Medical Response Services

Quality Report

Cricket Street
Wigan
Greater Manchester
WN6 7TP
Tel: 01942 297395
Website: www.emrs.co.uk

Date of inspection visit: 15 September 2020
Date of publication: 12/11/2020

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

Overall summary

Medical Response is operated by Mr. Warren Bolton . The service provides a patient transport service.

We inspected this service using our focused inspection methodology. We carried out a short-announced inspection visit on 15 September 2020 in response to risks found at the last inspection for which enforcement action was taken. We did not rate the service.

To ensure that the provider was now meeting the requirements outlined in the enforcement action we looked at some aspects of the safe, effective, responsive and well-led domains. Specifically, we looked at the key lines of enquiry:

In 'Safe' we looked at:

- Mandatory training
- Safeguarding
- Assessing and responding to patient risk
- Incidents

In 'Effective' we looked at:

- Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

In 'Responsive' we looked at:

- Learning from complaints and concerns

In 'Well Led' we looked at:

- Leadership
- Governance
- Managing risks, issues and performance

Following the inspection, we put our concerns formally in writing to the provider and asked that urgent actions be put in place to mitigate the risks to patient safety. The provider provided a detailed response including improvement actions already taken or planned. All actions were due for completion by 31 October 2020. This provided assurance that sufficient action had been taken to mitigate any immediate risks to patient safety. We will continue to monitor this information through our routine engagement with the provider.

We found:

- The service did not always provide mandatory training in key skills to all staff and made sure everyone completed it.
- Staff were not up to date with safeguarding training.
- There were no risk management plans in place to mitigate identified risks.
- Staff had received inappropriate restraint training and the restraint policy did not reflect best practice regarding the use of restraint.

Summary of findings

- The inclusion/ exclusion policy, that provided guidance about which patients the service could safely transport, was not freely available to staff and we found examples where it had not been followed.
- Incidents were not always reviewed well and we found key concerns, where staff were not following the services policies, had been missed.
- Policies were not in place and staff were not trained appropriately to protect the rights of patients' subject to the Mental Health Act 1983.
- It was not always apparent that leaders had the skills and abilities to run the service or that they understood and managed the priorities and issues the service faced.
- Leaders did not always operate effective governance processes, either throughout the service or with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.

However, we found the following areas of good practice:

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.
- Management meetings were documented appropriately and audits and staff performance were reviewed at managers meetings.

Following this inspection, we told the provider that it must take some actions to comply with the regulations. We also issued the provider with two requirement notices that affected the Patient Transport Service. Details are at the end of the report.

Ann Ford

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services		The service in an independent ambulance provider which provides patient transport services including the transportation of mental health patients, including those detained under the Mental Health Act 1983.

Summary of findings

Contents

Summary of this inspection

Page

Background to Medical Response Services 5

Our inspection team 5

Information about Medical Response Services 5

Detailed findings from this inspection

Outstanding practice 11

Areas for improvement 11

Action we have told the provider to take 12

Summary of this inspection

Background to Medical Response Services

Medical Response is operated by Mr. Warren Bolton . The service opened in 2011. It is an independent ambulance service in Wigan, Lancashire. The service primarily serves a number of regional acute NHS hospital trusts, local authorities and clinical commissioning groups. It also accepts patient referrals from outside this area.

The service has had a responsible individual in post since July 2011.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and an inspection manager. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Medical Response Services

The service is registered to provide the following regulated activities:

- Transport Services, triage and medical advice provided remotely.

During the inspection, we visited the ambulance headquarters office. We spoke with eight staff members including the nominated individual, the operations manager, the compliance manager, the office manager and four ambulance crew members. During our inspection, we reviewed 21 sets of patient records. We reviewed information that was provided by the service, before, during and after the inspection.

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 four times, and the most recent inspection took place in January 2020 when we rated the service as inadequate.

Patient transport services

Safe	
Effective	
Responsive	
Well-led	

Are patient transport services safe?

Mandatory training

The service did not always provide mandatory training in key skills to all staff and made sure everyone completed it.

Although the service provided training in key skills, several courses had expired for most staff. This particularly applied to the courses that were being delivered in the classroom. We were told that companies the service used were not undertaking any classroom-based training, due to the impact of Covid-19. Managers had sourced accredited online courses which staff were in the process of undertaking but this had not been completed at the time of the inspection.

Staff had completed 84% of online training overall. However, deprivation of liberty training was at 37% and safeguarding of vulnerable adults was at 40%.

Classroom training was at 34% overall and, course compliance in conflict management, safeguarding vulnerable adults and children and deprivation of liberty safeguards, were all below 30% completion rates.

Safeguarding

Staff did not always understand how to protect patients from abuse. Not all staff had received training on how to recognise and report abuse. Managers did not have the level of training required in the best practice guidance to support staff with safeguarding concerns.

Best practice guidance requires organisations to have access to level four safeguarding support. The nominated individual and the operations manager had completed level three safeguarding adults training but had not completed level four safeguarding training. This meant that at the time of our inspection the service had not had access to level four safeguarding support.

Staff were not up to date with safeguarding training. All staff had been offered safeguarding training, however only 40% of staff had completed level two adult safeguarding training and 26% of staff had completed level two safeguarding course for adults and children. This meant that staff had not received adequate safeguarding training and may not have been able to recognise or respond to safeguarding incidents appropriately. We were told that the service was transitioning from classroom to online training due to Covid -19 and this had created some delays in training renewal times. This was important as staff transporting patients would require safeguarding training level two in line with best practice guidance. The intercollegiate document, 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, fourth edition: January 2019' states that all staff working with children, young people and their parents should be trained up to level two.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Staff had not removed, minimised or responded to identified risk. It was not apparent that incidents were reviewed or investigated in line with best practice guidance. Staff were not trained appropriately in the application of restraint techniques. Staff did not receive the appropriate training or support in the form of guidance to safely manage or transport patients with mental health needs.

We were told by the nominated individual that he had recognised staff had received inappropriate restraint

training because they had been given security training. However, he could not tell us what had been put in place to provide guidance and training to staff when it was realised that the training was inappropriate.

We saw evidence of certificates which stated that the restraint training was for the security industry and was not specific to the needs of patients. This meant that staff were trained incorrectly and could potentially restrain people inappropriately or cause harm to patients as they had not received training that was appropriate to the patient group.

At the last inspection there was no inclusion/ exclusion criteria for staff to follow. The criteria provide staff with guidance as to which patients they are able to transport safely. At this inspection we were sent an inclusion/ exclusion policy but this was not freely available to staff and we were told the policy was not live. Staff told us they had learned verbally during induction which patients to include and exclude.

The inclusion/exclusion policy stated that the service did not transport patients who were sedated or medicated. We saw an incident where a sedated patient was transported. Although staff reported that the patient was sedated in the narrative of the incident form, this was not identified as in issue in the incident concern summary report and was not mentioned in the action plan or lessons learned. This indicated a lack of awareness of the inclusion/ exclusion policy by managers and a lack of scrutiny of the incident.

We also saw an example where a patient who was under 18 was transported. The inclusion/exclusion criteria in the booking policy stated that the service did not transport children but did not specify what age it considered a child to be. In England a child is defined as anyone who has not yet reached their 18th birthday.

At the last inspection the service did not have a deteriorating patient procedure. At this inspection the service had implemented a deteriorating patient procedure which was available to staff. We asked staff what they would do if a patient deteriorated during a journey. Three staff reported that they would call 999, one member of staff said they would head back to the hospital. This meant that most but not all staff understood the procedure.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise incidents and near misses and reported them appropriately. Managers did not always investigate incidents thoroughly and shared lessons were not always learned with the whole team, the wider service and partner organisations.

The service did not have an incidents management policy during the last inspection. At this inspection the service had implemented an incident management policy but we were not assured that incidents were being recognised, reported, graded, documented or investigated appropriately.

The incident folder contained ten incidents in total which appeared to be complete and within the scope of the provider's policy. However, it became apparent, following discussion with senior staff, that there were two incident report forms where information was omitted. Both incidents should have warranted police involvement. When we raised this with senior management, we were told that they didn't want to attract negative publicity and this had prevented them contacting the police. This meant there was a risk that the service was unable or unwilling to accurately highlight and record incidents of concern, seek appropriate learning and improvement to prevent similar incidents from reoccurring.

Staff received duty of candour training. 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 including any incident with a patient harm level of moderate or above. We spoke to staff about the duty of candour. Only one member of staff knew what the duty of candour was. This meant we were unsure how effective the training had been.

Are patient transport services effective?
(for example, treatment is effective)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

It was not always clear that staff supported patients to make informed decisions about their care and treatment. It was not always clear that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Patient transport services

Managers were not aware that the service was transporting patients detained under the Mental Health Act. They told us they did not transport patients who were detained under the Mental Health Act because they had an agreement with the hospital, they were collecting the patient from, that they did not take part in any patient care or have contact with patients during the journey. Therefore, their understanding was that they were not providing a service to the detained patient but to the hospital. However, there was no written agreement between Medical Response and the hospitals they worked with to show this was the case.

It was clear from our discussions that managers did not fully understand their own staff's involvement in providing care for these patients. We found examples where staff pushed patients to ambulances in wheelchairs or helped the hospital escorts to support patients to the ambulance by holding them up.

When we discussed this with the manager, they told us they did not think that pushing a patient in a wheelchair or helping the hospital escort to physically support if requested, was having contact with a patient. This meant the service did not fully understand their own responsibilities when providing care to patients who received patient transport services and there was no clear guidance for staff as to the level of contact, they were meant to have with patients.

We were told the hospital provided escorts for patients and this was recorded on patient movement logs. However, four movement log records, relating to patients detained under the Mental Health Act, contained no information to show an escort was present. We did not see any records containing the hospital escorts' details, which meant that this could not be traced back to individual staff if there was a problem.

Most mental health transfers were undertaken with standard patient transport service vehicles. The service had a specialist vehicle with containing a secure compartment if required. The manager told us this had not been used since January 2020.

However, we found one incident report showing a patient had been transported in the secure compartment in the secure mental health vehicle. We also found an incident recorded on the patient movement log, where staff went to collect a patient and returned to the ambulance base to pick up the secure vehicle on the request of the nurse. We saw no evidence of any risk assessments to show that a secure vehicle was the most appropriate form of transport for that patient.

Training records showed that staff received training in the Mental Capacity Act but did not receive training in the Mental Health Act. When we spoke to staff, they could not tell us what the Mental Health Act was or of its requirements when transporting detained patients. There was also no training in Mental Health Awareness provided to staff. This meant that staff were transporting patients sometimes with complex needs, that they were not trained to support.

During August 2020 the service carried out 23 journeys transporting patients detained under the Mental Health Act. There was no mental health policy providing guidance for these transfers because managers believed the hospital were responsible all aspects of patient care and safety during the transfer. There was no evidence that staff checked the paperwork required to transport a patient detained under the Mental health Act 1983. We were told this was also the hospitals responsibility. Managers could not provide us with a written agreement to show the hospital had agreed to this responsibility.

There was a patient movement log completed for each journey. Information collected on the patient movement log included whether the patient was aggressive, at risk of self harm, a ligature risk or sedated. The form also had a section for special instructions.

Although the movement logs showed some of these risks were present during journeys, we did not see any risk management plans for transporting these patients. This meant that there was no guidance for staff to follow if the patient presented a risk that the patient escort could not manage.

For example, we saw one record where all these concerns were present and one escort had been sent to accompany the patient. We were concerned that there was no plan to support the patient and escort during the journey, if something went wrong and the escort could not manage on their own.

We were told that there were no instances of patients being restrained by staff. All staff told us they had received control

and restraint training which we found was inappropriate for the patient group because it was security industry training, but it's use was not recorded. No members of staff could give us an example of when they would use this training

However, we saw evidence of an incident where a staff member had applied restraint by intervening and put their hand on a patient's wrist when they had believed a patient was going to strike a member of staff. During that same incident a member of staff was supporting the patient under the arms as they were unsteady on their feet whilst pushing the wheelchair. We saw no evidence of learning or review of this incident to see if this was the least restrictive form of restraint or indeed required.

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

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations

There was a complaints policy in place which was in date and was version controlled. This was available to staff within the policies and procedures file; located in the crew room, at the ambulance base location. The policy outlined timeframes for responding to complaints and a procedure for management to do so.

We reviewed two complaints held by the provider and both had followed the provider's complaints policy.

Are patient transport services well-led?

Leadership

It was not always apparent that leaders had the skills and abilities to run the service. They did not always understand or manage the priorities and issues the service faced. They were visible and approachable in the service for staff.

The nominated individual had been unable to supply information relating to themselves as specified in Schedule 3. We reviewed their personnel folder and found that there was record of qualifications held and an incomplete employment history.

We saw that there was a record of the nominated individual's disclosure and barring service (DBS) check with the records for other employees. This was a standard DBS check rather than an enhanced DBS check. The log stated that enhanced record was pending.

The provider held an electronic log of DBS checks. The organisations DBS policy stated that a record of all DBS checks would be held on the computer system and include the full name of the employee, national insurance number, DBS report reference and date of the report. We found the DBS log contained an employee ID number rather than a name and no national insurance number.

There was no appropriate process for assessing and checking that the nominated individual held the required qualifications and had the competence, skills and experience required to undertake the role. We found no evidence of any appraisal process being undertaken or previously completed. Therefore, we were not assured that the nominated individual had the managerial experience and leadership skills to effectively run the service.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Not all staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

During our last inspection there was a lack of policies and procedures to support staff. During this inspection, we found that several policies and procedures had been put in place. These included a deteriorating patient procedure; a procedure for managing patients' medication; a safe use of oxygen policy; an incident management policy and procedure; a duty of candour policy and a whistleblowing policy.

There was no policy concerning transporting patients detained under the Mental Health Act. This meant there was no policy guidelines to support staff transporting patients detained under the Mental Health Act.

Patient transport services

Some policies and procedures were clear and easy to understand. For example, there was an incident management policy which was in date, version controlled and had reference to a policy lead. There was an incident reporting process for staff to follow that accompanied the policy. Procedures were simple and enabled staff to follow them at a glance.

During our last inspection the service did not have a medicines management policy in place to provide guidance for staff in relation to the administration of medical gases or the transportation of patients own medication. At this inspection the service had a process for managing patients' medication and a safe use of oxygen policy. However, the oxygen policy stated that staff should be trained in using oxygen. We did not see any evidence of this training being completed or included in the training matrix.

Some policies seemed incomplete or did not seem to be relevant to the service.

For example, there was a safeguarding policy and procedures available to staff which was in date and version controlled. The policy stated that the nominated individual was the safeguarding lead although this had been changed to the operations manager which was not reflected in the policy.

The policy did not contain any guidance as to what staff should do, should they identify a safeguarding concern beyond reporting this to the nominated individual / safeguarding lead. The policy did not contain any information about reporting incidents to the local safeguarding board or the police. This meant we were unsure of whether safeguarding incidents would be managed appropriately.

There was a Mental Capacity Act Policy and Procedures document which contained information about the Mental Capacity Act, however it was unclear how the information contained in the policy related to the service or what guidance it was giving to managers and staff.

The service had a restraint policy. We were told the restraint policy related to the transportation of generic patients and not to patients detained under the Mental Health Act 1983, as managers believed they did not transport patients detained under the Mental Health Act 1983. We were concerned about the reasons why patients who were not detained would be restrained.

The policy provided several reasons for restraining a patient. These included a patient causing serious damage to the vehicle or equipment. We were concerned that this policy did not comply with regulations in the Health and Social Care Act which states that restraint should only be used when absolutely necessary and is proportionate to the risk of harm.

Policies were sent to staff through an electronic system and managers received an acknowledgement that staff had read policies which enabled them to track which staff had read policies. However, we found that staff did not have a clear understanding of all policies and procedures in place.

We found that staff were not always clear about what they had learnt during training and through reading policies. For example, staff had received training on the duty of candour but only one member of staff knew what this was.

Management of risks, issues and performance

At our last inspection we found that management meetings were not always documented in a way that could be clearly followed. During this inspection we found that management meetings had clear agendas and were documented appropriately. Audits had also taken place and these were reviewed at managers meetings. Audits included patient transport service documentation, safe recruitment, training and safeguarding.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff have received training to enable them to safely transport patients detained under the mental health act. This was a breach of Regulation 18(1)(2)(a).
- The provider must ensure that all training received by staff is appropriate for the patient group. This was a breach of Regulation 18(2)(a).
- The provider must ensure that all staff and managers receive safeguarding training to the appropriate level in line with the latest best practice guidance. This was a breach of Regulation 13(2).
- The provider must ensure that their policies regarding restraint reflect a proportionate response to the risk posed and that the policy is compliant with legislation and best practice with regards to the patient group they are transporting. This was a breach of Regulation 13(4)(b).
- The provider must ensure that managers have effective oversight of the quality and safety of the service. 17(2)(a)
- The provider must ensure that all policies are relevant to the service being provided. This includes the transporting of patients under the Mental Health Act 1983. This was a breach of Regulation 17(2)(a)
- The provider must ensure that where risks are identified, there are effective risk management plans in place. This is a breach regulation 17(2)(b).
- The provider must ensure that there is sufficient oversight of incidents, that risks and breaches of the services' policy are identified and managed and that learning is shared with appropriate external bodies as required. This is a breach of 17(2)(b).
- The provider must ensure that there is an appropriate process in place for assessing and checking the responsible individual holds the required qualifications and has the competence, skills and experience required to undertake the role. This was a breach of Regulation 4(3)(ii)(5).
- The provider must ensure that information relating to the responsible individual, as specified in schedule 3, can be made available to view or be supplied to the Care Quality Commission when requested. This is a breach of regulation 4(4)(c).

Action the provider SHOULD take to improve

- The provider should ensure it has access to level four safeguarding support.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 4 HSCA (RA) Regulations 2014 Requirements where the service providers is an individual or partnership