The Risk Practice Ltd

Showmed

Quality Report

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

Ratings

Overall rating for this ambulance location	Requires improvement
Emergency and urgent care services	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

ShowMed is operated by the Risk Practice Ltd and supplies doctors, nurses, paramedics, emergency medical technicians and first aiders to sporting and public events.

CQC do not regulate activities that are undertaken on an event site. However, CQC do regulate activities involving patients being transported from an event to hospital, which was an activity that was carried out by the service.

We inspected this service using our comprehensive inspection methodology. We carried out the short notice announced part of the inspection on 11 and 12 November 2019. Following this, further concerns about the service were raised with CQC and a further unannounced visit to the service took place on the 7 January 2020.

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?

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

We rated the service as **Requires improvement** overall.

We found the following issues that the service needs to improve;

- The service did not operate a system that protected people from abuse. This was because there was an increased risk that safeguarding referrals would not always be made in a timely manner.
- The maintenance and use of equipment did not keep people safe. The service had not maintained oversight of all equipment and staff had reported a high number of incidents when equipment had not been available or had been faulty.
- Staff did not use the system to help identify deteriorating patients. Staff had not documented a national early warning score for patients on any occasion.
- The service had not recorded whether there had been enough staff with the right qualifications, skills and experience to keep people safe from avoidable harm and to provide the right care and treatment. This was because records did not indicate which members of staff had been responsible for transporting patients to hospital.
- Staff had not always kept detailed records of patients' care and treatment. We reviewed 11 patient records, finding that none had been fully completed.
- The service did not use safe systems to safely store, record and prescribe medicines. The service had not maintained oversight and we found a large number of medicines discrepancies against what was recorded. In addition, the service had not used Patient Group Directives, which was not in line with the Human Medicines Regulations 2012.
- The service had not always managed incidents well. Managers had not always investigated incidents or learnt lessons. We found that there was not always documented evidence of an investigation into incidents that had been reported or actions taken to reduce the risk of a similar incident happening again.
- Managers had not checked whether care and treatment had been given in line with national guidance and evidence-based practice.
- The service did not always make sure that staff were competent for their roles. On checking personnel files, evidence of competencies had not always been checked at the start of their employment.

Summary of findings

- Staff had not always documented why patients had lacked Mental Capacity on occasions when they had acted in their best interest. On two occasions, staff had not fully documented the reasons why they had lacked Mental Capacity to make their own decision about care and treatment.
- Although the service had workable plans to turn their vision and strategy into action, there was an increased risk that this would not be achieved in a timely manner.
- Leaders had not always operated effective governance processes. We found that the service held patient safety group meetings, however, it was unclear how the service was planning to take action to make improvements where needed.
- Leaders had not always used systems to manage performance effectively. The service was not aware of all areas that we identified as requiring improvement during the inspection. In addition, risks had not always been minimised in a timely manner.

However, we found the following areas of good practice;

- The service provided mandatory training in key skills to all staff and made sure that everyone completed it.
- The service controlled infection risk well. Staff used equipment and control measures to protect themselves, patients and others from infection. They kept the premises and equipment visibly clean.
- On most occasions, staff assessed and monitored patients regularly, and gave pain relief in a timely way.
- Staff within the service communicated effectively and the service worked well with other agencies.
- Staff understood the need to treat patients with compassion and kindness as well as to respect their privacy and dignity.
- The service worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of individuals needs and preferences. Staff made reasonable adjustments to help patients access services.
- The service had planned to treat concerns and complaints seriously, investigate them and share lessons with all staff.
- Leaders were visible and approachable.
- Staff who we spoke with felt supported, respected and valued.

Following this inspection, we told the provider that it must take some actions to comply with the regulations. Due to the concerns that we had following the inspection, we issued enforcement action, telling the service that it had to make significant improvements. This is detailed at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals North, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Requires improvement 	Urgent and emergency services are provided at this location. We rated the service as 'requires improvement'.

Requires improvement

Showmed

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

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Background to Showmed

ShowMed is operated by The Risk Practice Ltd. The service opened in 1999. It is an independent ambulance service located in Bolton, with further bases in the Midlands and the South of England. The service provides doctors, nurses, paramedics, emergency care technicians, emergency care assistants and first aiders to organised sporting and public events nationwide.

The service had 10 permanent staff, with defined roles and responsibilities and 320 staff working for them on a casual basis. Staff referred to throughout the report included those employed on a permanent and on a casual basis. Staff were deployed to events based on an electronic booking system overseen by a dedicated workforce planning co-ordinator. Permanent members of staff included the registered manager who was the director of clinical care and training, a workforce director and a managing director.

The service supported a range of venues and events varying in size and location, for example, sporting arenas, race courses, cycling centres, concerts, filming locations, and historic buildings amongst others. The service had a member of staff responsible for major events planning, where large crowds were expected to attend. The service provided medical management, safety, event first aid and a patient transport service to its clients. We regulate the part of this independent ambulance service related to the urgent transfer of patients and their care and treatment during their transfer.

Between January 2019 and November 2019, the service transferred 11 patients from an event site via ambulance to local hospitals.

The service is registered to provide the following regulated activities:

• Transport services, triage, and medical advice provided remotely.

• Treatment of disease, disorder, or injury.

The service has had the current registered manager in post since 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, as well as two other CQC inspectors. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Detailed findings

Facts and data about Showmed

During the inspection, we visited the ambulance station at Bolton. We spoke with 11 members of staff including; registered paramedics, as well as members of the management team. In addition, we reviewed 11 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, and the most recent inspection took place in February 2018.

Activity (January to November 2019)

- In the reporting period January 2019 to November 2019, there had been 11 emergency and urgent care patient journeys recorded.

Track record on safety

- One never event
- 52 Clinical and non-clinical incidents
- 0 serious injuries
- 0 complaints

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	N/A	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	N/A	Good	Requires improvement	Requires improvement

Emergency and urgent care services

Safe	Requires improvement
Effective	Requires improvement
Caring	
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

During the inspection, we visited the ambulance station at Manchester. We spoke with 10 staff including; registered paramedics, as well as members of the management team. In addition, we reviewed 11 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, and the most recent inspection took place in February 2018.

Activity (January to November 2019)

- In the reporting period January 2019 to November 2019, there were 11 emergency and urgent care patient journeys undertaken.

Track record on safety

- One never event
- 52 Clinical and non-clinical incidents
- 0 serious injuries
- 0 complaints

Summary of findings

We rated the service as **Requires improvement** overall.

We found the following issues that the service needs to improve;

- The service did not operate a system that protected people from abuse. This was because there was an increased risk that safeguarding referrals would not always be made in a timely manner.
- The maintenance and use of equipment did not keep people safe. The service had not maintained oversight of all equipment and staff had reported a high number of incidents when equipment had not been available or had been faulty.
- Staff did not use the system to help identify deteriorating patients. Staff had not documented a national early warning score for patients on any occasion.
- The service had not recorded whether there had been enough staff with the right qualifications, skills and experience to keep people safe from avoidable harm and to provide the right care and treatment. This was because records did not indicate which members of staff had been responsible for transporting patients to hospital.
- Staff had not always kept detailed records of patients' care and treatment. We reviewed 11 patient records, finding that none had been fully completed.

Emergency and urgent care services

- The service did not use safe systems to safely store, record and prescribe medicines. The service had not maintained oversight and we found a large number of medicines discrepancies against what was recorded. In addition, the service had not used Patient Group Directives, which was not in line with the Human Medicines Regulations 2012.
- The service had not always managed incidents well. Managers had not always investigated incidents or learnt lessons. We found that there was not always documented evidence of an investigation into incidents that had been reported or actions taken to reduce the risk of a similar incident happening again.
- Managers had not checked whether care and treatment had been given in line with national guidance and evidence-based practice.
- The service did not always make sure that staff were competent for their roles. On checking personnel files, evidence of competencies had not always been checked at the start of their employment.
- Staff had not always documented why patients had lacked Mental Capacity on occasions when they had acted in their best interest. On two occasions, staff had not fully documented the reasons why they had lacked Mental Capacity to make their own decision about care and treatment.
- Although the service had workable plans to turn their vision and strategy into action, there was an increased risk that this would not be achieved in a timely manner.
- Leaders had not always operated effective governance processes. We found that the service held patient safety group meetings, however, it was unclear how the service was planning to take action to make improvements where needed.
- Leaders had not always used systems to manage performance effectively. The service was not aware of all areas that we identified as requiring improvement during the inspection. In addition, risks had not always been minimised in a timely manner.

However, we found the following areas of good practice;

- The service provided mandatory training in key skills to all staff and made sure that everyone completed it.
- The service controlled infection risk well. Staff used equipment and control measures to protect themselves, patients and others from infection. They kept the premises and equipment visibly clean.
- On most occasions, staff assessed and monitored patients regularly, and gave pain relief in a timely way.
- Staff within the service communicated effectively and the service worked well with other agencies.
- Staff understood the need to treat patients with compassion and kindness as well as to respect their privacy and dignity.
- The service worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of individuals needs and preferences. Staff made reasonable adjustments to help patients access services.
- The service had planned to treat concerns and complaints seriously, investigate them and share lessons with all staff.
- Leaders were visible and approachable.
- Staff who we spoke with felt supported, respected and valued.

Emergency and urgent care services

Are emergency and urgent care services safe?

Requires improvement

We rated safe as **requires improvement**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure that most staff completed it.

All staff were required to complete mandatory training modules every 24 months which were delivered via e-learning. This covered important topics such as equality, diversity and human rights, as well as handling medication, violence and aggression, lone worker training and radicalisation.

Records provided during the inspection indicated that 81% of all staff were up to date with mandatory training as of November 2019. A member of the management team had responsibility for maintaining oversight of this and to encourage staff to complete refresher training when needed.

We were informed that two further e-learning modules had been recently added for all registered paramedics to complete. Records provided before the inspection indicated that of September 2019, 47 paramedics had completed training about the Joint Emergency Services Interoperability Principles (key actions to take in the event of a major incident) and 41 paramedics had completed 'prevent' training.

Safeguarding

The service did not operate a system that protected people from abuse.

The service had a up to date safeguarding policy for adults and children which was available for staff to access. All staff who we spoke with knew how to access this.

The policy clearly outlined the roles and responsibilities of staff and gave examples of what should be considered as a safeguarding concern. In addition, all staff who we spoke with were able to give us examples of potential safeguarding concerns and staff knew how to report this.

However, there was an increased risk that safeguarding referrals would not be made in a timely manner. This was because the service had implemented a referral system which stated that some safeguarding referrals needed to be made immediately, some within 24 hours and others had no time limit. This was not in line with national guidance, which states that all safeguarding referrals, no matter what the concerns involve, should be made to a local authority immediately.

In addition, the safeguarding policy stated that all safeguarding concerns should be reported to the registered manager who would then be responsible for making a referral to a local authority. We had concerns that on occasions when the registered manager was not available, that a safeguarding referral would not always be made in a timely manner.

Since our last inspection of February 2018, the management team had added a safeguarding section to each patient report form which staff were required to complete for every patient. This was important as it had been added to provide oversight of whether the need for a safeguarding referral had been considered for all patients. However, on reviewing all 11 patient records that had been completed between January 2019 and November 2019, we found that this had not been completed on seven occasions.

All staff were required to undertake safeguarding level two training for adults and children. In addition, registered paramedics were required to complete safeguarding level 3 training for children. This was in line with guidance from the Intercollegiate standards for children and young people in the emergency care setting, 2018. Records indicated that 81% of staff were up to date with safeguarding training.

The registered manager had undertaken level four safeguarding training for adults and children, which was in line with national guidance, and was important as it meant that they had received appropriate training to reduce the risk of potential safeguarding incidents being missed.

The service had not always completed an up to date enhanced disclosure and barring service check for staff at the time that they were recruited. We reviewed 20 personnel files during the inspection, finding that this had

not been completed on 15 occasions. This meant that there was a potential risk that the service did not always have access to the most recent and up to date disclosure and barring service check for all staff.

In addition, during our inspection of 7 January 2020, we reviewed a further 12 personnel files, finding that there was no evidence of a disclosure and barring check having been completed for a member of staff who was currently active. We raised this with the management team at the time of the inspection, who informed us that they would be made inactive until this had been provided.

Following the inspection, the provider informed us that there were plans to make sure that all employees had subscribed to an electronic disclosure and barring update service, which provides up to date information about important information such as criminal cautions and convictions.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect themselves, patients and others from infection. They kept the premises and equipment visibly clean.

The service had an infection and prevention control policy that was available to all staff. This covered topics such as decontamination as well as sharps injuries. In addition, staff were required to complete an infection and prevention control module as part of the mandatory training. The policy also outlined the roles and responsibilities for making sure that uniforms were cleaned appropriately.

Personal protective equipment was available on all ambulances. This included disposable clinical gloves and aprons. Staff were aware of when these should be used.

All ambulances had spill kits available which were used to clean any bodily fluids. In addition, staff used disinfectant wipes to clean equipment such as wheelchairs and stretchers after use.

The infection and prevention control policy outlined the need for staff to be 'bare below the elbow' and to make sure that they decontaminated their hands following every patient contact. However, monthly audits that had been undertaken to monitor this had indicated poor compliance. There was an increased risk that improvements would not be made as we did not see evidence of actions taken to increase compliance.

Staff were responsible for completing daily cleaning checks prior to their shift. However, although cleaning checklists had been completed, they only recorded whether vehicles had been mopped. This meant that it was unclear if all areas of the ambulance had been cleaned so that the risk of infection was reduced as much as practicably possible.

All ambulances, garages, staff areas and offices were visibly clean and tidy.

Cleaning equipment was available in all ambulance stations. A colour coding system was used which separated equipment that was to be used in different areas. For example, in ambulances and in non-clinical areas. There were posters located next to all cleaning equipment to support staff in identifying the correct equipment to use.

The service had planned to make sure that both vehicles were deep cleaned every six weeks. We reviewed records which indicated that this had been done. Deep cleaning is important as it reduces the risk of infections being spread.

All staff were required to provide evidence of vaccinations during the recruitment process. On sampling personnel files, we found evidence that this had been completed on all occasions.

Environment and equipment

The maintenance and use of equipment did not keep people safe. The service did not manage clinical waste well.

The service had two ambulance stations. During this inspection, we visited the site at Bolton. We were informed during the inspection that both sites were used to store equipment and vehicles.

At the Bolton base, vehicles were kept inside the station securely. Vehicle keys were also kept securely in a separate locked key safe.

We found that the Bolton site was well organised and was free of clutter. Garage and office areas were visibly tidy. Bathroom and kitchen facilities were available for staff and were well maintained.

The management team had developed an 'ambulance ready' checklist, which included an inventory of what equipment was required on each vehicle. Although the

checklists that we sampled had been fully completed, a high number of incidents relating to missing or faulty equipment had been reported between January and October 2019.

Response bags were kitted to meet the requirements of different grades of staff who they would be used by. For example, paramedic response bags contained role specific equipment. We sampled two response bags, finding that they had been fully kitted and tamper tags had been used to indicate that they were ready for use. Tamper tags are important as they indicate if the bag has been opened since last been checked, reducing the risk of missing equipment.

However, we had concerns that the service had not maintained oversight of all equipment. The service did not have a policy or a process which outlined how equipment was to be made available and there was no requirement for the movement of equipment to be documented. During our inspection of the 7 January 2020, we observed one occasion when a response bag and a defibrillator was moved to a different location and this was not documented.

We had concerns that the service had not operated a system which meant that emergency equipment was always readily available on ambulances, which was particularly important if a patient required transport to hospital in a time critical situation. We found evidence of one occasion when equipment had been removed from an ambulance during an event, and subsequently the patient was transferred to hospital without emergency equipment being available. This meant that there was a risk of potential patient harm as emergency equipment was not available if needed.

We were provided with a log of all equipment that required servicing, such as wheelchairs, stretchers and defibrillators. Records indicated that that the location of equipment that was overdue servicing was unknown. This meant that there was an increased risk that faulty equipment would be used inappropriately. However, we sampled equipment in use at the Manchester base, finding that they had been serviced and had also received a portable appliance test when needed.

We found that equipment such as defibrillators and suction equipment were not secured on ambulances safely and that the management team had not risk assessed this to make sure that injury to staff or patients was reduced as much as practicably possible.

The service owned one ambulance and used a further ambulance on a long-term lease. Arrangements were in place to cover breakdowns, MOTs and servicing. We saw evidence that both vehicles had been serviced regularly and that their MOTs were in date.

We were informed that the service also leased further vehicles from a third-party company when needed. On these occasions, ambulances were provided with a stretcher, and the service were responsible for providing the rest of the equipment.

Following our last inspection of February 2018, the service had purchased two paediatric harnesses which could be used to safely transfer a paediatric patient when needed. However, it was unclear how the service made sure that this was readily available in case an emergency transfer was required. This meant that there was an increased risk that paediatric patients would not always be transported safely.

Clinical waste bins were available in response bags, on vehicles and in the garage area. However, we found that clinical waste that had been disposed of in the garage area had not been sealed and there was a strong odour coming from the clinical waste bin. This was not in line with best practice guidance and meant that there was a risk that infection would be spread.

Controlled substances hazardous to health (COSHH) had been stored securely which met appropriate legislation.

Fire extinguishers were available on both ambulances as well as at the ambulance station, and these had been recently serviced.

The service ordered medical gasses from a third party as and when required. We found that all medical gasses were stored securely in response bags, on ambulances or in the garage. During our last inspection of February 2018, we identified concerns that the service had not planned to separate empty medical gas cylinders from those that were full, reducing the risk of empty cylinders being used in error. During this inspection, we found that the service had acted to rectify this.

The service provided uniforms to all staff. This included a shirt, trousers, working shoes and coats. Staff were also provided with an identification badge, which we found that all staff carried appropriately. However, we had concerns that a system was not in place for reconciling identification badges and uniforms once a member of staff had left. This meant that the management team were unable to provide assurance that this had been completed for all staff who no longer worked for them.

The service had previously employed an equipment facilitator. However, this position was vacant at the time of our inspection, meaning that all staff had responsibility for making sure that ambulances and response bags had been stocked correctly. We were informed that this role would be recruited to in the future.

Assessing and responding to patient risk

Staff did not always use the system to help identify deteriorating patients.

The service used a system to identify deteriorating adult and child patients, which was based on a set of basic observations, such as a patient's pulse rate, respiratory rate, temperature or level of consciousness. This system is important as it helps staff identify patients whose condition has deteriorated over a set period.

We were concerned that staff would not always take appropriate action if a deteriorating adult patient had been identified and that the system was not being used. This was because although the service had a standard operating procedure for staff to follow, it was unclear about what the roles and responsibilities of staff were if they had identified concerns about a patient's condition. In addition, we sampled 11 patient records that had been completed between June 2019 and October 2019, finding that this system had not been used on any occasion.

We raised this with the management team at the time of the inspection, finding that they had not been aware of this shortfall. The service did not have a system to monitor compliance with this.

Staff had access to up to date information to follow when transferring patients from an event to hospital. The management team had developed a list of all local hospital services that were applicable to each event and this had been made available for all staff.

All vehicles were required to have an automated external defibrillator present for staff to use in the event of an emergency. An automated external defibrillator is a piece of equipment used to allow the heart to re-establish an effective rhythm when this has been lost.

Members of the management team were responsible for completing risk assessments for each event that the service attended. This included assessing what resources were required to keep patients safe. We sampled risk assessments for three events, finding that these had been fully completed.

We were informed that on occasions when an ambulance was present at an event and that there was no exclusion for the vehicle to remain on site, there was a potential for the service to transport patients to hospital if needed. On site managers were responsible for making sure that this was co-ordinated in the event of an emergency.

However, it was unclear if all on-site managers had completed appropriate training to undertake their roles. Following the inspection, we were provided with training certificates which indicated that six members of staff had undertaken a training course in September 2018, although only four of the records had been signed by staff to say that they had completed this.

Staff we spoke with were aware of their responsibilities when transporting patients who had a do not attempt cardiopulmonary resuscitation order. We found that the service had a policy which clearly outlined the roles and responsibilities as well as actions to take in the event of an emergency.

All staff were required to complete conflict resolution as part of their mandatory training. This included key topics such as de-escalation as well as managing violence and aggression.

Staffing

The service had not recorded whether there had been enough staff with the right qualifications, skills and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The service employed nine members of staff on a permanent basis as well as 320 staff on a casual basis. Most casual staff were employed by other ambulance services,

including NHS ambulance trusts. The service employed first aid practitioners, nurses and doctors, who were only responsible for providing care and treatment at an events site.

The required staffing establishment was calculated within risk assessments that were completed for each event. This covered how many staff were needed as well as what competencies were required. The service's workforce planning co-ordinator was responsible for ensuring that the correct numbers of staff were available.

Managers informed us that when an ambulance was provided to an event, there was a potential that they would have to transfer a patient to hospital and that in these cases a minimum of two trained technicians were required. However, the service did not have a policy or a process in which the requirement for this was documented.

We reviewed records for 11 patient journeys that had been undertaken between January 2019 and November 2019, finding that it was unclear on all occasions who had been responsible for transporting the patient to hospital. The management team informed us that the initial patient record was usually completed by the first practitioner who had attended the patient at an event and each patient record had not been updated following this.

This was important as it meant that we had concerns that patients had been transferred to hospital by staff who did not have the correct skills or competencies. Following the inspection, the service acknowledged that this system could be improved and provided evidence which indicated that staff with the correct training had been available on nine out of the 11 occasions.

The service had a recruitment process which clearly outlined what checks needed to be completed when staff members started their employment. For example, all staff were required to provide important documents such as photographic identification, certification of competencies along with a written reference. During the inspection of 11 and 12 November 2019, we sampled 20 personnel files, finding that this had not always been fully completed. For example, key documentation such as evidence of competencies or photographic identification was not always present.

We sampled a further 12 personnel files during our inspection of 7 January, identifying continued concerns that key information such as driving checks were missing on all occasions.

This was monitored using a central database which also indicated which staff were active or inactive. However, we found that this had not been kept up to date. For example, staff informed us that although records indicated that three members of staff were active, they were currently inactive as not all required documents had been returned.

Records indicated that as of September 2019, the staff turnover rate was 4%. We were informed that this figure included all staff who were employed by the service and that the main reason for staff leaving was that they were unable to complete the minimum of shifts needed for them to be used for future events.

We were informed that levels of staff sickness were low, although this had not been formally monitored. The service had planned to manage episodes of short notice sickness, to make sure that all shifts were covered correctly.

Records

Staff had not always kept detailed records of patients' care and treatment.

The service had a up to date records management policy which was available to all staff. This covered important topics, such as maintaining patient confidentiality, as well as the requirement to document all aspects of care and treatment provided to patients.

However, we found omissions in all 11 patient records that had been completed between the 3 June 2019 and 7 September 2019, meaning that a contemporaneous patient record had not been kept for each patient journey. Omissions included but were not limited to the national early warning score (used to identify a deteriorating patient) as well as documenting who had been responsible for transporting a patient to hospital.

The service had a clear process for storing records. Locked boxes were available at ambulance stations and we found that these were used appropriately. Staff who we spoke with were aware of the system and their responsibilities for keeping patient records secure at all times.

However, we found that patient records had not always been stored securely. This was because on checking two

equipment bags that had recently been used, we found two patient records. This meant that there was an increased risk that patient confidentiality would not always be maintained.

On occasions when patients had been transported to hospital, we were informed by management that photocopies were taken and given to hospital staff following the handover of patients. However, it was unclear if this had been completed as this had not been formally documented on any patient records that we reviewed.

Medicines

The service did not use safe systems to safely store, record and prescribe medicines.

The service had a up to date medicines management policy which was available to all staff. This was in date and staff were aware of how to access it. Staff had access to a wide variety of emergency medicines and followed guidance from the Joint Royal Colleges Ambulance Liaison Committee when administering these.

The service had a service level agreement with an NHS Trust for the supply of medicines. Managers informed us that medicines were supplied within 48 hours when needed.

Medicines were stored securely in individual drugs bags which were located at the ambulance station. At the beginning of every shift, staff were responsible for making sure that medicines were available to use if needed.

We found that the overall management of medicines was poor. This was because when sampling all medicines, we found that there were a large number of drugs missing. For example, discrepancies included 100 paracetamol tablets, 14 chlorphenamine ampules, 23 ibuprofen tablets, 5 rectal diazepam as well as 10 ampules of adrenaline 1:1000. Additionally, we found that some medicines in two of the drugs bags were out of date.

We also found that the service did not operate a clear system to record when medicines had been ordered, received or disposed of.

In addition, medicines were not stored in their original packaging along with leaflets, meaning that there was an increased risk that medicines would be administered in error as it was difficult to differentiate between them, particularly for those medicines where their presentation was similar.

Although there was reference to Schedules 17 and 19, Human Medicines Regulations 2012 within the medicines management policy, the service outlined the requirement for but did not have any Patient Group Directions, despite storing and using medicines that were exempt from these Regulations. Patient Group Directions provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

We reviewed all patient records that had been completed between January 2019 and October 2019, finding that medicines that had been administered to patients had been clearly documented on most occasions. However, we found one occasion that the administration of oxygen had not been documented correctly.

During our last inspection of February 2018, we found that the service did not have a system to make sure that empty medical gas cylinders were stored separately from those that were full. During this inspection, we found that a separate area had been identified to store cylinders that were empty. All other medical gasses were stored securely in drugs bags or on ambulances.

Incidents

The service had not always managed incidents well. Managers had not always investigated incidents or learnt lessons.

The service had a up to date incident reporting policy which outlined the roles and responsibilities of staff to report incidents as well as how to do this. All staff who we spoke with knew how to access this and how to report incidents. In addition, staff were able to give examples of when they had reported an incident.

The service had reported one never event and no serious incidents between January and October 2019. 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. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

Following the never event that had been reported, we saw evidence that the incident had been investigated and an action plan had been implemented to reduce the risk of a similar incident reoccurring.

Between January 2019 and October 2019, there had been 52 clinical and non-clinical incidents reported. However, on reviewing a sample of 19 incident reports, we had concerns that there was no documented evidence of an incident investigation having been undertaken on any occasion. This was important as it meant that it was unclear what had caused the incident. We also noted that there was no documented evidence of learning from any of the 19 incidents. This meant that it was unclear if the service had acted to reduce the risk of similar incidents happening again.

On reviewing minutes of all patient safety group meetings that had been held between January 2019 and November 2019, we saw evidence that incident reports had been discussed, but we also found that there was no documented discussion or action which indicated that improvements had been made when needed.

We found evidence which indicated that feedback had been sent to staff on all occasions that incidents had been reported, thanking them for taking the time to bring incidents to the attention of the management team. However, we also found that feedback to staff had not included actions taken to reduce the risk of a similar incident happening again.

The service had a policy detailing when statutory notifications should be made to the CQC or other external bodies such as the Health and Safety Executive. A statutory notification is when a service is required to inform the CQC or other external bodies about any significant incidents, including when a service user has died or if there has been a serious injury obtained.

The service had a duty of candour policy that was available to all staff. 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. Duty of candour should be discharged if the level of harm to a patient is moderate or above.

On reviewing incidents that had been reported between January 2019 and October 2019, we did not find any incidents when there had been a requirement for the duty of candour to be discharged. However, there was a risk that this requirement would not be met as the level of patient harm had not been assessed for any of the incidents that had been reported.

Are emergency and urgent care services effective?

Requires improvement

We rated effective as **requires improvement.**

Evidence-based care and treatment

Managers had not checked whether care and treatment had been given in line with national guidance and evidence-based practice.

The management team had some regard to best practice guidance. This included guidance from both the National Institute for Health and Care Excellence (NICE) as well the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) 2019.

We found that protocols were available for staff. Staff that we spoke with had an awareness of these and knew how to locate them if needed. This included a paediatric policy which had been introduced since our last inspection.

The service had also implemented a clinical investigations tool, which was important as it supported staff to complete recommended diagnostic tests for individual conditions such as a patient having a diabetic emergency or a heart attack.

However, we noted that the service did not use any condition specific pathways. More importantly, the service had not monitored whether staff had provided care and treatment to patients who had suffered with specific conditions, meaning that there was an increased risk that

care, and treatment was not always provided in a way that met best practice guidance. This also meant that there was an increased risk that the service would not always make further improvements when needed.

The management team informed us that the service had been reliant on staff knowing how to treat a variety of conditions in line with best practice guidance, based on their existing knowledge and training.

Pain relief

On most occasions, staff assessed and monitored patients regularly, and gave pain relief in a timely way.

The service had several medicines available for staff to use when managing a patient's pain relief. This included paracetamol and ibuprofen, entonox (a medical gas that is administered to manage pain) as well as penthrox (an inhaled medication that is used to reduce pain following trauma).

The service had policies and procedures to support staff in administering these medicines and staff were also directed to follow the most up to date guidance from the Joint Royal Colleges Ambulance Liaison Committee. In addition, we saw evidence that 19 members of staff had received training in administering penthrox safely.

All staff were required to document a pain score for every patient that was assessed and treated. We reviewed 11 patient record forms that had been completed between January 2019 and November 2019, finding that a patient's pain score had been documented correctly on most occasions. In addition, a patient's pain score had been reassessed to test the effectiveness of the pain relief following its administration. This was in line with best practice guidance.

However, on one occasion we found that a patient's pain was not controlled using pain relief that was available for staff to use. We noted that the service did not have any policies or procedures to support staff to consider whether to seek further medical assistance, particularly as the service did not stock controlled drugs such as morphine (a strong pain killer that is given directly into a patient's blood stream). This meant that there was an increased risk that a patient's pain would not always be managed appropriately.

The service had undertaken an audit of patient record forms between January 2019 and April 2019. This indicated that compliance with pain management was low, with results varying between 50% and 70%.

Response times

The service had not monitored response times so that they could facilitate good outcomes for patients.

The service did not monitor its response times, meaning that it was unclear whether patients had always been transported to hospital in a timely manner, particularly for patients who had time critical conditions.

Members of the management team informed us that hospital handover times were not formally monitored, although this had been included on the risk register since 2017. We were informed that if any issues were identified, they would be discussed during patient safety group meetings.

Patient outcomes

The service had not monitored the effectiveness of care and treatment or used findings to achieve good outcomes for patients.

Patient outcomes and compliance against nationally agreed pathways were not routinely monitored. For example, the service had not planned to monitor important clinical quality indicators, such as if patients had been transported to the correct place of care for conditions such as a heart attack or stroke. This meant that there was an increased risk that the needs of patients would not always be met, and that the service would not always be aware of when improvements were needed.

Competent staff

The service did not always make sure that staff were competent for their roles.

The service had an induction policy that the service had planned to follow for all new staff. The induction programme was important as it familiarised staff with their roles and responsibilities and was an opportunity for new staff to make sure that they were aware of all policies and procedures that the service had.

However, on reviewing 20 personnel files on the 11 and 12 November as well as 12 personnel files on the 7 January

2020, we found that induction checklists had not been completed for staff on 24 occasions. This meant that it was unclear if all staff had received an induction in line with policy.

During our inspection, we were informed that a peer to peer appraisal system had been introduced as compliance with the previous staff appraisal system had been poor. This was completed following a set format and allowed staff the opportunity to evaluate their own performance with a colleague, as well as identifying areas that they wanted to improve. A member of the management team reviewed these once completed. However, only a small number of staff had completed these at the time of the inspection.

The service had a driving standards policy which all staff were required to comply with. We were informed that all paramedics and emergency medical technicians had completed driver training, including blue light driver training with their substantive employers.

However, we were not assured that appropriate driving checks had been undertaken on all occasions when needed. Although we were informed that evidence of this was requested as part of the recruitment process, we sampled six personnel files for staff who had driving responsibilities, finding that this had only been completed on two occasions.

The service had implemented a skills matrix which outlined the roles and responsibilities of different levels of staff such as ambulance technicians or paramedics. This outlined different skills that they were able to perform as well as medicines that they could administer.

We were informed that a revised training needs analysis had been completed but was currently in draft format at the time of our inspection.

The management team informed us that they had previously ran continuing professional development days for staff. However, these had been stopped as only a small number of staff had been able to attend. Continuing professional development is important as it allows staff to develop or to refresh their existing skills and knowledge.

The service had planned to check the professional registration of all staff, including paramedics. On reviewing personnel files, we found that this had been completed on all occasions when needed.

Multidisciplinary working

Staff within the service communicated effectively and the service worked well with other agencies.

The management team informed us that they worked closely with event providers. We were informed that positive working relationships had been developed so that the best possible service could be provided.

Staff informed us that multidisciplinary team working was good on occasions that a patient needed to be transferred from site. We were informed that communication at events was positive.

The service had clear procedures for making sure that all patient handovers were facilitated on arrival at hospital. Staff who we spoke with were aware of their responsibilities regarding this and were able to describe the process that was followed. This was important to ensure the continuity of patient care between the service and other providers, including NHS trusts.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had not always documented why patients had lacked Mental Capacity on occasions when they had acted in their best interest.

The service had an up to date policy which covered the Mental Health Act, Mental Capacity Act, Deprivation of Liberty safeguards, as well as consent to care and treatment. This was available for all staff to access.

In our last inspection of February 2018, we identified concerns that consent to care, and treatment had not been obtained or documented. Following the inspection, the service had taken action to make the required improvements. On reviewing 11 patient records that had been completed between January 2019 and October 2019, we found that this had been documented on most occasions.

However, we had concerns during this inspection that Mental Capacity Assessments had not been documented in line with policy or best practice guidance. This was because on two occasions when Mental Capacity assessments had been required, these had not been fully completed. Although appropriate checkboxes had been completed, there was no further documentation of what information

had been relied upon to assess each patient's Mental Capacity. This meant that there was an increased risk that patients would not always be able to make a decision about their own care and treatment appropriately.

Gillick competence was covered in the service's policy and was included in mandatory training that all staff were required to complete. This was important as the service were able to transport children of a variety of ages. Gillick is a term used to describe if a child under 16 years of age can consent to their own medical treatment without the need for parental permission or knowledge.

Are emergency and urgent care services caring?

There was insufficient evidence to rate caring. However, we noted the following practice;

Compassionate care

Staff understood the need to treat patients with compassion and kindness as well as to respect their privacy and dignity.

Staff showed an awareness of the importance of maintaining patients' privacy and dignity. Staff who we spoke with informed us that they made sure that privacy and dignity was always maintained, particularly when transferring the patient to the ambulance and taking the patient through public areas.

We were unable to observe care and treatment that was provided to patients as the service were not undertaking any type of regulated activity at the time of the inspection.

Emotional support

Staff informed us of occasions when they had provided emotional support to patients and families to minimise their distress.

Staff were able to give us examples of when patients had become anxious during their journey and that they did their best to relieve any anxieties or provide emotional support when required.

Staff also understood the need to support the relatives of a patient when needed. An example of this would be if a patient had deteriorated during the journey to hospital.

Understanding and involvement of patients and those close to them

Staff understood the need to involve patients and relatives when making decisions about their care and treatment.

Staff demonstrated an awareness of involving patients in any decisions that were made about their care. Staff informed us that they regularly checked the needs of patients and their families during patient journeys.

Are emergency and urgent care services responsive to people's needs?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

The service worked with others in the wider system and local organisations to plan care.

During the inspection we sampled six management plans and risk assessments that had been completed before events. This was important as it determined important topics such as staffing requirements as well as how many ambulances would be required.

We were informed by members of the management team that they attended safety advisory group meetings along with other services such as the local authority, police and fire brigade. This was important as it meant that the service was able to plan for events cover alongside other key agencies.

Meeting people's individual needs

The service was inclusive and took account of individuals needs and preferences. Staff made reasonable adjustments to help patients access services.

The service had a standard operating procedure for staff to follow if translations services were needed. This stated that staff should contact an on-call manager who would access this via telephone. We were informed that this service was available 24 hours a day, seven days a week. We also found that multilingual phrasebooks were on every vehicle.

Staff also had access to pictorial communication books. This was important as it supported staff when providing care to patients who had communication difficulties.

Staff had access to an up to date geriatric policy which provided key information to staff about managing older patients. This had information about the management of patients who were living with conditions such as dementia.

We also found that there was a policy which supported staff when transferring bariatric patients and there was access to appropriate equipment to facilitate this when needed.

The service was reliant on training that staff had received from their substantive employers to meet the needs of other groups of patients, such as those with learning difficulties. We were informed that there were no current plans to introduce this as part of training that was provided to staff.

Access and flow

It was unclear whether patients had received care in a timely way.

Between January 2019 and November 2019, the service had transported a total of 11 patients from an event site to hospital. All the other activity undertaken took place on an events site and was exempt from Regulated Activity.

Managers informed us that patient transport between an events site and hospital was co-ordinated by the member of staff who was in charge on the day of the event. This meant that they were responsible for making sure that the correct staff and vehicle was available in a timely manner.

However, we found that the service had not planned to monitor the timeliness of patient transfers on occasions when this had happened. This meant there was an increased risk that the service would not always identify areas of poor performance and make improvements when needed.

Learning from complaints and concerns

The service had planned to treat concerns and complaints seriously, investigate them and share lessons with all staff.

The service had an in-date complaints policy which was available to staff. This clearly outlined the complaints process and what action should be taken if a complaint was received. We were informed that a member of the management team was responsible for handling complaints.

The policy stated that all complaints would be managed within 25 days of a complaint being received and that the complainant would be kept up to date with the progress of their complaint.

The complaints policy also outlined that an action plan for further learning and service improvement should be completed on occasions when a complaint had been received. This was important as it demonstrated that the service was committed to making improvements from complaints when needed.

Records indicated that the service had not received any complaints between January 2019 and November 2019.

The service had not planned for patients or relatives to be able to contact an independent body such as the Independent Sector Complaints Adjudication Service (ISCAS). Organisations such as the Independent Sector Complaints Adjudication Service are independent bodies that can make final decisions on complaints that have been investigated by the provider and are not resolved to the complainant's satisfaction.

Are emergency and urgent care services well-led?

Requires improvement 

We rated well-led as **requires improvement.**

Leadership

Leaders were visible and approachable.

The service had identified clear roles that were required. This included the workforce director, human resources co-ordinator as well as clinical team leaders. All leaders had clear roles and responsibilities.

We were informed during the inspection that the service had identified the need for and was in the process of recruiting a clinical lead, a head of service delivery as well as a pharmacist. It was anticipated that these positions would be filled at the beginning of 2020.

The service had employed seven team leaders whose main responsibilities were to lead teams of staff when providing cover at events. We also found that team leaders covered an on-call rota between 5pm and 9am, seven days a week, acting as an emergency point of contact when needed.

We spoke with nine members of staff during the inspection who informed us that leaders were accessible and supportive.

Vision and strategy

Although the service had workable plans to turn their vision and strategy into action, there was an increased risk that this would not be achieved in a timely manner.

The service had implemented a vision which was to be the caring face of events. A set of values had also been implemented, which included leading, listening, focussing on people, working together and being adaptable.

The service had also set several strategic objectives which included high quality care, excellence in staff as well as meeting the needs of clients and patients. However, on reviewing these, it was unclear how all the strategic objectives would be achieved. This was because no completion or dates to review the progress of these had been identified, meaning that there was an increased risk that strategic objectives would not always be achieved in a timely manner.

We were informed that plans had been made to implement other strategies, such as an equipment strategy. However, we had concerns that this had not been implemented in a timely manner and it was unclear when this would be completed by. This was because there was no clear date for completion identified.

Following the inspection, a revised equipment strategy was provided which indicated actions to make improvements and timeframes in which these should be completed.

Culture

Staff who we spoke with felt supported, respected and valued.

We spoke with nine members of staff who informed us that their experiences while working at the service had been positive. They stated that there was a positive working culture at the service and that everyone was extremely supportive.

The service had policies which provided information about the management of grievances, bullying and harassment, as well as detailing the process that staff could follow if they wanted to raise concerns anonymously. This system was important as it helps to protect patient safety and the quality of care, as well as improving the experience of workers.

However, not all staff who we spoke with were aware of this. In addition, when reviewing policies, we found that this information was difficult to find, meaning that there was an increased risk that this system would not always be used effectively.

The management team informed us that they had identified the need to develop access to psychological services for staff so that staff were able to deal with stress or anxieties that they had experienced at work in a timely manner. This was important as it would potentially support the mental wellbeing of all staff members.

Governance

Leaders had not always operated effective governance processes.

The service had a clear governance framework in place. This outlined all meetings that had been planned along with the frequency of these. For example, patient safety group meetings were planned every two months. We reviewed minutes of these meetings, finding that they had taken place in February, July and September 2019. This meant that they had not always been held as planned.

On reviewing minutes from the patient safety group meetings, we found that although they did not follow a set agenda, several key topics had been discussed during each meeting. However, we noted that actions with timeframes for completion from the meetings had not been documented. This meant that there was an increased risk that the service would not always make improvements in a timely manner.

We were also informed that other key meetings had been planned, such as team leader, human resources and finance meetings. Members of the management team

informed us that these had taken place as planned, but a formal record of these had not been kept. This meant that it was unclear what had been discussed during these meetings as well as whether any actions had been taken to make improvements to the service where needed.

During the inspection, we found that the service had several service level agreements with third party service providers. The service level agreements included pharmacy. We were provided with the service level agreement for pharmacy, but it was unclear what processes the service had in place to monitor the effectiveness of this, which was important to make sure that the needs of the service had been met. In addition, we were not provided with evidence of other service level agreements such as the provision of medical gasses despite requesting these during the inspection period.

The service had several policies and processes which were available to staff. On reviewing these, we found that the majority were in date and a date for further review had been identified. Members of the management team informed us that some policies and processes were reviewed at the patient safety group meeting. We found evidence that the safeguarding policy and process had been reviewed in one of these meetings and that staff who had attended had been able to input into these.

Management of risks, issues and performance

Leaders had not always used systems to manage performance effectively. Risks had not always been minimised in a timely manner.

The service had planned to discuss all risk and issues at a patient safety group meeting that had been scheduled to be held every two months. On reviewing minutes of these meetings, we found that although a variety of risks and issues had been discussed, it was unclear what actions had been implemented to make improvements as well as when any actions were to be completed by.

We found that there were a limited number of systems in place to monitor the quality and safety of the services that were provided. This included a hand washing audit that had been completed monthly as well as a patient record audit which had been completed monthly until April 2019. On occasions when these had been completed and the required standard was not met, we did not see evidence of actions taken to make any necessary improvements.

In addition, the patient record audit only measured compliance against several indicators such as whether the patient's details had been documented correctly. This meant that the management team were unaware of other issues that we identified during the inspection, such as staff not calculating the national early warning score correctly, as well as Mental Capacity assessments not being documented in line with best practice and policy.

Although the service had several policies and procedures to support staff when delivering care to patients, we found that they did not always include important information. For example, the policy to support staff when transporting patients to hospital did not clearly outline who was responsible for undertaking this activity as well as how this should be documented. This was important as during the inspection we reviewed 11 patient records, finding that it was unclear who had transported a patient to hospital, meaning that we were not assured that the correct level of staff had always been available to meet the patient's needs.

The service had not planned to check whether care had been delivered to patients in a way that met best practice guidance. This meant that there was a potential risk that the management team would not always be aware whether patient's needs had been met.

We saw evidence that the service used a risk management system to document ongoing risks that the service currently faced. Members of the management team were able to identify the key risks that had been documented.

However, on reviewing the risk management system, it was not always clear whether action had been taken to mitigate all risks in a timely manner. For example, the service had documented a risk in 2017 of equipment not always being available. Although a mitigating action was for an equipment strategy to be implemented, this had not been completed in a timely manner.

The service had completed several health and safety risk assessments, which included manual handling, fire safety as well as other environmental risk assessments. We found that these had been kept up to date and detailed a number of controls that had been implemented to reduce the risk to staff and patients.

The management team had subscribed to an update service to receive patient safety alerts. We were informed that the managing director held responsibility for making sure that any alerts that were relevant to the service had been implemented.

Information management

Staff could access up to date information about the service when needed.

Policies were available for staff to access electronically. This meant that staff had access to policies and procedures.

The service used an electronic system to monitor important areas such as vehicle maintenance and recruitment processes. The electronic system allowed members of the management team to have up to date access to a variety of other information.

Public and staff engagement

Leaders had engaged with staff and patients to plan and manage services.

The service had completed a staff survey in 2019 so that staff had an opportunity to feedback about how they felt the service was being managed. However, only a small number of staff had completed this. Positive indicators included support from the management team as well as having clear roles and responsibilities. However, on the small number of occasions that staff had provided negative feedback, there was no documented evidence of actions being taken to make improvements.

Following the inspection, we were provided evidence that feedback had been sought on one occasion.

Feedback to staff was delivered in several ways, including newsletters, emails and during briefs that took place at the start of every event.

The service had planned to seek feedback from patients and relatives when possible. Patients and relatives were given feedback cards which could be completed, and feedback could also be completed online.

Between January and August 2019, the service had received 17 compliments thanking staff for the care that had been provided.

Innovation, improvement and sustainability

Leaders were committed to making improvements to the service.

We found that the service had made several improvements against areas that had been identified as breaches of Regulation during our last inspection of February 2018. This included implementing a paediatric policy as well as separating medical gasses, reducing the risk of empty medical gas cylinders being used in error.

Following our inspection of 11 and 12 November, we were provided evidence that the service had planned to make improvements against some of the shortfalls that had been identified during the inspection.

For example, during our inspection of the 7 January 2020, we found that the management team had revised key policies such as the medicines management policy as well as the ambulance conveyance policy. However, these were in draft format at the time of our visit so we were unable to evidence if these had been implemented and available for staff.

The service had made plans to introduce a digital radio system to improve communications between staff at an event.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The service must operate a safeguarding system in a way that reduces the risk of safeguarding referrals not being made in a timely manner. Regulation 13(2)
- The service must ensure that pre-employment checks are properly completed, including but not limited to staff competencies as well as up to date Disclosure and Barring service checks. Regulation 19(1)(a)(b)
- The service must operate an effective system to maintain oversight all equipment, ensuring that equipment is always available for staff to use when needed. Regulation 15(1)(d)
- The service must ensure that all equipment, including defibrillators are securely stored on ambulances, reducing the risk of harm to staff and patients. Regulation 15(b)
- The service must operate a clear process to manage deteriorating patients and make sure that all staff complete this. Regulation 17(2)(b)
- The service must operate a system to make sure that only competent staff transport patients from an events site to hospital. Regulation 17(2)(b)
- The service must ensure that a contemporaneous patient record is kept on all occasions. Regulation 17(2)(c)
- The service must use safe systems to correctly store, record and prescribe medicines. Regulation 12(2)(g)
- The service must ensure that there all reported incidents are investigated, and actions are taken to reduce the risk of similar incidents happening again. Regulation 17(2)(b)
- The service must ensure that all services that are provided are monitored so that poor compliance can be identified, and improvements can be made when needed. Regulation 17(2)(a)
- The service must ensure that the reasons why patients lack Mental Capacity are clearly documented, in line with best practice and policy. Regulation 17(2)(c)

Action the hospital SHOULD take to improve

- The service should ensure that clinical waste is stored correctly, reducing risk of infection being spread.
- The service should ensure that service level agreements are reviewed regularly to make sure that they are meeting the needs of the service.
- The service should ensure that all staff have access to an appraisal system so that they are able to discuss their performance.
- The service should ensure that there is clear guidance for staff to follow regarding raising concerns and speaking up.
- The service should consider amending how vehicle cleaning is recorded to include whether all areas of ambulances have been cleaned thoroughly.
- The service should consider implementing a system to make sure that staff return all uniform and identification when they leave their employment.
- The service should consider implementing timely actions to make sure that the vision and strategy is achieved.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How this Regulation was not being met;** The service did not operate a system that protected people from abuse. Regulation 13 (2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How this Regulation was not being met;** The service did not operate an effective system to maintain oversight of all equipment. The service had reported a high number of incidents when equipment had not been available for staff to use. Equipment was not always safely stored on vehicles in a way that reduces the risk to staff and patients. Regulation 15 (1)(b)(d)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How this Regulation was not being met;** The service had not always monitored the services that were provided.

This section is primarily information for the provider

Requirement notices

The service had not always investigated reported incidents and acted to reduce the risk of similar incidents happening again.

Regulation 17 (2)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How this Regulation was not being met;** The service had not always checked staff competencies as well as seeking an up to date disclosure and barring service check prior for staff prior to the start of their employment. Regulation 19 (1)(a)(b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How this Regulation was not being met;** The service did not use safe systems to safely store, record and prescribe medicines. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How this Regulation was not being met;** The service did not have a system in place to make sure that only competent staff transported patients from an events site to hospital. The process for managing deteriorating patients was unclear. We found omissions in all 11 patient records that we checked. Regulation 17 (2)(a)(b)(c)