standard of 'eKt/V >= 1.4,h')
  - and the Urea Reduction Ratio (URR)
- On average 65% of patients had effective dialysis based on the first standard.
- For the URR, Renal Association guidelines indicate a target of 65%. The average URR for the patients at the Darlington unit from March 2017 to May 2017 was 92%. Patients with these levels of waste reduction through dialysis have better outcomes and improved survival rates.
- We also looked at the standards indicating patients' hemoglobin (Hb) was at safe levels. Anemia can be a complication of renal failure and dialysis associated with increased risks of mortality and cardiac complications. From March 2017 to May 2017, the average number of patients with the NICE recommended target of Hb (100-120 g/l) was 66%. This meant the other 34% of patients had lower Hb levels. Where patients had low levels they were given injections of a hormone-stimulating agent to help, their body produce more red blood cells, iron injections and blood transfusions.
- Potassium levels in the blood are monitored as part of the Renal Association standard. Potassium levels should be between 3.5-6 mmol/l. From March to May 2017, an average of 5% of patients had high levels of potassium (greater than 6.0 mmol/l). If potassium levels are higher than 6mmols, it can cause acute cardiac problems. This means around 95% of patients had potassium levels within acceptable ranges.
- In the same timeline, outcome standards for the unit showed 0% of patients received Haemodiafiltration (HDF) treatment. HDF is a more effective treatment for kidney failure and prevents long term cardiovascular complications. The clinic manger told us that there were water quality issues with the previous water treatment plant that prevented the use of Haemodiafiltration therapy. There are currently plans in consultation with the named Nephrologist to offer patients the Haemodiafiltration treatment option.
- From March to May 2017, we saw 98.6% of patients who attended three times a week were dialyzed for the prescribed four hours treatment time. This is above the minimum standard of 70%. It also meant that 1.4% of patients in the unit did not attend three times per week.
- In the 12 months leading up to our inspection, 100% of patients received high flux dialysis. High flux dialysis is a form of more effective clearance of the waste products and fluid. High flux dialysis delay long-term complications of haemodialysis therapy.
- We saw vascular access audits were completed every month. The unit manager told us that the vascular access nurse from the local NHS hospital visited on a regular basis to provide staff with clinical advice and support. We reviewed the audits completed for the last three months and saw staff were fully compliant.
- The unit had an audit schedule, which included hand hygiene, documentation, patient experience and infection control. Staff could not recall the most recent results but were able to show where audit results were located. We saw several audit results displayed on the walls of the unit.
- The unit monitored treatment variances, such as cannulation problems, chest pain, clotting, high and low blood pressure, changes in procedure, machine malfunctions and patients who did not arrive for dialysis. There were a total 80 variations in the last six months prior to inspection. These results were used to look at issues and make improvements where possible. No trends were identified but we saw that general feedback was given to staff.
- Patients who did not attend appointments (DNA) were also logged within this system. The unit manager told us all DNA variations were linked to the same patient and discussions were in place with the renal consultant. Staff were supporting this patient who did not wish to stay for the full length of treatment.
- The provider did not formally monitor or audit, arrival and pick up times, for patients who used patient transport services, against NICE quality standards.

Dialysis patients should be collected from home within 30 minutes of the allotted time and collected from the unit within 30 minutes of finishing dialysis. The unit manager told us there were very few problems with lengthy delays.

Competent staff

- There was a comprehensive training programme available for staff. Registered nurses and dialysis assistants were required to complete a series of mandatory clinical competencies, to support their role and responsibilities. Competencies were measured and monitored against the National Health Service Knowledge and Skills Framework.
- We reviewed the competency files of four registered nurses and two dialysis assistants based on the unit. There was evidence of up to date training records for registered nurses and the dialysis assistants, attendance and sign off by senior nursing staff. The use of mentors was evident.
- New staff were supported by mentors and time was provided to enable staff to shadow colleagues.
- For existing staff the unit provided on-going professional development opportunities for assessment and maintenance of competence, which is pivotal to the Nursing and Midwifery Council (NMC) revalidation approach. For example; annual assessment 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. Five of the nine registered nurses including the unit manager had undergone specialist training and had completed a renal qualification.
- Dialysis assistants were given training and competency assessed to enable them to administer anti-coagulant injections (this medicine prevents patients developing blood clots or thrombosis). This followed company guidance and was intended to highlight training and development needs to discuss in annual appraisals.
- There were link nurses at the unit with areas of interest and additional training. They had responsibility for updating other staff about the topic. Link nurse roles were;

- Aseptic Non Touch Technique
- Infection prevention and control/hygiene
- Holiday co-ordination
- Vascular access
- Health and safety
- Transplant
- Moving and handling
- Stock and ordering

- The unit manager completed staff appraisals during October – February each year. Human resources (HR) had provided the manager with training around undertaking appraisals.
- Staff we spoke with all told us they had an annual appraisal, which helped them think about their skills, competence and areas for development.
- During our inspection, we saw 100% of staff on the unit had received an appraisal during the last 12 months.
- All staff were involved in the 'talent matrix'. Staff were asked to self-assess their progress during the last 12 months and discuss with the unit manager. The aim of the document was to enable self-reflection and develop strengths and weakness.
- Nurses approaching re-validation were supported by the unit manager.
- Diaverum had recently introduced an online training academy. All staff on the unit were working through the online modules as either a refresher to current knowledge or an enhancement on baseline clinical skills.

Multidisciplinary working

- We observed effective teamwork and support within the unit between nurses, dialysis assistant and healthcare assistants.
- Patients attending the unit were under the care of four renal consultants from the commissioning trust.
- The consultants had overall responsibility for patient care and reviewed patient outcome reports and prescribed changes to treatment. Medications and diet would be discussed and agreed at a monthly multidisciplinary team meeting (MDT) with the dietician and unit manager.
- MDT meetings for two of the consultants were held offsite at the local NHS hospital whilst the remaining two consultants came to the unit on a Tuesday and Wednesday every week.
- In addition to this consultants held a monthly clinical governance review of all patients and one to one reviews held in the renal outpatient clinic within the unit.

- If medical staff were required, outside of these arrangements, the dedicated consultants were available via telephone or email and out of hours, cover was provided by an on call rota of renal doctors.
- Patients told us they saw their consultant and dietitian regularly and consultants would see them straight away if there were any issues with their blood results.

Access to information

- Staff we spoke with told us they had the information they needed to look after patients. This included previous treatment records, current observation records, up to date prescriptions, and patient's clinic letters from the renal team to their GPs.
- Electronic records including blood results from the local NHS trust were accessible to staff on the unit and results were also recorded on paper cards, should there be any issues obtaining electronic results.

Consent, Mental Capacity Act and Deprivation of Liberty

- Consent to treatment means 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.
- We saw the provider had a policy specific to patient consent, which was issued in 2012. The policy showed it was due for review in 2018, which meant unit practice was not reviewed against current best practice during this time period.
- We reviewed the unit's policy specific to obtaining consent prior to dialysis treatment. The policy showed an issue date of the 2013 but was not due for review until July 2017.
- We found patients gave formal, informed written consent for dialysis treatments, blood borne virus screening and for the use of anonymised clinical information. The consent was revised annually.
- We reviewed consent forms in five patient files. All were found to be fully completed and in line with professional standards. We observed nurses seeking verbal consent prior to undertaking care and treatment.
- Staff were able to describe mental capacity and best interest processes but were not able to provide us with any examples of patients who were subject to these processes, as those living with dementia would not normally be considered suitable for dialysis in this unit.
- Staff within the unit were required to undertake three yearly Deprivation of Liberty (DoLS) training. We reviewed the training spreadsheet and saw 100% had completed this training, which was covered as part of the mental capacity training.

Are dialysis services caring?

Compassionate care

- We spoke with 11 patients during our inspection. All patients and relatives we spoke with told us staff were kind, knowledgeable and made them feel relaxed. We observed patients were treated with compassion, dignity and respect.
- Privacy and dignity of patients was maintained and we saw the use of curtains to screen each patient when required. Space between each dialysis chair was limited but sufficient to enable staff to speak with patients in a discreet manner. We saw positive and discreet interaction between nurses and patients.
- The last patient survey in the unit, completed in October 2016 showed a 40% response rate, which was worse than the previous survey of 79%. The overall average performance score was also comparatable than the previous one, showing 87% compared to 88% previously. The October 2016 survey showed 87% of patients would be likely to recommend the unit to friends and family in need of dialysis and 89% of patients felt they could trust the staff.
- We did not receive any completed comment cards from patients; however, we spoke with 11 patients during the inspection. Some of these patients had been using the service for up to ten years. All patients were complimentary about the care and compassion shown to them by all staff at the service. One patient told us 'staff are lovely here, always helpful'.
- Staff would ensure facilities were provided for families, should they wish to have private discussions. For example, there was a meeting room or the manager's office could be made available for confidential discussions when required.

Understanding and involvement of patients and those close to them

- We observed that patients deemed suitable for shared care were given a shared care questionnaire. Shared haemodialysis care is when patients at dialysis units are supported to undertake tasks involved in their own treatment to the extent that they wish. The questionnaire outlined all aspects of the dialysis treatment for the patient to answer whether they would like to take over that aspect of care. This meant patients could be involved in shared care activities as much or as little as they wanted or felt confident about.
- Patients were encouraged to ask questions about their care and treatment and were given direction regarding dialysis options. One patient told us if they had any problems with anything, the nursing staff would arrange for them to be seen by the consultant.
- When patients first started treatment, they could come to visit the unit first with a family member or friend for a look around. Several patients had visited the unit prior to commencing dialysis as part of the outpatient pre-dialysis clinic managed by the local NHS trust. A patient told us staff made them feel very welcome when they came to look around the unit for the first time.
- There were information packs available so patients knew what to expect from the service and what the anticipated benefits and risks of treatment were.
- Relatives were not able to stay with patients during treatment due to infection prevention procedures. However, if someone had additional needs such as learning disabilities, staff told us that a family member or carer could remain with them.
- Senior managers told us a 'named nurse' was allocated to each patient to provide continuity for patients and ensure care plans and information was regularly updated.

Emotional support

- Staff we spoke with told us because they cared for patients frequently over a period of years; they became familiar with them and felt as if staff felt like 'family'.
- Patients were positive about the emotional support provided by nursing staff.
- One patient told us that staff on the unit make dialysis 'bearable' and always 'have a laugh'.
- Patients could access the support of counsellors or psychology support if needed. Nurses identified the need and accessed support for the patient through the trust's consultants or referred directly to social workers and mental health services.
- We saw information was available for patients regarding accessing support and advocacy services.

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

Service planning and delivery to meet the needs of local people

- The dialysis unit had been in operation since 1994, but was taken over by Diaverum in 2011 and was commissioned by South Tees NHS Trust. The contract for the unit was last reviewed in 2011 and was extended until 2022 to tie in with other local unit contracts.
- The unit's service contract, and specification, were defined and agreed directly with the commissioning trust's renal team. Performance against the contract was monitored by the trust through key performance indicators, regular contract review meetings, and measurement of quality outcomes including patient experience.
- The unit did not maintain direct links with the commissioning team but worked closely with the NHS referring teams who had direct contact with commissioners.
- Patients were referred for haemodialysis treatment from the local NHS trust renal unit and consultant nephrologist team. We saw criteria for referrals were in place and patients were assessed as physically well enough for satellite treatment, had functioning haemodialysis vascular access and lived in the local area. All staff we spoke with told us that it was important that patients were 'stable' in terms of their renal care before commencing treatment.
- Patients who had additional needs such as those living with dementia, or who had challenging behaviour were not treated at the unit.

- The unit was built prior to the requirements current buildings legislation (Department of Health Renal care Health Building Note 07-01: Satellite dialysis unit). There was space for transport services to drop off and collect patients.
- There was sufficient parking for patients at the main entrance and available bays for blue badge disabled parking and wheelchair access was provided.
- The unit manager told us that the staff on the unit spoke regularly to the local patient transport liaison office if they had any issues but there was no formal monitoring of patient arrival times and pick up. We were not able to see that senior managers maintained any regular dialogue with local transport providers.
- The unit did not monitor travel or waiting times for patients. This meant they were not assured that patients they did not wait for treatment after arrival and for transport or were delayed returning home after treatment. The unit manager told us that transport was usually 'regular' and they would contact the local patient transport liaison office should there be any problems.
- The receptionist when they were on duty kept an eye on ambulance pick up times and followed them up when patients had been waiting for a long time.
- The unit manager told us they would contact the local patient-transport liaison officer if there were any issues. There was no formal transport group but the unit manager told us they had previously had a good response from the liaison officer when issues had arisen. The unit manager gave an example of contacting the transport service, as it was brought to attention that a patient had been required to stop their treatment early to make sure they were ready for an earlier transport pick up. The issue had been readily resolved and pick up time changed.
- The unit manager told us patient transport issues could be discussed as part of the contract review meetings with the trust, as the trust also commissioned the patient transport service, if there were persistent issues. The regional business manager attended these meetings on behalf of the unit.
- The unit was not meeting the 'Accessible Information Standard' (2016) at the time of our inspection. The standard aims to make sure that people who have a disability, impairment, or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services.

Access and flow

- Referrals for admission were directed by the four consultant nephrologists at the local NHS trust's renal unit who would contact the clinic, usually the unit manager, to inform the team in the dialysis unit that there were new patients for admission.
- The unit manager told us referrals had gradually declined during the last 12 months. The unit was operating at 72% capacity at the time of inspection.
- The utilisation of capacity in the unit in the three month reporting period was as follows: December 84%, January 84% and February 84%. Staff we spoke with told us the unit did not cancel patient appointments.
- There was no waiting list for treatment at the unit and staff we spoke with said this was consistent. There were no cancellations due to non-clinical reasons in the last 12 months.
- The number of 'holiday' dialysis patients, which could be supported on the unit, varied due to the decrease in general referral numbers.
- The unit had an established appointment system, which promoted structure, timeliness and minimised delays. Staff we spoke with told us that they facilitated a flexible approach to the patient's dialysis sessions and would change the day of patients dialysis, and/or times as far as possible to accommodate external commitments and appointments or social events the patients may have. Patients were asked to arrive at staggered intervals of 15 minutes apart to reduce unnecessary waiting.
- We saw that there were nine cases where patients were transferred out to another health care provider. These patients had transferred for care and treatment and not due to deterioration or emergency care.

Meeting peoples individual needs

- Patients had access to Wi-Fi, personal televisions in each chair space and reading materials. Patients were able to bring anything in from home, such as electronic devices, to help pass the time during their dialysis sessions.

- Patients were provided with a nurse call system and nurses ensured that the call bell could be reached by patients during dialysis. We observed the call system in use and we saw nurses responded to alarms promptly.
- We saw staff speaking with patients about their treatment and blood results. Patients told us they were given a monthly sheet to show the results and they were presented in a way they could understand.
- We asked nursing staff if patients were provided with any other activities or stimulation. The unit manager told us they would occasionally organise a quiz and would have a social event at the end of the year but they were not offered routinely.
- The unit had a meeting room, staff offices, toilets for staff and patients, and a kitchen where staff prepared drinks and sandwiches for patients.
- There was a range of information and magazines available in the waiting area regarding dialysis, such as healthy eating, supported holidays and self-care information.
- We asked the unit manager if literature and support was available to patients for whom English was not their first language. We were told that leaflets were available and the unit had access to an interpreter service should it be required. Interpreters could also be accessed upon request through the local trust.
- Staff we spoke with told us that patients were allocated a dialysis appointment times to fit in with social care and work commitments. For example, day appointments for elderly or vulnerable patients with more complex care needs or evening appointments for working patients.
- The unit was accessible by people who used wheelchairs. There was a hoist, which could be used if someone was unable to get on to the dialysis chair and personal evacuation plans in plans for those patients with mobility needs.
- Staff rarely cared for patients living with dementia, as these patients were usually cared for in the referring hospital premises. There had been no situations in the reporting period where it was necessary for the unit to apply for a deprivation of liberty safeguards (DoLs) authorisation.
- Staff we spoke with told us about adjustments which could be made for someone with a specific need. For example, learning disabilities, they could have someone with them during treatment.
- The unit had a system in place, which could monitor how quickly the call bells were answered, but there had been no formal audits around this.

Learning from complaints and concerns

- The provider used a complaints management policy and procedure, which set out the process and staff responsibilities for handling compliments, comments, concerns and complaints. The policy defined the severity of complaints and set out a 20 working day timescale for the response to complaints and concerns. The clinic manager was responsible for ensuring complaints were responded to within the policy's timescales.
- We reviewed the patient handbook provided to patients by staff on the unit and saw that information about the complaints process was included in the new patient handbook. Patient complaints could be made verbally, in writing, by email or online.
- Data provided by the unit indicated that there had been two complaints in the 12 months prior to the inspection. One of which was managed under the formal complaints procedure.
- We reviewed both complaints. One related to an issue at the local NHS hospital and the other regarding a patient who felt unsupported by staff at the unit. The complaints were fully investigated and the patients were satisfied by the unit manager's response.
- The complaint investigations demonstrated patients' concerns were taken seriously and the service had responded appropriately within the policy guideline of 20 working days. The unit manager told us that all complaints were dealt with quickly to try to resolve any issues as soon as possible.

Are dialysis services well-led?

Leadership and culture of service

- There was a clear leadership and staffing structure in the Diaverum organisation and that was applied regionally to this unit. There was a unit and deputy manager, who had both worked for several years within the organisation and were able to demonstrate extensive experience within the renal field. The unit manager was supported predominantly by the nursing director.

- One nurse worked in a supported development team leader position in the unit. Senior managers were present during inspection. The unit manager was also present during the unannounced inspection.
- Morale within the unit was good and all staff we spoke with told us that they enjoyed their job. One nurse told us 'It's a good place to work. We all support each other and the manager is always around'.
- There was a friendly culture, and the manager was visible and approachable. The atmosphere was relaxed and we saw positive dialogue between staff and patients.
- The unit manager told us they received management information, support and training through six-weekly regional and six-monthly national meetings for unit managers.
- The unit manager was visible on the unit and proactively spoke with all patients during dialysis.

Vision and strategy for this core service

- The organisation mission was 'to improve the quality of life for renal patients'. The vision was to be 'the first choice for renal care'. Three values stemmed from these two elements, which were 'competency, inspiration and passion'.
- In order to achieve the mission and the vision, the organisation had five priorities, which included focusing on improving quality of life, pursuing operational efficiency and being a 'great' place to work. The manager was able to explain the background of each priority to us. For example the priority to be a great place to work stemmed from previous staff survey results.
- All staff were clearly able to describe the organisations mission and felt proud to be able to contribute to the overall quality of the patient's life.

Governance, risk management, and quality measurement

- There was a governance framework in place to support staff delivering care and managing units. For example, the clinic manager was overseen by the nursing director and operations director. Overall responsibility for governance and quality monitoring was held by the newly appointed Quality and Compliance officer.
- The unit manager told us there was no formal timetable for the nursing director visits to the unit and explained there was a close working relationships with corporate teams such as human resources and the recruitment teams. Communication was effective, the manager told us advice, and support was always available at the end of a telephone.
- The unit manager told us that they had undertaken a local improvement exercise in 2016 with senior managers to look at working practices and identify areas where improvements could be made. We reviewed the document and saw that an element of wasted time had been identified specific to health care assistants and the excess use of paper towels. We saw an action plan and solutions, which addressed this.
- Monitoring meetings took place with the trust to review performance against the service contract. Other working arrangements were in place with companies who maintained and replaced equipment, provided medicines and removed waste.
- There was a risk assessment log in use. The register separately held 10 risk assessments in total. All risks were identified in November 2016 and were due to be reviewed again in November 2017 or if a new concern was identified. Risks identified included clinical waste and sharps management, several regarding the environment, the movement of machines and stock and violence and aggression. We saw actions plans in place to mitigate against risks.
- A unit risk register was also in place, which identified five specific risks. These included loss of heating, water, electricity and telephone, supplier management problems, staffing crisis and failure of the water treatment plant. Each risk also included a description, assessment of likelihood and severity of the risk, overall risk level, mitigating actions, target for completion of actions, risk status and responsible persons. All risks were identified in November 2016 and were again due to be reviewed again in November 2017. Staff we spoke with were clear what these risks were and were appropriate to the environment.
- Monthly performance measures were monitored and included; clinical patient outcomes; compliance; staff usage, retention, absence, accidents and training; waste, water and electrical consumption and other costs. The unit manager looked at this information monthly and identified and trends or areas for improvement.
- We saw that following the failure of the water treatment plant (WTP) in February 2016 that a corrective action/ learning log was developed by the unit manager. We

saw this document was shared with patients, staff, renal consultants and the WTP manufacturers. The exercise was regarded as highly successful by the senior managers within the in the organisation and the unit manager was recognised for their clear leadership skills.

- Several policies had not been reviewed at the time of inspection. Governance processes required strengthening to ensure policies and procedures were reviewed regularly and were reflective of best practice.
- The audit programme was not inclusive of medicines management checks and clinical practice was not reviewed against policy guidelines.
- Patient arrival and pick up times were not monitored in accordance with NICE guidance.
- The safeguard policy did not refer to safeguarding children and staff had not received any safeguard training specific to children. There was a potential risk that staff may not recognise safeguarding information disclosed to them in relation to children.

Public and staff engagement

- We saw views and experiences of patients had been sought through the national Diaverum unit survey 2016. The survey was conducted by an independent company and enabled patients to feed back through a secure survey. The response rate was lower than the previous unit survey but generally showed that patients remained satisfied with their overall care and treatment.
- The survey action plan showed three areas for improvement. These included addressing waiting times for patient transport and improve the patient toilet facilities in the waiting area. We saw waiting times had improved but the manager told us it was constantly being reviewed.
- The unit encouraged patients to feedback at any time and took a proactive approach to addressing concerns or issues.
- The unit results were benchmarked against other dialysis units within the organisation. Darlington scored below average in terms of their response rate.
- We saw the unit manager had made changes to the unit following feedback from the patients. One example included the change in lighting used in the unit to increase the volume of light.
- A staff survey 'My Opinion Counts' was carried out in November 2016; senior managers told us 85% (eleven respondents) of staff responded. Of those that replied;
- 85% said they would recommend the unit to friends and family who needed dialysis.
- Around 90% received constructive feedback from their manager.
- Around 85% said the company supports training and development.
- Around 80% felt ideas and opinions were valued.
- Senior managers told us the survey would be repeated next year. We were unable to ascertain if there was an action plan based on the previous results as the number of participants was so small.
- There was a policy and process in place to enable staff to raise concerns at work through a nominated compliance officer. The policy also detailed how staff could access support or raise concerns outside of the organisation through 'public concern at work'. Poor practice concerns could also be raised through this policy, which was introduced following an NHS peer review in August 2016.
- The corporate human resources (HR) lead told us they visited the dialysis units periodically to make checks regarding things like; follow up actions from the staff satisfaction survey, although there were plans to improve this process to corroborate data submitted from each unit.
- The unit was not meeting the Workforce Race Equality Standard (WRES) (2015) at the time of our inspection. This is a requirement for locations (providing care to NHS patients with an income of more than £200,000) to publish data to show they monitor, assure staff equality, and have an action plan to address any data gaps in the future.

Innovation, improvement and sustainability

- The unit opened a pre dialysis clinic in conjunction with the local referring hospital to enable patients to attend without long journeys and to familiarise themselves with the unit.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must develop their children's safeguarding policy in line with current national guidance and ensure all staff are trained to an appropriate level, relevant to their role, in accordance with the intercollegiate document "Safeguarding Children and Young People" (2014).
- Ensure patient records are regularly reviewed, to ensure appropriate assessment of need is identified, re-evaluated and care plans are developed to lesson any identified safety concerns.
- All medicines must be dispensed and administered in accordance with NMC guidance.

Action the provider SHOULD take to improve

- Review policy and procedures in relation to confirming patient identify before medicine administration and include medicine audits as part of the provider audit programme to check compliance.
- Ensure that the Workforce and Race Equality Standards (2015) and 'Accessible Information Standard' (2016) are implemented appropriately.
- The provider should consider screening patients for Carbapenemase-producing enterobacteriaceae (CPE) when patients returned from receiving healthcare treatment abroad or when they returned from being an inpatient in UK hospitals, known to have had problems with the spread of CPE.
- Review the governance arrangements to include consistent policy review processes are in place and ensure the audit programme is designed to improve quality standards. For example, medicines management.
- Ensure arrival and pick up times for patients are monitored in accordance with NICE quality standards

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care plans were not always completed for patients, with an assessed medical conditions. Medicines were not always administered in accordance with NMC guidance.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not have a children's safeguarding policy and staff had not received children's safeguarding training relevant to their role.