

Invictus Medical Services Limited

Invictus Medical Services Ltd

Quality Report

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

Ratings

Overall rating for this
ambulance location

Inadequate



Emergency and urgent care services

Inadequate



Summary of findings

Letter from the Chief Inspector of Hospitals

Invictus Medical Services Ltd is operated by Invictus Medical Services Limited. The service provides an emergency and urgent care ambulance service by conveying patients from event sites to the local acute NHS trust. Invictus Medical Services Limited was not commissioned by other organisations to deliver services. Work was acquired through a tendering process with event organisers. Although the provider told us they would provide patient transport services if the opportunity arose, this activity was not being provided at the time of this inspection. We were not able to observe staff carrying out regulated activities as, at the time of the inspection, the service was not delivering any regulated activities. The service had one emergency ambulance to carry out the regulated activities.

The service did provide medical cover at events. However, the CQC does not currently have the power to regulate events work, therefore we did not review that work within this report.

We previously inspected the service on 27 November 2018, using our comprehensive inspection methodology. Due to the concerns we had about the lack of governance, the management of safety and staffing concerns, the service was rated inadequate and placed in special measures. We urgently suspended the registration of the provider because we believed that people were or might have been exposed to the risk of harm if we did not take this action.

We carried out a focused follow up inspection on 18 February 2019 to assess whether the provider had made enough changes to the service to lessen the risk to people using the service. Following this inspection, we told the provider of additional areas where it must take some action 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 one requirement notice that affected Invictus Medical Services. This was not a full inspection and the rating and actions of the previous report remained active until we carried out a comprehensive inspection.

On 1 July 2019 we carried out an inspection using our comprehensive inspection methodology, following which the service remained rated as inadequate and remained in special measures.

On 17 January 2020 we carried out a focussed inspection of the service. At this inspection we assessed the provider's progress against specific areas of concern and breaches of regulation that were identified at the inspection in July 2019. This was not a full inspection and the rating of inadequate remains until we carry out a comprehensive inspection.

We gave the service two weeks' notice of our inspection to ensure everyone we needed to speak with was available. We spoke with two of the directors. The registered manager, who was the third director, was unavailable for this inspection. The service contracts self-employed staff when needed, they had not carried out any regulated activity since the last inspection and therefore no staff or patients were available to speak with.

Our rating of this service stayed the same. We rated it as **Inadequate** overall.

We found the following areas of improved practice:

We found the provider had addressed the specific concerns raised at the inspection in July 2019. In particular:

- The safeguarding lead had completed level 3 training about both safeguarding children and young people and safeguarding adults.
- The provider had reviewed and revised safeguarding policies, which now included current national best practice guidance.
- The service followed processes to ensure all equipment on the ambulance was available, clean and in date.
- Equipment was serviced by professionals to ensure it was safe to use.
- The provider had purchased a child harness to enable children to be conveyed on the stretcher.

Summary of findings

- The provider had reviewed and revised their medicines management policies to reflect the service provided and reference current legislation and best practice guidance.
- The provider had made some improvements to the governance of the service. They held monthly meetings which were recorded, there was now a planned programme for review and revision of policies and procedures.
- The provider had a risk management policy and manager meeting records detailed some of the actions the service was taking to lessen risks to the service and to people who used the service.

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

- The provider should consider changes and improvements to the governance and risk management of the service to demonstrate ongoing effective and safe leadership of the service.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Emergency and urgent care services

Rating

Inadequate



Why have we given this rating?

This rating is from the previous comprehensive inspection. We did not re-rate this service as part of this focused inspection.

The provider had acted to address areas of concern and breaches of regulation identified at the previous inspection in July 2019. Processes were followed to ensure equipment on the vehicle was available, was in date, was clean and was safe to use. There was now a planned programme for review and revision of policies and procedures. Recent revisions to safeguarding policies and medicine management policies meant that they were relevant to the service and included reference to best practice guidance and relevant legislation. The provider had made some improvements to the governance of the service. The provider had made some improvements to the management of risks.

However, the provider should consider changes and improvements to the governance and risk management of the service to demonstrate ongoing effective and safe leadership of the service.

Invictus Medical Services Ltd

Detailed findings

Services we looked at

Emergency and urgent care

Detailed findings

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Background to Invictus Medical Services Ltd

Invictus Medical Services Ltd is operated by Invictus Medical Services Limited. It is an independent ambulance service in Ryde, Isle of Wight, primarily serving the communities of the Isle of Wight. The service was registered by the Care Quality Commission (CQC) in January 2018 to provide transport services, triage and medical advice remotely and urgent and emergency treatment. Invictus Medical Service Ltd is not commissioned by other organisations to provide services. The service obtains work through tendering processes with event organisers.

The service has had a registered manager in post since registration with CQC on 26 January 2018. A registered manager is a person who has registered with CQC to manage a service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2012 (Regulated Activities) Regulations 2014, and associated regulations about how a service is managed.

Following our findings at an inspection of this service on 27 November 2018, we rated the service as inadequate and urgently suspended the registration of the provider until 28 February 2019, because we believed that people were or might have been exposed to the risk of harm if we did not take this action. We carried out a focused follow up inspection of this service on 18 February 2019 to assess whether the provider had made enough improvements to meet regulatory standards. At that inspection we found that although some improvements had been made there were still concerns about some areas of the service.

We carried out a comprehensive inspection of this service on 1 July 2019, at which time we identified areas of concern and breaches of regulation. Following the inspection of 1 July 2019, Invictus Medical Services Ltd remained rated as inadequate.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, a CQC assistant inspector, and a specialist advisor with expertise in paramedic services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Detailed findings




How we carried out this inspection

On 17 January 2020 we carried out a focussed inspection of the service. At this inspection we assessed the provider's progress against specific areas of concern and breaches of regulation that were identified at the inspection in July 2019.

During the inspection, we visited the location. We spoke with two of the three directors. The registered manager, who was the third director, was not available for the inspection. The service did not directly employ any staff in addition to the registered manager, however they recruited self-employed staff as and when needed to

deliver the service at events where they may be required to convey patients to the local acute hospital. We were not able to speak to any of these staff. We were not able to see any care being delivered to patients or speak with them as there was no one receiving care during our inspection. During our inspection, we reviewed records, policies and procedures relevant to the areas being looked at during the focussed inspection. We inspected the one ambulance the service had to carry out the regulated activities.

Emergency and urgent care services

Safe	Inadequate	
Well-led	Inadequate	
Overall	Inadequate	

Information about the service

Invictus Medical Services Ltd is an independent ambulance service located on the Isle of Wight, Hampshire. The service is registered with CQC to provide transport services, triage and medical advice provided remotely, and treatment of disease, disorder or injury. The service provided emergency and urgent services by conveying patients from event sites to the local acute NHS trust. Invictus Medical Services Ltd was not commissioned by other providers or services to provide an ambulance service. Work was acquired through a tendering process with event organisers. Invictus Medical Services Ltd had three directors, one of whom was the registered manager. The service had one ambulance.

Summary of findings

The provider had acted to address areas of concern and breaches of regulation identified at the previous inspection in July 2019. Processes were followed to ensure equipment on the vehicle was available, was in date, was clean and was safe to use. There was now a planned programme for review and revision of policies and procedures. Recent revisions to safeguarding policies and medicine management policies meant that they were relevant to the service and included reference to best practice guidance and relevant legislation. The provider had made some improvements to the governance of the service. The provider had made some improvements to the management of risks.

However, the provider should consider changes and improvements to the governance and risk management of the service to demonstrate ongoing effective and safe leadership of the service.

Emergency and urgent care services

Are emergency and urgent care services safe?

Inadequate



This rating is from the previous comprehensive inspection. We did not re-rate this service as part of this focused inspection.

Safeguarding

At the previous inspection in July 2019, although the registered persons had training to assist staff to understand how to protect patients from abuse, this did not follow national guidance. Senior staff and paramedics did not have the levels of safeguarding training as recommended by best practice guidance to protect patients.

During the inspection on 17 January 2020 we found the directors understood how to protect patients from abuse and had completed training about how to recognise and report abuse, and they knew how to apply it.

The provider had reviewed and updated the safeguarding policies, which now referenced current national guidance, including the intercollegiate Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018 guidance and the intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff fourth edition: January 2019.

There was documentary evidence that the director nominated as the safeguarding lead had completed level three safeguarding children and young people training and level three safeguarding adults training. A second director had completed level three training for both safeguarding children and young people and safeguarding adults. The third director, who was also the registered manager and a registered paramedic employed with the local NHS ambulance trust had completed level two training for both safeguarding children and young people and safeguarding adults. This director planned to complete level 3 safeguarding training for both children and young people and adults with the local NHS ambulance trust to meet the recommendation detailed in the intercollegiate documents that paramedics should have level three training about safeguarding.

Cleanliness, infection control and hygiene

At the previous inspection in July 2019 the service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. They did not keep equipment and the vehicle clean.

During the inspection on 17 January 2020 we found the service controlled infection risk well; used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the vehicle visibly clean.

The provider had made improvements with their management and control of infection risk. We found the ambulance was clean and free from dust. The provider had introduced a cleaning programme, which included weekly standard cleaning and monthly deep cleaning. Policies and procedures provided guidance about how standard and deep cleaning should be carried out. We saw documentary evidence that deep cleaning was carried out monthly: dates 14 January 2020, 14 December 2019, 14 November 2019, 16 October 2019 and 12 September 2019. Dates of the last completed weekly standard clean and monthly deep clean of the ambulance were detailed on a wipe board in the ambulance. This was a new process since the inspection carried out on 1 July 2019. The service's policies and procedures stipulated that the vehicle was cleaned prior to being used at an event or for conveyancing purposes and was cleaned after use at events or after conveyance of a patient. The provider told us that the service had not carried out any event work or conveyances since the last inspection in July 2019, so we could not assess the provider's compliance with this policy. However, in conversations and review of their policies and procedures the directors demonstrated intent to ensure the ambulance was clean prior to carrying out any regulated activity.

At the inspection in July 2019 the child harness built into the seat was visibly dirty. At the inspection on 17 January 2020, the child harness on the seat was visibly clean and free from dirt. This reduced risk of cross infection.

At the inspection in July 2019 bins on the ambulance were unsafe and posed a risk of cross contamination. At this inspection on 17 January 2020 we found that the provider had acted to lessen the risk of patients being subjected to cross contamination from items falling on them from the bins. We saw the general and clinical waste bins on the

Emergency and urgent care services

ambulance were held in a secure manner. They were held in place with heavy duty bands, designed for that purpose. We tested the opening of the bins and saw they were secure, and that rubbish would not fall out of them.

Environment and equipment

At the previous inspection in July 2019 the service failed to ensure the vehicle and equipment kept people safe. We found consumables that were out of date on the ambulance. The service could not be assured the equipment was in safe and working order as the equipment had not been serviced in line with the manufacturer's guidelines. Staff did not manage clinical waste well.

At the inspection on 17 January 2020 we found the service had acted to ensure the vehicle and equipment kept people safe, and processes were in place and followed to ensure clinical waste was managed well.

At the inspection on 17 January 2020 we saw the items identified at the previous inspection as having no assurance that they were safe to use had been serviced. A service certificate dated 8 July showed the stretcher was fit for use. A service certificate dated 8 July 2019 showed the carry chair was fit for use. A service certificate dated 28 October 2019 showed the defibrillator on the ambulance was fit for use. A service certificate dated 8 July 2019 showed the tail lift was fit for service and was due a service on 8 July 2020. Service certificates evidenced the oxygen piping was serviced. The provider had engaged a professional to carry out electrical safety testing on the service's portable equipment. We saw evidence (service certificates) that electrical safety testing had been carried out on 8 July 2019 for the portable electrical equipment held on the ambulance. This included the suction machine and electrical components of the defibrillator. These actions lessened the risk to patients, as there was now assurance that equipment was safe to use.

At the inspection on 17 January 2020 we checked a large sample of sterile supplies on the ambulance and we did not find any out of date items. The provider had a process to check the supplies on the ambulance monthly during the monthly manager checks. Part of this process was to identify any equipment and supplies that were due to expire in two months' time, at which time the provider ordered replacement equipment. Equipment identified as due to expire in two months' time had an orange sticker

placed on it and placed it at the front of the equipment, to be used first. We saw documentary evidence that the monthly manager checks were completed on 14 January 2020, 14 December 2019, 14 November 2019, 16 October 2019 and 12 September 2019. The date of the last completed monthly managers check was detailed on a wipe board in the ambulance. This was a new process since the inspection carried out on 1 July 2019. This meant the risk of harm to patients due to receiving treatment with equipment that was past the manufacturers use by date was lessened.

At the previous inspection the provider did not have a child harness to enable a child to be conveyed on the stretcher. At the inspection on 17 January 2020, we saw the provider had purchased a child harness that could be used with the stretcher. The harness was suitable to use on the stretcher and the directors had trialled the use of it, so they were assured they knew how to use the harness. This meant children could be now conveyed on the stretcher.

Medicines

At the previous inspection in July 2019 the provider did not demonstrate they managed medicines in a safe manner.

At the inspection on 17 January 2020 the service used systems and processes to safely administer and record medicines.

We saw the provider had reviewed and revised their medicine management policies and procedures to reflect the service provided and to include relevant and up to date national guidance. The service held no medicines, other than those that could be purchased by the public from a pharmacy. We were told all other medicines used during the carrying out of regulated activities, were those medicines owned and held by paramedics under their individual professional accountability. The service had processes that paramedics had to follow, which included the recording of the administration of medicines, whilst deployed by Invictus Medical Services Limited. The provider stated the service did not hold or order any controlled drugs, these were held by individual paramedics under their professional accountability.

Are emergency and urgent care services well-led?

Emergency and urgent care services

Inadequate



This rating is from the previous comprehensive inspection. We did not re-rate this service as part of this focused inspection.

Governance

At the previous inspection in July 2019 leaders did not operate effective governance processes.

At the inspection on 17 January 2020 the directors operated more effective governance processes, and were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We found the provider had made some changes to the governance processes. There were clear lines of responsibility for each of the directors.

The provider held monthly management meetings, of which written records were made. There was no set agenda that all meetings followed, but agenda items that needed to be discussed at each meeting were detailed on the meeting record. Review of the record of the management meetings showed that although the service was acting to improve the service, as described by the directors during the inspection, there was limited information detailed about this. There were some details of planned actions to make changes and improvements to the service and to review the effectiveness of those actions.

However, the service followed a planned programme for review and revision of policies and procedures to ensure they remained in line with current legislation and best practice guidance.

Management of risks, issues and performance

At the previous inspection in July 2019 leaders did not have or use systems to manage performance effectively. They did not identify risks which meant action could not be identified to reduce their impact.

At the inspection on 17 January 2020 directors used systems to manage performance more effectively. They identified the most relevant risks and issues and identified some actions to reduce their impact.

We found the provider had made some changes to processes to manage performance and risks. Following identification of concerns raised in previous CQC inspection reports, vehicle equipment safety and availability had been improved by the provider's manager monthly check lists and the introduction of schedule servicing of equipment by relevant professionals. Discussion with the directors showed they had not considered a similar process for routine vehicle checks. We received information two days after the inspection that showed the provider had implemented a monthly managers vehicle roadworthiness inspection process, which included visual vehicle checks. This included checking tyre pressures, checks that all lights, indicators and hazard lights were working and checking fluid and oil levels in the vehicle.

The provider had a risk management policy that had been reviewed and revised since the inspection in July 2019. The service had completed risk assessments for some risks they had identified. The records showed these had been actioned and closed off as not being a risk anymore.

Records of monthly management meetings showed the directors considered the impact the CQC rating had on the delivery of the service. The meeting records gave some detail about the action the service was taking to improve their CQC rating.

The provider had introduced processes to monitor and manage performance of the service. This included auditing of patient record forms and supervision of staff deployed by the service. However, as the service had not carried out any regulated activities since the inspection in November 2018 it was not yet possible to assess the effectiveness of the monitoring and management of the performance of the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

The provider should consider changes and improvements to the governance and risk management of the service to demonstrate ongoing effective and safe leadership of the service.