Mr Anthony Howell

Ambulance UK trading as St Bridget's Ambulance Service

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 know to CQC and information given to us from patients, the public and other organisations.

Ratings

Patient transport services (PTS)

Summary of findings

Letter from the Chief Inspector of Hospitals

Mr Anthony Howell was the provider who owned and managed Ambulance UK trading as St Bridget's Ambulance Service. The service provides a patient transport service (PTS) and is registered to provide transport services, triage and medical advice provided remotely.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 15 February 2017, along with an unannounced visit to the service on 8 March 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

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

Services we do not rate

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

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

- The provider did not have a manager in place consistently for the day-to-day management of the regulated activity.
- The provider did not have an effective system to assess, monitor and improve the quality and safety of the services provided. There was no evidence of incidents reporting and any learning to improve practices.
- Information was not readily available to patients or their carers about how to make a complaint or raise a concern about the service. The complaints system in place did not support service users to not identify themselves, if that was their choice.
- Effective systems and processes were not in place to implement the statutory obligations of duty of candour.
- Staff had not received training related to management of patients they were caring for as part of patient transport services. Staff recently recruited did not have documented evidence that induction training completed.
- Not all staff had completed mandatory training for the equipment used in the patient transport vehicles.
- The safeguarding process was not fully developed which did not protect patients using the service.
- Medicines were not managed safely or securely. The service used medical gases. There was no medicines management policy in place with clear lines of accountability.
- Staff had not checked emergency equipment to ensure equipment was within use by dates and fit for purpose. There was no expiry date on the oxygen mask we checked, and no guidance regarding flow rates.
- The provider was not always completing pre-employment checks as detailed in their own recruitment policy.
- Staff did not follow infection control policy and procedures to safeguard patients from the risk of cross infection. This included no spillage kits on the vehicles at our planned inspection.
- Staff had not fully completed the patients booking forms and details of persons undertaking the role were not always recorded and signed.
- There was no risk register and the provider was unable to demonstrate how risks identified and escalated in order to protect patients. There was no process where risks could be assessed, tracked, managed or mitigated.

Summary of findings

- There was no governance structure for the service and no formal means of discussing clinical issues within the service.
- There was no process to collect patients' data in order to monitor and improve patients' outcomes.
- There were no performance management or checks to ensure staff had the required qualification for the role they were performing.
- Policies and procedures had not been developed to support practices for patient's transport services.
- Staff had not fully completed the ambulance vehicle checklist and conditions of use form prior to each patient journey.

We found the following areas of good practice:

- An annual satisfaction survey of patient/ relative feedback was undertaken by the service. There was a 26% response rate and demonstrated high levels of satisfaction with the service.
- Relatives we spoke with commented that staff were kind, caring and sensitive.
- Staff we spoke with said they could approach the provider if there were any concerns.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two warning notices to be compliant by 2 May 2017, and two requirement notices, due to the level of concerns and immediate actions they needed to take. Details are at the end of the report. The provider following the inspection voluntarily suspended the service. We will be returning to inspect the service before any further regulated activity is provided.

Professor Edward Baker
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Ambulance UK trading as St Bridget's Ambulance Service

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Ambulance UK trading as St Bridget's Ambulance Service

Mr Anthony Howell was the provider who owned and managed Ambulance UK trading as St Bridget's Ambulance Service. The service was first registered with the Care Quality Commission (CQC) in 2010. It is an independent ambulance service in Bournemouth, Dorset. The service primarily serves the communities of the Bournemouth area.

The provider also has two care homes and a domiciliary care agency registered with the CQC. Resources such as premises and staffing are shared across services the provider has registered with the CQC.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and a specialist advisor with expertise in patient transport services.

Emma Bekefi, Inspection Manager, oversaw the inspection team.

How we carried out this inspection

The service provided patient transport services that included medical repatriation for adults. The service had three vehicles: a stretcher ambulance, a wheelchair ambulance and a 15 seater minibus .Seven staff were employed. Requests for bookings were accepted from individuals, NHS and private hospitals, care homes, social services, district nurses and medical repatriation organisations.

The service is registered to provide the following regulated activities:

Transport services, triage and medical advice provided remotely.

We spoke with six staff including; patient transport drivers, ambulance crew and management. We were not able to speak with any patients during the inspection, We spoke with four relatives following the inspection. During our inspection, we inspected three vehicles and reviewed 27 patients' booking forms.

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 had last been inspected by CQC in January 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Detailed findings

Facts and data about Ambulance UK trading as St Bridget's Ambulance Service

Activity (February 2016 to January 2017)

- In the reporting period February 2016 to January 2017 there were 67 patient transport journeys undertaken.

Seven staff supported the work of the ambulance service, which included the provider. The other six staff worked both with the ambulance service, and in the providers' two care homes or domiciliary care agency.

Track record on safety

- No reported never events
- No reported clinical incidents
- No reported serious injuries
- No reported complaints

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The service provided patient transport services that included medical repatriation for adults. The service had three vehicles: a stretcher ambulance, a wheelchair ambulance and a 15 seated minibus .Seven staff were employed. Requests for bookings were accepted from individuals, NHS and private hospitals, care homes, social services, district nurses and medical repatriation organisations.

The service is registered to provide the following regulated activities:

Transport services, triage and medical advice provided remotely

Summary of findings

We always ask the following five questions of each service:

Are services safe?

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

- The internal incident reporting process was not effective. There was not a system to ensure all incidents were recorded and monitored and no learning or outcomes arising from incidents were shared with staff.
- Staff did not understand the duty of candour. At the time of the inspection, staff had received no formal training.
- There were no infection prevention control audits conducted to ensure high standards of cleanliness were being maintained. Staff did not clean vehicles after every patient journey. The wheelchair vehicle appeared to have ingrained dirt. We were concerned there was not a process in place for the deep cleaning of vehicles.
- Staff did not know that safeguarding concerns should be raised with the local authority. The provider lacked understanding of the full responsibilities, and staff had only a basic understanding of their responsibilities. The manager had not undertaken any safeguarding training, and staff had not undertaken safeguarding training at the appropriate level.

Patient transport services (PTS)

- There was no checklist for staff to ensure equipment was in place on the vehicle, and not gone past the manufacturers expiry date.
- The provider had a recruitment policy in place, but did not always fully complete pre-employment checks so did not adhere to the policy.
- Medicines were not always managed safely. The provider had no spare medical gas cylinders. There were no hazard signs to indicate medical gases being carried on the stretcher vehicle.
- No environmental risk assessments were in place, for example, in relation to medical gases management and an ambulance vehicle left with the engine running and unattended.
- Staff had not received all mandatory training needed to develop or maintain the skills to provide safe care.

Are services effective?

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

- The service did not have systems in place to routinely monitor how the service was performing. The service did not carry out any local audits as a way of monitoring performance and making improvements. There were limited policies and guidelines to support staff to provide evidence based care and treatment.
- Documented assessments and plans of care were insufficient because patient booking forms were not fully completed.
- Systems were not in place to ensure staff competency. The provider did not keep records of driver safety checks. There was no recorded evidence that staff had a full induction.
- There were no systems in place to ensure that the service used relevant and current evidence-based guidance standards, best practice and legislation to provide effective care.

However, we found the following areas of good practice

- Crew members understood the need to gain full consent prior to any treatment or interventions.

Are services caring?

We found the following area of good practice

- Four relatives we spoke with said staff were kind, caring and sensitive the patients' needs.

Are services responsive?

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

- The completion of patient booking forms was insufficient to ensure staff could identify patients' individual needs.
- The provider had a stretcher with a suitable safe working load limit for a bariatric patient. Other equipment such as the 'evac' chair and wheelchairs did not have a safe working load limit on them, so we could not be sure if these would be suitable for a bariatric patient.
- The vehicles and the provider website did not have information readily available informing patients or their relatives how to make a complaint. The complaints system in place did not support service users not to identify themselves, if that was their choice.

Are services well-led?

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

- There were no effective governance arrangements in place to evaluate the quality of the service and improve its delivery.
- The provider did not demonstrate the necessary knowledge to lead effectively. The provider had little understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, what the business was registered for, or what their responsibilities were to ensure compliance.
- The provider did not demonstrate sufficient understanding of risk and its management relating to the business. There were no processes or systems in place for the identification of, recording, monitoring, or managing risks associated with the business.
- There was no audit strategy or plan in place, which meant that the quality and performance of the service were not assessed to ensure patients were not put at risk.

Patient transport services (PTS)

- The service did not always proactively involve all staff, to ensure that their views were heard and acted on.

However, we found the following area of good practice

- An annual satisfaction survey of patient/ relative feedback was undertaken by the service. There was a 26% response rate which demonstrated high levels of satisfaction with the service.
- Staff we spoke with were passionate about their roles and providing excellent care.
- Staff we spoke with did say they could approach the provider if there were concerns.

Are patient transport services safe?

Incidents

- The service had a system in place for reporting incidents. Staff could report incidents using a paper record. Discussions with staff did not assure us that staff understood which incidents should be reported. Some staff told us they would report to management and would not complete the incident form. No incidents had been reported by the service in the 12 months prior to our inspection in February 2017.
- From February 2016 to February 2017, there had been no never events reported by Ambulance UK. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- If a member of staff reported an incident, we were not assured of a system for learning lessons.

Duty of candour.

- The duty of candour states that providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- The provider had a policy in place, which described their responsibilities under the duty of candour legislation. When we spoke with the provider, they did not relate the duty of candour to incidents that could occur to patients. Two staff we spoke with did not understand what the term duty of candour meant and their responsibilities in reporting any notifiable incident.

Cleanliness, infection control and hygiene

- We looked at all three ambulances that were used as patient transport vehicles. Two of the three vehicles appeared dirty and infection control policies and procedures were not followed.
- There was a cleaning schedule in all the vehicles. We checked the infection prevention and control schedule on two of the vehicles along with the log book detailing journeys vehicles had undertaken. The internal process was for all vehicles to be cleaned in between patients

and at the end of the day or beginning of each shift and "made ready". On one vehicle according to the journeys log the vehicle had been used 11 times, but infection control schedule was not completed from 22.09.16 until 07.01.17. On the wheelchair vehicle, according to the journey's log, the vehicle had been out on 26.01.17, 13.02.17, 14.02.17, there was no evidence that the vehicles had been cleaned in between patients' and cleaning schedules were not signed. The wheelchair vehicle was visibly dirty on inspection on 15 February with leaves, gravel and bits of twig evident.

- The stretcher vehicle had carpet around the sides, which was not good infection control practice as carpet is more difficult to clean. The service did not have a process for deep cleaning of the three ambulance vehicles.
- The infection control policy stated that vehicle cleaning must take place after every patient journey. Ambulance interior surfaces and equipment must be cleaned with surface wipes. On 15 February 2017, there were no surface wipes available in any of the three vehicles. We went back unannounced on 8 March 2017, surface wipes had been placed in all three vehicles. When we went back unannounced on 8 March 2017, the wheelchair vehicle remained dirty. There appeared to be ingrained dirt on the ramp used to enable wheelchairs on to the vehicle.
- The infection control policy stated to use a fresh solution of disinfectant solution if an ambulance became contaminated with blood or body fluids. The solution used for cleaning the vehicles was 'made up' in a spray bottle which was named but not dated. It was not clear when this was made up, so we were not assured that the solution was fit for purpose.
- Staff told us they used a blue mop bucket and handle for cleaning the ambulances. In the cleaning room, there were three mops and buckets. One red, one blue and one turquoise. All were very dirty and unable to distinguish usage according to colour code. The four coloured mops and buckets according to a code on the wall in the cleaning room were blue for general, red for bathrooms, green in catering areas, and yellow for isolation rooms. The use always of a 'blue' mop did not follow the provider policy, if a patient potentially may have had an infection. A staff member who was responsible for cleaning the vehicles was unable to tell us which mop they used for the ambulance. The mops were used for the care home and also the ambulances posing high infection control risks and transfer of organisms.
- On 8 March 2017, on our unannounced inspection the provider had replaced the buckets and mops. There was still no yellow mop to clean the area around a patient staff cared for in isolation, for example, due to an infection.
- There was no internal procedure for disinfecting or cleaning the mops at certain temperature to ensure effective infection control.
- On 15 February 2017, we found there were insufficient cleaning materials including hand gels in order to promote and maintain good infection control. Hand gel was only available in the front of the vehicles. There was none available to the staff with the patient to be able to decontaminate their hands. On our unannounced inspection 8 March 2017, hand gel had been placed in the rear of the stretcher vehicle, but not the wheelchair vehicle or 15 seater minibus.
- There was not sufficient personal protective equipment in the vehicles such as aprons and different sized gloves. On the patient transfer services stretcher vehicle used there was a box of gloves of one size. There were no gloves on the other two vehicles that did not enable staff to comply with the ambulance service infection control policy. The Ambulance UK t/a St Bridget's policy stated that protective personal equipment is recommended for all tasks involving direct contact with people.
- There were no spillage kits provided on the vehicles in line with their policy when we inspected the service on 15 February 2017. This was brought to the attention of the provider. On 8 March 2017, spillage kits had been placed on the stretcher and wheelchair vehicle, but not the 15 seater minibus.
- There was no system in place to monitor cleanliness. The provider did not have a system in place for Infection control audits to be carried out to ensure that cleaning was effective, any contaminates were removed and appropriate action to reduce the risk of cross infection.

Patient transport services (PTS)

- The service did not undertake any hand hygiene audits, and the provider was unable to demonstrate staff compliance with infection control practices.
- One of the surfaces on the transfer slide was damaged, which would make it difficult to clean. We raised this to staff within the service on 15 February 2017.However, when we returned on 8 March 2017, the transfer slide surfaces remain damaged, and unsecured in the stretcher ambulance vehicle.

Environment and equipment

- There were three vehicles, a stretcher ambulance, a wheelchair ambulance and a 15 seater minibus that could accommodate two wheelchairs if some seats removed. The three ambulance vehicles were parked in a car park behind one of the two residential care homes where the office was located.
- On 8 March 2017, we observed the stretcher ambulance that contained emergency equipment was not secure for 24 minutes. The engine was left running with the key in the ignition and the vehicle was unlocked. This meant that staff could not be assured that the emergency equipment was fit for use as it was left unattended for a prolonged period.We remained with the vehicle, and awaited the return of staff members. We raised this with staff who did not seem to recognise our concerns and went back inside leaving the vehicle unsecure. The staff member responsible for the vehicle returned and said they were charging the stretcher in the vehicle. We asked the staff member if this had been risk assessed and were told no. We raised our concern with the person in charge and the provider. We requested a risk assessment regarding this practice, but no risk assessment or assurance was provided to us.
- The oxygen mask on the patient transfer stretcher vehicle on the 15 February 2017 did not have an expiry date, no guidance re flow rate, and was in a bag that had been opened, so open to environmental dirt. On 8 March 2017, the oxygen mask had been replaced and was in a sealed bag. There was still no expiry date that we could find on the packaging.
- There was no razor with the defibrillator if needed in order to ensure the adhesive pads could be secured safely and effectively when needed.
- There was disposable suction equipment on the vehicle used for patient repatriations. This was not sufficient because it was too small for the potential volume of body fluids it may need to suction.
- The system for checking the equipment including emergency kit was not effective. On 15 February we looked at the first aid kits on the three vehicles and found one of the kits had expired in 2014. We brought this to the attention of a staff member and the kit was removed. During the previous CQC inspection in 2013 an out of date first aid kit was also found on one of the ambulance vehicles.
- The service did not have a daily checklist in place to check all equipment that staff should carry on the vehicle in place and ready for use. This issue of a daily equipment checklist was raised at the previous CQC inspection in 2013 and had not been addressed.
- A patient transfer slide was not secured in the stretcher ambulance vehicle. We discussed this concern with staff at the inspection, who were going to look into the concern.
- Staff told us that if they found a fault with a vehicle or some faulty equipment they would report it to the provider. However, there was no faulty equipment policy or written procedure in place.
- The provider did not always store equipment separately and this posed infection control risks, such as a feeding cup in the same bag as a bedpan and urinal. Patients were put at risk of infection by these items being stored in the same bag.
- Staff did not have personal protective equipment to use, as stated in the Ambulance U t/a St Bridget's Ambulance policy.
- The equipment was secured on the stretcher vehicle in bags with straps that were hung over the driver's seat headrest. This included the bag with the defibrillator in and the medical gases. If the vehicle was in an accident the bags may have come dislodged and the weight of these bags may have affected the integrity of the driver's seat. On 8 March 2017, this equipment other than the defibrillator had secured with a harness fixed to the floor of the stretcher vehicle. This still left a concern in the event of an accident of the defibrillator becoming dislodged and harming a patient or a member of staff.

Patient transport services (PTS)

- The clinical waste bin was in the vehicle car park at the rear of the building. The clinical waste bin was not locked. This meant clinical waste could be removed from the bin and present a health and safety risk. We raised this with the provider and when we returned on 8 March 2017 a yellow bin with a lock was in place. There was no dedicated clinical waste bin in the vehicles which meant any contaminated waste would not be managed safely. Staff told us they would place this on the floor of the vehicle.
- We checked the room on 15 February 2017 where the cleaning solution undiluted was stored. The room was locked, but the key was above the door and accessible to non- authorised people. When we went back to the room later on the 15 February 2017, the key was in the lock. The room was on the ground floor of one of two of the provider's residential care homes. We went back unannounced on 8 March 2017, and the key was then being held in a separate room.
- On the 15 February we found within the room with the cleaning materials and mops there were three food freezers and two fridges with food including meat and trifle, which presented a risk of cross contamination. On the 8 March 2017, the mops had been moved to the sluice within the care home.
- The service was compliant with Ministry of Transport (MOT) testing and servicing of the vehicles.
- The linen used on the three vehicles was washed and cleaned in the providers care home at the location. None of the vehicles carried spare linen, in case it was required during a patient journey.
- Staff had recently replaced the emergency equipment kit and a random sample of the equipment showed they were in date.
- The stretcher and seats in the vehicles had belts to ensure staff transported patients safely. Patients carried on stretchers were strapped in using belts and these were fitted with locking mechanisms to stop them moving during the journey. Staff told us they would explain to patients that this was for their safety. There were also five points securing system for wheelchairs in the vehicles.

Medicines

- The provider had no medicines policy in place therefore there were no clear lines of accountability. The emergency vehicles contained medical gases and at the time of the inspection there was no process in place for checking stock. There were no spare medical gas cylinders and no procedure for the safe storage and disposal of empty cylinders.
- The provider showed us records that some staff in June 2016 had received training regarding the administration of medical gases. A staff member told us they could give medical gases if prescribed on prescription; however, there was no internal policy for the administration of medical gases. Two crew members had been unable to join this training, and did not administer medical gases and further training was planned.
- Patients' or their accompanying carers were responsible for their own medicines administration whilst in transit.

Records

- There was no policy in place for the storage, transport and destruction of patients' records. During the inspection, we found that staff did not always manage patient records effectively. Records were incomplete and some were not legible. The filing system was chaotic and did not follow a pattern and was hard to follow. Some patients' records could not be found such as risk assessments and patients' booking forms.
- Patient details were available to crew members for patient journeys, and then patient information returned to the administrator. However, for the 27 patient booking forms we checked on 15 February 2017 and 8 March 2017, none were fully completed.
- We reviewed 'St Bridget's Ambulance service vehicle checklist and conditions of use' form that was in use at the time of the inspection. Information on the form included vehicle details, mileage, fluids, tyres, steering, lights, wipers, breaks and horn. Staff confirmed these forms should be completed for every patient journey. Out of 27 forms we reviewed on this inspection four were partly completed, the remaining 23 forms were not completed. This did not provide assurance that ambulance vehicles were always safe to use when care was being provided.

Safeguarding

- Staff training records evidenced staff only had received basic awareness training on safeguarding adults. This was a concern because this was not reflective of national guidelines for safeguarding, specifically the Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document (2016).
- The three staff we spoke with could recognise what might be safeguarding concern and knew they had a responsibility to protect vulnerable adults and children from abuse. The three staff said they would inform the provider if they had a safeguarding concern. Staff did not know to make a safeguarding referral to the local authority. Staff were at level 1 and needed to have undertaken level 2 safeguarding training. No safeguarding concerns had been reported by the service.
- The manager was the safeguarding lead for service. They had not undertaken any safeguarding training at the appropriate level in order to fulfil this role. The manager should have undertaken level 3 safeguarding training. When we asked what they would do if a member of staff reported a safeguarding incident to them, they said they would investigate. The provider did not talk about actions including involving other agencies, such as raising a safeguarding concern with the local council. Following the inspection, the provider confirmed they planned to apply to undertake safeguarding training with the local borough council.
- The service did have a safeguarding policy for vulnerable adults and children in place. A Mental Capacity Act (2005) policy was also in place and marked as under review in December 2016. The provider did not have an established system in place that could be evoked effectively to protect people using the service from improper treatment and abuse. For example, there was not a safeguarding alert form for staff to complete to support referral to external agencies.
- The provider demonstrated a lack of understanding of their responsibility to prevent, report abuse including referral to other agencies as required.

Mandatory training

- Mandatory training included adult abuse, moving and handling, health and safety, dementia and emergency aid training, and completion rates were 86%. However, the provider had not aligned mandatory training to the ambulance service. For example, first aid training and vehicle awareness and safety training were not listed. A senior member of staff told us that staff working on the ambulance did receive first aid training; however, they were unable to provide any evidence of this when we requested to see the records. One member of staff told us they last had first aid training about three years ago.
- We asked for details of training staff had received to use the 'evac' chair, which staff used for transporting patients. The staff member in charge of the service was not able to provide us with this information. From patient booking forms, we could see that the 'evac' chair was used to assist patient transfers.
- The provider confirmed that a senior staff member was responsible in providing most of the training in house. This included health and safety, and moving and handling training, for all staff as part of their induction. In order to provide moving and handling training the person must undertake additional training such as "train the trainer" training and updates. Records provided to us at the inspection showed that this person's training was out of date. The provider subsequently sent evidence that the person had valid certification until July 2018.
- Some of the staff also undertook transfers of patients and used their emergency "blue light" ambulance. These were used for patients' repatriation journeys. The provider told us these staff had not undertaken any additional training to drive the emergency vehicle as recommended by the institute of health and care development .They might not have had the skills to handle the vehicle safely including at high speed that may impact on safety of staff and patients.

Assessing and responding to patient risk

- Staff told us that one crew member sat with patients being transported in the rear of the vehicle. This meant they could directly observe the patients throughout the journey and respond if they witnessed and decline in the patients' condition. However when we checked the patient journey log book, we noted that on three patients' journeys 16 September, 26 September and 1 November 2016, there was only one crew member listed. We tried to cross check this with the

corresponding patient booking forms, but these forms were missing. A senior staff member told us they did not know who had accompanied these patients, as this information should be in the patient's journey log book.

- If patients became ill during their journey staff informed us they would stop the vehicle as soon as it was safe to do so and call 999. They would then inform their manager and would support the patient as best they could until help arrived. We did not see a written policy or procedure to support staff.

Staffing

- Seven staff worked for the service with varying levels of knowledge and skills. Four of these staff undertook driving responsibilities, and three worked as crew in the back. On some journeys staff with driving responsibilities worked as a crew member, to be with the patient. .We did not see any records of competencies that staff had worked through in their personnel files. A senior staff told us that patient transport journeys would be planned to ensure there was a driver and care assistant available.
- The staff working for Ambulance UK t/a St Bridget's Ambulance service were described as 'generic'. For example, one member of staff was a maintenance employee for the care home, and another cleaner. Patient journeys were usually planned in advance, so staffing could be planned. If a short notice booking received, the service would not accept if they could not supply two staff.
- We reviewed six personnel files and found the provider did not always adhere to safe recruitment policy. Pre-employment checks were not always completed and this included gaps in service. A member of staff had a four year gap in their employment record, there was no evidence in their recruitment folder that this had been explored. Records showed a staff member had commenced work in April 2016 and had worked on the patient ambulance on 16 and 26 September 2016. The Disclosure and Barring Service (DBS) check was not received until 26 October 2016. The provider was not following their own induction policy and procedures.

Response to major incidents

- The provider did not have a major incident plan, as they did not provide acute cover.
- The provider did not have any business continuity plans in place.

Are patient transport services effective?

Evidence-based care and treatment

- There was no system in place to demonstrate that policies had been developed, reviewed, and updated to reflect current practice. We reviewed five policies in place for the service. None of the five policies had a date when first produced, which version number now in use, or date of next review. Policies reviewed included the infection control and induction policy. We did not have any evidence that staff were aware of current evidence based guidance, standards and best practice were used to develop how services, care and treatment delivered.
- We asked in particular to see the policy/procedure and risk assessment on patient repatriation. This information was not provided to us when asked. On 8 March 2017, we reviewed details of a patient repatriated on 5 August 2016. There was no booking form completed, no risk assessment to identify what equipment may be needed to keep the patient safe. For example, if the patient required oxygen or particular equipment. We could not see that patients had their needs assessed and care planned and delivered in line with evidence based guidance, standards and best practice.

Assessment and planning of care

- Information about patients' needs was collected at the point of booking, and communicated to staff face to face. Information included the patients' age, weight, medical conditions, disabilities and any infections. However, of the 27 patient booking from we reviewed, none contained enough information to know how any risks identified managed. For example, patients' weights were recorded but not their body mass index (BMI), so it was not possible to say if the patient was bariatric, or what bariatric assessment or support may be required to ensure the safe transport of the patient. Patient booking forms stated patients being moved, for example, from the lounge to an upstairs bedroom or to a care home. There was no risk assessment completed to ensure the safe moving and handling of patients. The

records did not always contain information that evidenced what equipment was required or used and number of staff to ensure the safe movement and support of patients..

- There was no evidence that risks were assessed as part of point of bookings to ensure that care could be provided safely and necessary equipment was available.
- For patients with a longer planned journey time, the stretcher ambulance vehicle had a bag with a beaker, plate and knife and fork, to use for patients' with a longer journey time. It was not evident how patients' nutrition and hydration needs were considered and there was no arrangement such as bottle water in the vehicles.

Response times and patient outcomes

- The service did not formally monitor patient outcomes. There were no formal contractual or service level agreements in place.
- Response times were not being monitored. A senior staff member during the inspection in September 2013 told CQC inspectors the service were about to implement a system to monitor punctuality. This was not in place at the time of our planned inspection on 15 February 2017 or unannounced inspection 8 March 2017.

Competent staff

- The service had an induction policy and procedure in place. The policy stated that on commencing work with the service before being able to work independently, you would receive shadow training. Also, a more experienced peer would observe you to ensure you were competent to work. For two staff that had commenced work for the service since April 2016, there was no documented evidence that the staff completed induction.
- Driver and Vehicle Licensing Agency (DVLA) checks were conducted at the start of employment. The crew at the start of their employment signed a form to say they would notify their employer of any changes to their license. We saw where two staff driving vehicles had signed these forms. The employer did not undertake any further reviews themselves.
- On 3 March 2017, the provider sent through a draft procedure form entitled 'St Bridget's Driving Assessment'. This included 17 boxes to be completed, for example, driving license seen, type of licence held, and any points. The aim of the procedure to establish that employees were not a threat to either themselves or to other road users and pedestrians but this was not in use at the time of our inspection.
- The provider told us they assessed staff fitness to drive ambulances. Four staff drove ambulance vehicles at the time of our inspection in February 2017. The provider also told us that after an initial assessment they would then occasionally observe them driving the ambulance vehicle. The provider did not keep documented records of these assessments and there was no formal timetabling of when this took place. The provider reported that no staff had an accident whilst driving an ambulance vehicle when transporting patients.
- Following the inspection, we raised a number of serious concerns with the provider. On 12 March 2017, we received information that the provider was looking into the provision of driver competency and awareness training and blue light training. However, it remained that staff, at that time, had not received such training.
- The provider had completed appraisals for four of the staff in relation to their work in the care home and domiciliary care agency, but not their ambulance service work. Appraisal for two of the staff was not due as they had been employed less than a year. The provider had not been appraised, as there was no internal or external process for them to be appraised.

Coordination with other providers and multi-disciplinary working

- The service did not have any formal contracts in place.
- The provider used a third party for the provision of appropriately qualified staff when repatriating patients. These were usually patients who were flown back home after illness. The provider did not have any system in place to gain assurance about the repatriation company used.
- We were not able to observe if there was effective multidisciplinary team working with other providers. We did telephone organisations who the provider was listed as providing transport for, but they were not sure if it was this service they had used.

Access to information

- Staff used the information that had been completed on the patient's booking forms. On the day of our unannounced inspection, the crew had to come back after approximately five minutes for an 'evac' transfer chair. This raised concern for us about how preparations, including equipment required for a patient journey, took place.
- There was no information on the booking form to inform staff of patients' wishes such as 'do not attempt cardiopulmonary resuscitation (DNACPR). This was updated on the day of the planned inspection on 15 February 2017, and was included on the booking form. The updated form included a box for staff to tick if a patient had a 'do not attempt cardiopulmonary resuscitation (DNACPR) order in place', and for staff to request a copy of the form if in place for patient journeys.
- Satellite navigation system was provided on the stretcher vehicle, but not the wheelchair ambulance or 15 seater minibus. Staff told us that they used their own mobile telephone if needed when providing patient transport. This was not a satisfactory method of communication particularly if they relied on this for jobs allocation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Crew members we spoke with understood the need to gain full consent prior to any treatment or interventions.
- Staff had received training in the Mental Capacity Act 2005. The training was via e learning, information provided by the service showed that six staff of seven staff involved with the service had completed the training and were up to date. The member of staff we did not receive any training records for was the owner who managed the service.

Are patient transport services caring?

Are patient transport services caring?

Caring means that staff involve and treat you with compassion, kindness, dignity and respect.

Compassionate care

- We were not able to observe crew interacting with patients, as during our inspections there was only one patient journey which took place on 8 March 2017.
- We spoke with a crew member when they returned from the above patient journey. The crew member told us the patient transport journey had gone well, however the patient had felt cold when asked, so the crew member provided an additional blanket.
- Comments from the annual quality assurance survey with service users included 'very caring the way they handled and transported mum' and sensitive and compassionate in every part of moving'.
- Following the inspection we were able to speak with four relatives, who had been present when the service had met the needs of their loved one. All four relatives told us the staff were sensitive to their relatives needs and kind. The relatives particularly noted how staff had spoken with patients, explaining what was happening even when patients due to their health probably did not understand what was happening.
- A relative commented that staff had provided care in a dignified way while they transferred their father down the stairs. This was particularly important to the family who knew he would not be able to return home.

Understanding and involvement of patients and those close to them

- All four relatives told us they felt involved in the planning of the patient journeys, and two particularly said they 'felt confident in the hands of the staff'.
- Relatives were supported to travel with the patients if they wished.
- A relative commented how staff wearing uniforms had helped their mothers understanding that they could trust the staff to assist her with the patient journey.
- A senior member of staff also showed us a letter explaining how details of costs of a patient transport journey were made known to people using the service.

Emotional support

- A relative we spoke with said how reassuring it had been for a family member to be able to travel on the ambulance with a patient who was terminally ill, to support them during the journey to a 'home'.

Patient transport services (PTS)

- A staff member told us how they supported a patient who was anxious and kept them informed of the journey they were undertaking. Another staff member gave us an account of how they had supported a patient who was confused.

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

Service planning and delivery to meet the needs of local people

- The service had three vehicles; a stretcher ambulance, a wheelchair ambulance and a 15 seater minibus. The stretcher vehicle had been used approximately 60% of the time, and the wheelchair vehicle approximately 40%. The 15 seater-minibus had been rarely used.
- The service from February 2016 to January 2017 had undertaken from three to nine patient transport journeys a month. This included two patient repatriations in August 2016.
- There were no formal contracts in place. Journeys were either self-pay or referred by social workers or district nurses needing urgent transport to transfer patients.
- The service took advance and on the day bookings, and workloads were managed around this. The relatives we spoke with and healthcare staff told us the service was good at responding, even on short notice bookings.

Meeting people's individual needs

- A member of staff from the repatriation company always provided an escort for a patient repatriation, to ensure their medical and nursing needs could be safely met. For example, for the case we reviewed, this was a doctor. We were unable to review the details for the second patient repatriated, as the patient booking form was missing.
- The provider told us translation services were not available for patients whose first language was not English. The provider told us they would decline the booking if the staff were not able to communicate with the patient.
- The patient booking process meant patients individual needs should be able to be identified. However because the forms were not fully completed, there was a risk staff may not know about a patient's individual needs. For example, of the 27 forms we reviewed, only three had the medical conditions box completed.
- The stretcher ambulance vehicle was suitable for a bariatric patient, with a safe working weight limit of 318kg. A staff member told us the service did not have any other bariatric equipment. However records showed that bariatric patients had been transported as full assessment of needs were not completed. The vehicles had the facility to convey wheelchair and stretcher patients.

Access and flow

- For self- pay or individual bookings, the service provided a flexible service to meet the needs of the individual.
- Bookings were only accepted when there was sufficient staff to provide the support needed.

Learning from complaints and concerns

- The service had a complaints policy and procedure in place, but the policy had no version number, when it was published or when it was due for review. This meant staff may not have the most up to date information to support them if a complaint or concern made by a patient or a relative.
- There was an attached 'ambulance complaint form' but we did not see any of these available in the ambulance vehicles or the web site for the service so it was not clear how patients or their carers would make a complaint if they wished to. Post inspection the provider told us service users could request a copy of the complaints procedure, using the provider's feedback form. This system meant that the complaints procedure was not readily available, and did not support service users not to identify themselves, it that was their choice.
- The provider told us they had not received any informal or formal complaints from February 2016 to February 2017.
- We did not see any evidence of dissatisfaction with the service from relatives we spoke with, or other individuals who had used the service.

- Staff told us that feedback would be provided and the provider would investigate all concerns raised about the service. There was no process for cascading and sharing any lesson learned from incidents or complaints.

Are patient transport services well-led?

- Mr Howell, the owner, currently managed the service. When we went on our unannounced inspection on 8 March 2017, Mr Howell had gone on leave abroad. We asked a senior staff member who had been nominated to manage the service during Mr Howell's26 day absence, and they advised no one had been nominated. This meant there was no management oversight in place during the period annual leave taken by Mr Howell.
- Mr Howell was not taking action to provide assurance that the service delivered quality care. On 12 March 2017, we received an email stating that Mr Howell was considering appointing a manager to take operational responsibility for the service.
- Staff told us that they felt listened to and that Mr Howell was approachable. For example, in 2016 a new type of stretcher purchased that provided the patient with a smoother up and down movement, and involved less manual handling for staff.

Vision and strategy for this this core service

- We asked the provider what their vision was for the service. They told us 'to maintain a good service by not taking on too much'. The provider also told us there was 'no development plan – no strategy' to develop the service.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- At the time of the inspection, there was no risk register used to record risks identified, regarding patients, staff or the business. This meant there was no formal process for identifying and prioritising risks and recording measures implemented to mitigate the identified risks within the organisation. The provider was unable to tell us what the current risks were relating to the service.
- No internal audits had been set up to monitor compliance with areas such as cleanliness, infection control and record keeping. There were risks to staff and patient safety, through lack of observation and monitoring of performance.
- We observed and the provider confirmed that governance meetings did not take place. We were told there had been a staff meeting approximately three months prior to the inspection, but we did not receive a copy of the minutes of this meeting following a request. We were told that the minutes could not be located.

Public and staff engagement (local and service level if this is the main core service)

- The service undertook an annual quality assurance survey with service users. Categories of service measured included timely and efficient service, competency and professionalism of ambulance crew and respecting human rights and dignity. Staff invited service users to complete a feedback form at the end of their patient journey. The provider included a stamped addressed envelope for patients, or their next of kin or a representative to return feedback forms. The service had a 34% response rate in 2015 and a 26% response rate in 2016. Most of the respondents demonstrated a high level of satisfaction with the service.
- The service did not submit a staff survey in information returned to us pre-inspection.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- There was no innovation, plans in place to improve or sustain the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure effective governance and risk management systems are in place and understood by all staff. The provider must implement systems and processes to assess, monitor and improve the quality and safety of the services.
- Information about how to make a complaint or raise a concern about the service must be readily available for patients and their carers using the service. The complaints system in place must also support service users not to identify themselves, if this is their choice.
- Ensure incidents that affect the health, safety and welfare of people using services are reported, investigated and actions taken to prevent recurrences.
- Ensure that systems and processes are put in place to ensure all staff understand and implement the statutory obligations of the duty of candour.
- The service must improve its system and process for safeguarding, to ensure that all staff are trained appropriately and understand their responsibilities in protecting people from avoidable harm and abuse.
- Ensure that the risks to the health and safety of service users receiving care or treatment are sufficiently assessed. Booking forms must be completed fully to support patient care.
- Ensure that accurate, complete and contemporaneous records are kept in respect of service users.
- Ensure that persons providing care or treatment to service users have the competence and skills to do so safely. All staff must complete mandatory training and regular appraisals of their work.
- That appropriate infection control and prevention methods are used to prevent the spread of infection.
- Ensure that all equipment is fit for use and available when needed.
- Ensure that medicines are managed and stored correctly.
- Ensure recruitment policy is followed, and recruitment checks always completed before an employee commences.
- A risk register is in place that describes risks to the service and what plans are in place to reduce the risks.
- Ensure the range of policies in place support he operations within the regulated activity. Effective review and updating of the policies also needs to be in place.

Action the hospital SHOULD take to improve

- Consider actions that could be taken to improve response rate to feedback questionnaire, to increase user representation.

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
Transport services, triage and medical advice provided remotely	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **Regulation 20 :Duty of candour** 20(1) Registered person must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. • There was not an effective system in place and procedures were not developed to support a culture of openness and transparency and ensure all staff follow them. • Staff had not received appropriate training relating to the duty of candour and reporting notifiable incident.

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 **Regulation 13- Safeguarding service users from abuse and improper treatment.** 13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users. (3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

This section is primarily information for the provider

Requirement notices

- **There was no safeguarding procedures accessible for staff to follow to record and report any allegations of ill treatment or abuse.**
- The nominated lead person for safeguarding had not completed any training. They demonstrated a lack of understanding of their responsibilities to protect people using the service from risk of abuse. They had not completed the relevant training in order to carry out this role effectively.

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
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Regulation 12 (1) (2) (a) (b) (c) (d) (e) (g) (h), HSCA 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment 12 (2) (a) assessing the risks to the health and safety of service users of receiving care or treatment; • Patient booking forms were not being fully completed so risk assessment could not be completed to ensure staff were fully prepared to meet patients' needs. 12 (2) (b) doing all that is practicable to minimise any such risks; • Patient A weight was recorded as 21 stone. No risk assessment was recorded to show what support the patient required, for example staff and equipment, to be safely moved. 12 (2) (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; • There was no evidence that had received manual handling training specific to working for the ambulance service, for example, use of the 'evac chair'. • The safeguarding lead had undertaken no safeguarding training to undertake the role. • Ambulance crew had only received basic awareness training on safeguarding adults. This did not meet with national guidelines. 12 (2) (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way;

This section is primarily information for the provider

Enforcement actions

- There was an out of date first aid kit on the stretcher vehicle, an oxygen mask in an open bag. The suction equipment was not fit for purpose, as too small. There was no medical equipment checklist on the vehicle, so as staff could check what should be held on the vehicle.
- Of 27 patient vehicle checklist forms to be completed for each patient journey that the provider had in place, only four of the 27 were partially completed.
- The defibrillator and patient transfer slide were not safely secured in the stretcher vehicle. There was a possibility of these becoming dislodged in the event of an accident posing risks to patient and staff in the vehicle, and this equipment may become damaged when it is needed.

12 (2) (g) the proper and safe management of medicines;

- A risk assessment had not been undertaken to manage the hazard with the plan to store medical gases in a shed.
- There was no compressed gas hazard sign on the stretcher vehicle ambulance vehicle to indicate three medical gas cylinders being carried.

12 (2) (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated;

- Staff had not completed the box on the 27 patient booking forms about patients' infection status, so the service was not able to assess the risks and take appropriate action.
- There was only one size of gloves on the three vehicles, no aprons, and hand gel was only available to in the rear of the stretcher vehicle.
- The three ambulance vehicles were not cleaned after every patient use by staff, and the wheelchair vehicle was dirty on inspection. The wheelchair vehicle appeared to have ingrained dirt. The service did not have a schedule of regular deep cleaning in place.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Transport services, triage and medical advice provided remotely

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (1) (2) (a) (b) (c) (f) HSCA 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance.

1. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

- There were no audits in place to monitor compliance in all aspects of service provision. This meant there was no effective way to measure the quality of the service being delivered against the required standard and to make improvements where required.
- Information about how to make complaints or raise concerns about the service was not readily available to patients and their carers. The complaints system in place must also support service users not to identify themselves, if that was their choice.

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

- You did have systems and processes to ensure that you are complying with mandatory training requirements for staff working for the service.
- Your systems and processes did not prevent the risk of people working before all checks confirmed as satisfactory.
- There was no system in place to demonstrate that policies in place for the operation of the service were being reviewed and updated to reflect current practice.
- We were not assured about the effectiveness and governance of the review of your policies, as they did

This section is primarily information for the provider

Enforcement actions

not contain up to date information, such as the duty of candour. The range of policies did not meet all the needs of the regulated activity undertaken, for example, patient repatriation.

- There was no process in place to manage risk.

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

- Records were incomplete and were not up to date. Decisions relating to care and treatment were not fully recorded in a way that met people's needs.

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

- There was no evidence that any activity took place to enable the evaluation and improvement of practice.