Hamilton Renal Dialysis Unit

Quality Report

50 Crest Rise,(off Lewisher Road),Leicester,Leicestershire,LE4 9LR
Tel: (0116) 246 4176
Website: http://www.freseniusmedicalcare.co.uk/

Date of inspection visit: 27 July 2015
Date of publication: 01/03/2016

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?	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Hamilton Renal Dialysis Unit has provided dialysis services since 1 June 2010. Fresenius Medical Care acquired this unit in 2011. The service is commissioned by University Hospitals of Leicester NHS trust. A haemodialysis service is provided by the unit through an NHS contract. The contract is a fully managed contract with the building, equipment, consumables and staff all supplied by Fresenius Medical Care.

The dialysis unit is located in north east Leicester and provides dialysis for people in the local area. The service is registered to provide haemodialysis to 19 patients at designated times. The service runs three dialysis sessions a day from 06.00 to 22.30, six days a week with the ability to treat 57 patients a day.

Hamilton Renal Dialysis Unit was selected for a comprehensive inspection as part of Wave one of single speciality inspections of dialysis units. As this was a pilot inspection we did not rate the service.

We carried out an announced inspection of Hamilton Renal Dialysis Unit on 27 July 2015. The inspection team inspected the renal dialysis service.

Our key findings were as follows:

Are services safe at this unit?

- We found systems in place for reporting incidents at the unit. Staff knew how to report incidents and were encouraged to do so by their managers.
- Staff monitored patients before, during, and after dialysis to minimise risks to individual patients.
- Nursing staffing was managed effectively to give appropriate care to patients.
- All patient areas were visibly clean; infection prevention and control processes were in place and equipment had been checked regularly.
- Medicines were stored and administered safely.

Are services effective at this unit?

- Evidence based care and treatment was delivered to patients, which followed national guidance.
- Clinical staff had completed mandatory training and most had received annual appraisals.
- We found an audit programme in place for 2015, which included audits of medical records, medicines management, infection prevention and control and the effectiveness of dialysis treatment.

Are services caring at this service?

- We saw care delivered which was very responsive to patient's needs.
- Patients were treated with respect and dignity.

Are services responsive at this service?

- We saw a service delivered that was very responsive to patients' needs. The opening hours catered for patients to complete their treatment after work and at weekends.
- The unit had measures in place to support patients' differing needs such as interpreters and information in languages other than English.
- We saw evidence of the service responding to patient complaints.

Are services well led at this service?

- The leadership and governance at the unit promoted delivery of high quality care. Members of the management team were well respected amongst both staff and patients.
- There was a shared vision throughout the unit of providing excellent patient care.

Summary of findings

- Staff felt valued and an ethos of teamwork was apparent.

We saw several areas of outstanding practice including:

- The data provided to compare services and the effectiveness of services demonstrated thorough analysis of dialysis treatment.
- The provision of extended opening hours catered for patient's individual needs and gave greater flexibility for treatment.

However, there were also areas of poor practice where the provider needs to make improvements.

In addition the provider should:

- Consider a formal identification process for all patients prior to commencing treatment.
- Should consider a local risk register with reference to concerns that the managers highlighted during the inspection.
- Ensure all bank and agency staff have time set aside for orientation and induction prior to starting a shift and caring for patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Dialysis Services		Not Applicable

Summary of findings

Contents

Hamilton Renal Dialysis Unit

Services we looked at
Haemodialysis

Summary of this inspection

Background to Hamilton Renal Dialysis Unit

Hamilton Renal Dialysis Unit is an independent healthcare location owned by the provider, Fresenius Medical Care Renal Services (IDC) Limited. It is commissioned by a local NHS trust to provide a dialysis service for NHS patients over the age of 18 years with renal disease, who are low risk and do not require dialysis in a hospital setting. The contract is a fully managed service with facilities, equipment, consumables and staff all supplied by the provider.

The unit provides three haemodialysis sessions a day between Monday and Saturday, and has 19 dialysis chairs/beds for treatment. The unit has the capacity to treat up to 57 patients a day. Transport to and from the unit is provided by the Fresenius Medical Care transport services.

We carried out a comprehensive inspection of Hamilton Renal Dialysis Unit on 27 July 2015. Our inspection was part of a pilot looking at a comprehensive inspection framework that had been developed for use in independent dialysis units specialising in providing a single service.

CQC do not currently have a legal duty to rate this provider.

Our inspection team

The team included a CQC inspection manager, two CQC inspectors and a nurse specialist with a background in renal dialysis.

How we carried out this inspection

We carried out a comprehensive inspection of Hamilton Renal Dialysis Unit, as part of a pilot inspection programme. We used a comprehensive inspection framework developed for use in independent dialysis units specialising in providing a single service.

To get to the heart of the patients' experiences of care we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well led?

Before visiting the unit, we reviewed a range of information we held about the service. We carried out an announced inspection on 27 July 2015. We spoke with seven patients and seven staff individually and reviewed eight patients' records of their care and treatment. As part of our inspection we used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us.

We would like to thank all staff, patients and carers for sharing their balanced views and experience of care and treatment at Hamilton Renal Dialysis Unit.

Summary of this inspection

Information about Hamilton Renal Dialysis Unit

Hamilton Renal Dialysis Unit is registered to provide long term haemodialysis treatment to people with renal disease. The service has 19 dialysis stations where people receive their treatment including three individual rooms used for isolation purposes.

The service operates six days a week. People receive treatment during the day time hours opening from 06.00 until 22.30, Monday to Saturday inclusive.

Currently the unit cares for 107 patients between the ages of 18 to over 65 and provided 16,013 sessions of dialysis in the last 12 months.

The unit employ eight dialysis nurses, three allied health professionals and three dialysis assistants.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dialysis Services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Dialysis Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Hamilton Renal Dialysis Service is an independent healthcare location owned by the provider, Fresenius Medical Care Renal Services (IDC) Limited. It is commissioned by a local NHS trust to provide a dialysis service for NHS patients over the age of 18 years with renal disease who are low risk and do not require dialysis in a hospital setting. The contract is a fully managed service with facilities, equipment, consumables and staff all supplied by the provider.

The unit provides three haemodialysis sessions a day between Monday and Saturday, and has 19 dialysis chairs/beds for treatment. The unit has the capacity to treat up to 57 patients a day. Transport to and from the unit is provided by the Fresenius Medical Care transport services.

The service employs 11.38 whole time equivalent (WTE) staff, including a newly appointed on-site clinical manager. A regional chief nurse and area head nurse also supplied clinical support.

Summary of findings

Services at Hamilton Renal Dialysis Unit were safe. There were effective systems for reporting incidents and staff were aware of how to report incidents, including potential abuse. Investigations into incidents took place and lessons learnt were shared with staff in addition to actions being taken to reduce the risk of similar incidents happening again.

The equipment was maintained and the environment was visibly clean, well maintained and staff adhered to infection control measures. Medications were managed safely. Patient records were stored safely and were predominantly up to date. Risks to patients using the service were appropriately assessed and managed.

Staffing levels met the British Renal Society recommended guidance with a heavy reliance on bank and agency staff to maintain safe staffing levels. During our visit, bank staff were seen not to have received a local induction to the unit prior to commencement of a shift.

Evidence based care and treatment was delivered in accordance with national guidance and National Institute for Health and Care Excellence (NICE) quality standards. Patient outcomes were monitored and were above UK Renal Association standards. Staff were suitably qualified and skilled. Consent to care and treatment was obtained in line with legislation and guidance.

Services in the unit were caring. Patients were extremely positive about the quality of care and treatment they were receiving. We witnessed patients involved in the planning of their care and we saw staff treated patients with dignity and respect.

Dialysis Services

The services at the unit were responsive to the needs of the patient. Waiting times prior to treatment were kept to a minimum. Appointments were flexible where possible to cater for any changes a patient may request for example, if an important personal or family event coincided with the planned appointment.

There was a culture of teamwork and supportive local management in the unit. Staff felt respected and valued. Staff were proud of the service they offered and focused on providing good quality care. The unit's manager was responsible for local leadership at the service.

Are dialysis services safe?

There were effective systems for reporting incidents and staff were aware of how to report incidents, including potential abuse. Investigations into incidents took place and lessons learnt were shared with staff in addition to actions being taken to reduce the risk of similar incidents happening again.

The equipment was maintained and the environment was visibly clean, well maintained and staff adhered to infection control measures. Medications were managed safely. Patient records were stored safely and were predominantly up to date. Risks to patients using the service were appropriately assessed and managed.

Staffing levels met the British Renal Society recommended guidance with a heavy reliance on bank and agency staff to maintain safe staffing levels.

During our visit, bank staff were seen not to have received a local induction to the unit prior to commencement of a shift.

Incidents

- There were electronic systems for reporting incidents. Staff, including agency staff, told us they were aware of how to report incidents and were encouraged to do so. There was evidence of learning from incidents, for example the addition of practical training sessions in dealing with clinical emergencies.
- Staff were familiar with and could describe the process for investigating incidents.

Cleanliness, infection control and hygiene

- The unit was visibly clean and well maintained. The provider employed two cleaners to clean the unit six days a week. Patients we spoke to all commented on how clean the premises were. We observed that bedside clinical waste bins filled quickly, these were changed between each patient. Staff transferred clinical waste to a dedicated locked area for storage until collection by a waste management contractor.
- Staff adhered to the principles of five moments of hand hygiene. This is a World Health Organisation process that defines the key moments for hand hygiene, for example before patient contact.

- There was a good supply of personal protective equipment (PPE), which was used by both staff and relatives when required.
- The unit had three side rooms for use as isolation rooms for patients identified as having an increased infection risk, for example, patients with a blood born virus, Methicillin Resistant Staphloccocus Aureus (MRSA) or patients who had returned from holiday in a high risk area. MRSA is a bacterium responsible for several difficult-to-treat infections. Patients who had returned from holiday in a high risk area were nursed in these side rooms for three months. Patients identified as high risk had dedicated dialysis machines that were used for them alone. Warning signs were placed on equipment to highlight that it could be used only for a specific patient.
- There had been one episode of MRSA and two of Methicillin-sensitive Staphylococcus aureus (MSSA) reported in the last twelve months. MSSA is another type of bacteria which can adversely affect patients.
- Infection prevention and control (IPC) policies were in use. Water quality testing was performed to monitor micro-bacterial and endotoxin levels (bacteria which in high levels can be dangerous to dialysis patients). This was monitored by the provider's central laboratory on a monthly basis. In the last twelve months one unacceptable level had been received. The water treatment plant was decontaminated and repeat testing was performed. The repeat test was acceptable.
- Machines were automatically sterilised between each patient as part of the dialysis machine cycle. This was done in accordance with the IPC policy.
- Staff completed monthly hand hygiene and IPC audits, results demonstrated 100% compliance. A local NHS trust unannounced IPC audit identified 85% compliance to IPC policy in all areas. Findings from the audit had been analysed and an action plan to address the areas of non-compliance had been produced. We saw evidence that actions had been taken in the areas highlighted by the audit, such as hand washing post removal of PPE.

Environment and equipment

- The 16 bedded unit was separated into four bay areas which meant nurses were able to see their patients easily. This did mean however, that during set up and termination of dialysis sessions the alarms were loud and continuous and could be heard across patient areas However, patients and staff reported they did not find the alarms intrusive.
- There were 28 dialysis machines in use at the unit. All had been serviced within the last twelve months. A record was kept of the yearly servicing and calibration of all the unit's equipment.
- Staff checked the resuscitation equipment daily, including whether items were appropriately packaged, stored and ready for use.
- There were hoists available for use for less mobile patients and those who required lifting.
- There was sufficient secured storage areas for consumables within the unit. Consumable items such as bottled saline were stored off the ground on pallets.
- A standard operation procedure was in place for monthly water quality testing. This was monitored by the provider's central laboratory.

Medicines

- Medicines were stored, managed, administered and recorded safely and appropriately. Audit records confirmed that medicines requiring cold storage were maintained at the correct temperature. The provider confirmed a medicine top up service was provided by the commissioning trust as required. Advice and support was also sought and received from the commissioning trust.
- Paper prescription charts were in use and signed appropriately. There was evidence of withheld doses of medication documented and the reason was given for witholding these. We saw staff following Nursing and Midwifery Council guidance on intravenous injection of medication.
- Staff administered medications prior to commencement of treatment. Routine medication was provided by the unit. Patient specific medication was brought into the unit by each patient and self-administered from their own supply.

Records

- Patient paper records were kept in a closed cabinet behind the staff desk. During their treatment, patient's records were moved to a folder on top of the dialysis

machine beside the patient's chair or bed. This provided access to them for the nurse during dialysis. These notes included clear printed treatment charts and detailed care plans.

- We looked at eight patient notes, one of which had information missing. The patient's records stated that a living will was in existence, but it could not be found. This was raised with the clinic manager who was familiar with the patient and addressed the matter by planning to contact the family to discuss the living will.
- The dates of admission were missing on the new patient assessment of two sets of paper notes. However, electronic records were also in use at the unit, and contained records of all dialysis events.
- Electronic data systems were linked between the dialysis unit and the trust that commissioned the service, which allowed results for patients to be shared between the two sites. Copies of discharge details from any recent hospital admissions were kept in the patient's notes.

Safeguarding

- Staff demonstrated an awareness of the procedure to follow if abuse of a patient was suspected or alleged. Adult safeguarding level two training was provided annually for all staff. Children were not treated or permitted in the unit. The service had a suitable adult safeguarding policy in place.
- The clinic manager was the safeguarding lead and fed back any safeguarding issues and updates to the provider's area head nurse.
- Staff completed training in safeguarding adults. An average 92% of staff had completed adult safeguarding training.

Mandatory training

- Mandatory training for staff working in the unit included topics such as basic life support, safeguarding, manual handling, hand hygiene, blood borne virus training and anaphylaxis training.
- Training was delivered using a combined learning approach, either as electronic learning, face to face or work based training. Staff were paid for time spent completing online training in addition to their shift.
- We saw data demonstrating a high compliance rate with regards to staff undertaking training. Eleven out of 13 staff had undertaken 90% of the 30 topics covered in mandatory training. The other two staff had completed 22 and 24 topics. Staff training and compliance had been a recent focus by the clinical manager. The 90% completion rate demonstrated a marked improvement on the average 55% compliance in May 2015.

Assessing and responding to patient risk

- Hamilton dialysis unit had a strict admission and exclusion criteria. The requirements for deciding a patient's suitability for treatment at the unit were clearly outlined in the unit's admission policy document.
- During treatment, the nursing staff and the dialysis machines analysed data to monitor the patient's condition. Staff also observed patients closely for signs of deterioration whilst treatment was in progress.
- Monthly progress assessment meetings were held with the multidisciplinary team including nephrologist, dietician and clinic manager. Patient progress, blood results and the patient's clinical condition were discussed. Additionally, a discussion would be held concerning patients whose care was deviating from the normal care pathways, such as early termination of treatment on a regular basis against medical advice. The British Renal Society (BRS) gives a recommended duration for treatment of patients to maintain blood target levels. If patients terminate their treatment early, then this can reduce the effectiveness of their care.
- There was no formal policy or process in place for patient identification; this was undertaken by asking a patient their name. We observed this taking place prior to administration of medication. Patients placed themselves in their usual chairs with the staff they were familiar with. The lack of a full and formal identification process could potentially lead to misidentification of a patient. During our visit we saw one gentleman who had difficulty in hearing and another who spoke very little English. Both of these patients may have been at greater risk of being misidentified if they could not hear or fully understand the nurse delivering their treatment. We saw evidence from meetings that the process of patient identification was undergoing review.
- Patients who became unwell during dialysis were assessed by staff and transferred by emergency ambulance to a nearby NHS hospital if required. A transfer agreement allowed direct contact to the renal registrar at the commissioning trust, although patients would attend the emergency department for assessment.

Nursing staffing

- At the time of our inspection the unit had three full time dialysis nurse vacancies. The clinical manager told us that the lack of trained nurses in renal dialysis and the prevalence of bank work available to nurses with dialysis training, caused difficulty in recruiting permanent staff for the unit.
- The unit employed eight dialysis nurses, three allied health professionals and three dialysis assistants.
- There was a ratio of four qualified nurses and one dialysis assistant per shift for nineteen patients, which was in accordance with BRS recommendations. The provider met planned staffing levels for the unit.
- Due to staff shortages, high numbers of the provider's bank staff and other agency staff were used. Seventy five bank shifts and 110 agency shifts had been undertaken in the last three months. On average this equated to two staff per day being agency staff.
- Staff assured us that all bank and agency staff were provided with an induction on their first day of work at the dialysis unit. During inspection we witnessed an agency staff starting work without thorough induction. Block bookings were made with the provider's renal agency staff to fill the gaps and improve continuity.
- Patients we spoke to told us that although staffing levels had increased recently, they would have liked to have more support staff to assist with tasks such as the provision of food and drinks and handing out blankets if patients were cold during their dialysis.
- Patients told us they felt safe under the care of the unit's staff and that staff never failed to attend when assistance was needed despite how busy they were. During our visit, we observed occasions where three members of staff were attending to patients who required extra assistance during their dialysis. This did however leave two members of staff looking after the remaining patients for the duration of the incident. Despite staffing levels meeting the guidelines set by the BRS there was a risk that if multiple patients required assistance then there would be limited staff remaining to monitor the other patients.
- Staff handover meetings occurred at the beginning of each day, we were told that staff were informed of any changes within the service and any high risk cases during these meetings. Individual patient care was allocated to a named member of staff for each shift. Bay allocations for nursing staff and the nominated nurse in charge were written on a board in the unit for both patients and staff to see.
- Staff were encouraged to continue to learn and develop and were supported to attend the renal qualification course.

Medical staffing

- There were no medical staff on site at the unit. Arrangements had been made for the unit's staff to contact the renal consultant or medical registrar on call at the commissioning NHS trust for assistance in the event of concerns about a patient. Members of staff could give examples of when this had occurred and the outcome. We were told that out of hours (between 07.00 and 08.00 or after 20.00) the time it took for the renal consultant or medical registrar to call back could be slower, but this had not compromised patient care. We did not see evidence or recordings of this.
- Consultant clinical reviews of patients were performed during outpatient clinic's held at the unit.

Major incident awareness and training

- The dialysis unit had a major incident policy highlighting the actions to take and each individual's responsibilities in the event of an emergency. Staff were able to show the inspection team how to access the emergency contact details and policy.
- Staff were able to describe a recent incident where the power had failed. They also told us about the actions taken to maintain patient safety and treatment during this incident.

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

Dialysis services at the unit were effective. Evidence based care and treatment was delivered in accordance with national guidance and National Institute for Health and Care Excellence (NICE) quality standards. Patient outcomes were monitored and were above British Renal Society standards. Staff were suitably qualified and skilled. Consent to care and treatment was obtained in line with legislation and guidance.

Evidence-based care and treatment

- Patient needs were assessed and care and treatment was delivered in accordance with the National Institute for Health and Care Excellence (NICE) quality standards. Patients had risk assessments undertaken relating to pressure ulcers and risk of falls.
- National guidance for diagnosis and treatment of central venous catheter related infections was in use. In line with the recommendations, all staff were trained in taking blood culture tests when indicated.
- The provider had a process in place to monitor the data from each unit, and compare the performance and clinical outcome figures against other dialysis units within the provider group. This data included audits of patient records, medicine management audits and patient dialysis hours. The unit performed the same as or better than other units.

Nutrition and hydration

- Staff provided drinks and biscuits to patients during dialysis and patients were also encouraged to bring their own appropriate food to their sessions.
- Information displayed around the unit educated patients on diet and nutrition.
- Dieticians reviewed the patients monthly after their blood results were available; alternatively patients could contact the dietician for advice. The importance of good nutrition was highlighted to patients as being an integral part of their treatment.

Patient outcomes

- Minutes were seen of the monthly quality assurance meetings held to monitor patient outcomes using the current electronic data. These figures were reviewed locally by the clinical manager and consultant as well as centrally at head office. In addition to this, monthly audits were sent to both the provider and the commissioning NHS trust.
- Data was collated for the Renal Registry for the commissioning NHS trust, but did not identify specifically those receiving treatment at Hamilton Renal Dialysis Unit. This meant that the unit could not compare their patient figures to other NHS trust patients using the Renal Registry data, although the unit would be able to with the provider's other facilities.
- Monthly audits of patient outcomes were collated as a scorecard. In the last six months figures quantifying haemodialysis adequacy, the unit's percentages were between 88% and 94%. This figure was significantly better than the British Renal Society recommendation of 65%. This is a measure of how effective the dialysis treatment is at removing the harmful waste products.

Competent staff

- New staff had an induction period of six weeks when new staff were considered to be supernumerary (employed as an extra worker). New staff worked a probationary period of six months. One new member of staff said she they were supported well during their induction and staff training was very helpful.
- Training was available for all staff in renal dialysis and end of life care in addition to other general mandatory training.
- A leadership training programme was in place to support the current and deputy clinical leaders. This was being supported by the area head nurse and unit training lead with an action plan in place.

Multidisciplinary working

- Multidisciplinary teams (MDT) comprising of the clinical manager, nephrologist and dieticians met monthly to discuss patient care. In discussions with patients, it was evident that patients were aware and involved in their own plans of care.
- Staff referred patients to a social worker as required; this was done via the commissioning NHS trust.

Seven-day services

- The dialysis unit ran three dialysis sessions a day between 06.30 and 22.30 Monday to Saturday.
- The session commencing at 17.30 enabled people to attend after their work.

Access to information

- Information, including blood results were shared electronically between the commissioning NHS trust and the dialysis unit.
- Staff including agency staff accessed the unit's policies and procedures on line, including safeguarding policies. The unit's policies were reviewed each year.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff received training about the Mental Capacity Act (MCA) 2005 and an introduction to dementia training for healthcare professionals. A named nurse was involved

in developing training relating to caring for patients living with Alzheimer's disease. The training was aimed to enhance the nursing team's awareness of the care and management of patients living with Alzheimer's disease with a focus on consent, the MCA (2005) and Deprivation of Liberty Standards.

- Staff told us when patients appeared to be unsettled or confused during treatment, they tried to involve the patient's family in planning their care. They also allocated appropriate areas of the unit to improve patient supervision and safety.
- We saw evidence of completed consent forms in all eight patient records. Two of these had the signature of an interpreter present on the consent. This indicated language services had been used in order to help the patient understand the consent process as English was not their first language.

Are dialysis services caring?

Services in the unit were caring. Patients were extremely positive about the quality of care and treatment they were receiving. We witnessed patients involved in the planning of their care and we saw staff treating patients with dignity and respect.

Compassionate care

- Patient participation in the 2014 service user survey was poor with only eight responses out of 110 patients. There were posters and leaflets asking for feedback on the care received at the unit. We saw evidence of the clinical managers responding to the comments that were received from the survey.
- All the patients that we spoke with told us that staff treated them with kindness and compassion. We saw relatives welcomed into the unit and treated like family by the staff. Without exception, we were told that staff were polite, friendly, and approachable.
- Staff assisted patients to their treatment chairs in an appropriate manner, using wheelchairs or lending a supportive arm if necessary.
- We saw a member of staff recognise a patient's distress at having blood on their own clothing. The staff member supplied a pair of trousers to the patient to wear home.

Understanding and involvement of patients and those close to them

- Patients were encouraged to be involved in their care and treatment. We observed and were informed of episodes where patients altered the timing and length of their dialysis treatment session. Patients were made aware of the impact of changes to the duration of their treatment, and provision made to alter appointment times.
- On occasions patients would receive a telephone call to ask if they would like to attend their dialysis a little earlier that day. Patients told us they appreciated the call and did not feel pressurised into moving the appointment. The patients we spoke to felt that it was a service that was considering their other needs.
- Patients and families were encouraged where possible to take responsibility for aspects of their care. The swipe card data management system enabled patients to log in and record their own weight on arrival at the unit.

Emotional support

- Staff at the unit worked with the consultant and matron at the NHS commissioning trust to provide social work support for patients.
- Support group information was available in the waiting area of the unit. The unit engaged with local patient representatives and advocacy officers.

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

The services at the unit were responsive to the needs of the patient. Waiting times prior to treatment were kept to a minimum. Appointments were flexible where possible to cater for any changes a patient may request for example, if an important personal or family event coincided with the planned appointment.

Service planning and delivery to meet the needs of local people

- The late opening of the unit allowed patients to access services after work.
- Patients were offered the opportunity to use the unit's patient transport service to take them to and from the dialysis unit. These drivers were solely for the use of the dialysis unit's patients. Drivers were available in the unit at the prearranged pick up and drop off times. The

transport services did not provide transport for any other of the provider's units. Patients who used the service did not have to wait for their transport both before and following their treatment. The unit did not audit waiting times for patients.

- There were sufficient free car parking spaces for those who drove to the unit.
- Call bells were available and in reach of all patients in each chair/bed space.
- Leaflets in the waiting room were available in languages other than English. Examples included nutritional information, feedback on the service, and how to make a complaint. Family members or members of staff were available to translate if necessary, however this may not be best practice or appropriate for patients. However, staff described using the commissioning NHS trust translation services for patients that required them.
- The department had good disabled access and five wheelchairs were available at the entrance for patient use. Beds were available for the care of bariatric patients.
- Patients and staff described a process for organising dialysis elsewhere in the country or abroad when the patients went on holiday. If capacity permitted the unit would treat patients who came to the area while on holiday. The unit did stipulate that any visiting patient's notes had to be transferred to the commissioning trust for proper assessment.
- Lockable cupboards were available for storing patients' personal valuables during treatment. Free wireless internet services were available for patients to access during treatment.
- One patient told us that they had asked to move their treatment bay as they always had agency staff and they worked at a slower pace. This was upheld by the unit and the patient moved to be cared for by permanent members of staff.
- Televisions were made available for patients during treatment and many brought their own activities or headphones. Staff and patients tailored entertainment to their individual needs.
- We saw evidence of patients altering their dialysis time to facilitate family events. Appointments were flexible where possible to cater for any changes a patient may request for example, if an important personal or family event coincided with the planned appointment.

Access and flow

- Hamilton renal dialysis unit had admission and exclusion criteria that detailed the clinical indicators relating to patients in order for them to be accepted for treatment. These criteria were set out in the provider admission policy.
- Patients described that they were initially given appointments at the end of the day when they first started to attend the unit. This allowed more time to discuss care and concerns. After a couple of weeks, patients were able to organise appointments at other times to suit their needs.
- Time delays are critical in dialysis care. Most patients described only having to wait fifteen minutes at a time for commencement of treatment. This was supported by a period of observation during commencement.
- We did however observe one patient waiting an hour prior to starting treatment. Communication with this patient was not adequate and the patient was unaware of the reason for the delay. The unit's management identified the delay and the situation was resolved. The patient told us that this had never happened before and had been very pleased by the flexible service they received from Hamilton Renal Dialysis Unit.

Learning from complaints and concerns

- The dialysis unit received four complaints in the first five months of 2015. The clinical manager handled complaints and had responded to both the patients and staff concerned. We saw evidence of the complaints process and response to the patients concerned. We also spoke to a patient who had complained and were told that changes had occurred as a result of the complaint.
- Patients expressed that the staff were very approachable and the new clinical manager would listen to them if they had a complaint. One patient commented that the receptionist was very open to concerns, and would follow up questions if she did not have the answer.
- Information about making complaints was available for patients. Patients we spoke with knew how to complain and one patient gave us two examples of complaints that the unit had been proactive in dealing with.

Dialysis Services

Are dialysis services well-led?

Leadership at the unit had a clear understanding of the issues of the service. There was a culture of teamwork and supportive local management in the unit. Staff felt respected and valued. Staff were proud of the service they offered and focused on providing good quality care. Responsibility for local leadership fell to the unit's clinical manager.

Vision, strategy innovation and sustainability for this core service

- The current contract with the commissioning trust has two years remaining and there were plans to expand the unit to cater for 28 dialysis chairs. Staff described the service as being committed to providing good quality care for patients. They were able to describe the plans and vision for expansion of the service.
- Staff received monthly updates via staff meetings on any changes proposed by the provider or those relating to the unit.
- The clinical manger had action plans in place for improving the response to patient surveys such as the use of 'Tell us what you think' leaflets and ensuring each patient is provided with a survey.

Governance, risk management and quality measurement for this core service

- Clinical governance meetings were held at head office. These were attended by a variety of staff including the clinical service director, area head nurse and clinic manager. There representatives circulated information to individual clinics. We saw evidence of the meeting minutes and actions taken relating to the unit regarding planned support of the new clinical manager.
- The unit was able to benchmark their performance against other Fresenius units via the company scorecards. Data showed the unit was equal to or better than two other regional provider units.
- The risk register was developed at head office and included over-arching topics rather than specific areas. None of the existing risks were specific to the unit and all risks were under investigation. There was no local risk register highlighting the issues picked up during inspection.
- The clinical manger was also responsible for leading on infection prevention and control (IPC), for which they linked with the local NHS trust. Unit audits were performed and results returned to the trust. Unannounced IPC visits and audits were performed by the NHS commissioning trust's infection prevention and control nurses, which demonstrated an 85% compliance with the IPC policies and procedures. We saw actions addressing hand hygiene and further local audits performed.

Leadership and culture of service

- Leadership at the unit had been a challenge recently, having had three clinical managers in 18 months. This was being addressed through the development of a supported leadership programme to enable the current clinical lead to target areas for improvement. Staff and patients reported that the new clinical lead had made a difference, including increasing the numbers of staff available and providing greater support for new members of the team.
- There was a culture of teamwork and supportive management. Staff were seen to work together in order to start and finish dialysis treatments in a timely fashion. Team leaders remained beyond their shift end and supported the other staff. Staff were paid for the time they worked including additional hours.

Staff engagement

- The management highlighted the provider's annual staff survey had not generated any responses from staff at the unit. The management were aware that this was not a good reflection of the unit's inclusive culture and did not have an explanation for the poor response. The clinical manager is working on ideas to address the poor response rate prior to the next survey in October 2015.

Patient engagement

- As a result of patient requests, one patient had been asked to write a booklet for other patients. This was to give answers to common quests and concerns from the patients view. This booklet was in the development stage at the time of our visit.

Outstanding practice and areas for improvement

Outstanding practice

- The data provided to compare services and the effectiveness of services demonstrated thorough analysis of dialysis treatment.
- The provision of extended opening hours catered for patient's individual needs and gave greater flexibility for treatment.

Areas for improvement

Action the provider SHOULD take to improve

The provider should consider a formal identification process for all patients prior to commencing treatment.

The provider should ensure all bank and agency staff have time set aside for orientation and induction prior to starting a shift and caring for patients.

The provider should consider a local risk register with reference to concerns that the managers highlighted during the inspection.