Air Med Transport Limited

Quality Report

2B Grosvenor Road
Handsworth
Birmingham
B20 3NP
Tel: 07944934938
Website: www.airmedtransport.co.uk

Date of inspection visit: 27 November 2019
Date of publication: 14/04/2020

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Air Med Transport Limited is operated by Air Med transport Limited. The service provides a patient transport service.

We planned to inspect this service using our comprehensive inspection methodology. However, this was changed to a focussed inspection as we could not make a full assessment of all areas of the service. We carried out a short term announced focussed inspection on 27 November 2019. We reviewed two of the five questions, are they safe and well-led? We did not review the questions, are they effective, caring and responsive to people's needs?

The service provided patient transport, including transporting persons detained under the Mental Health Act 1983.

We rated this service as **Inadequate** overall.

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

- Driver training was not always provided by an accredited provider. Staff used hard handcuffs but the provider could not provide assurance handcuff training had been completed.
- The service did not control infection risk well. Staff did not keep premises, equipment and vehicles visibly clean.
- The maintenance of vehicles and equipment put people at risk of avoidable harm.
- Processes to assess and respond to patient risk were unsafe.
- Policies available to staff were not always up to date.
- Staff had training on how to recognise and report abuse but we could not assess if staff understood how to protect patients from abuse as we did not speak with any staff during the inspection.
- The safeguarding lead had not completed level three safeguarding training.

Following this inspection, we suspended this service until the provider could demonstrate that it had improved.

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Heidi Smoult

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	Inadequate 	Premises, vehicles and equipment posed a risk to patients and staff. There was a lack of risk assessment for safely transporting patients. Staff who were driving patient transport vehicles were not all trained by accredited training providers. The service was not well led as there was a lack of clinical and operational oversight.

Summary of findings

Contents

Inadequate

Air Med Transport Limited

Services we looked at
Patient transport services.

Summary of this inspection

Background to Air Med Transport Limited

Air Med Transport Limited is operated by Air Med transport Limited. The service has been registered to provide a regulated service since March 2016.

The provider is an independent ambulance service that is based in Perry Barr in Birmingham.

The service mainly provides secure transport for patients with mental health needs and transport for patients discharged home from hospital.

Patients transported by the service are physically well which means vehicles were not equipped in the same way conventional ambulances might be. The vehicles are not adapted for patients with physical conditions and therefore did not have emergency equipment or drugs on board.

The service had a registered manager in place since registration in March 2016.

The service is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the provider's base unit, which is where the service was provided from. There were no other registered locations. We inspected two of the service's vehicles.

We spoke with the registered manager. We could not speak with any other staff as they were not available on the day.

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 was previously inspected on 17 May 2017. The service was not rated at the previous inspection as we did not rate independent ambulances at that time. The previous inspection report was published on 10 August 2017. The service received five requirement notices:

- The safeguarding lead was not trained to level 3 and did not have sufficient knowledge and qualifications to support their staff in safeguarding vulnerable adults and children.
- The provider must ensure that all equipment is strapped securely within all vehicles to prevent harm to drivers and passengers.
- The provider must ensure that all staff have documented DBS checks.
- The provider must ensure staff have access to translation services and visual aids to enable them to communicate with patients whose first language was not English and patients living with learning disabilities respectively.
- The service did not use a risk register or similar tool to assess and monitor their risks.

In the month of November 2019, the registered manager told us the service had only completed one mental health patient transfer.

The service employed 17 staff of which two were full time and one was part time. The rest were employed on a zero-hours contract basis, whereby the staff provided their shift availability and were then allocated shifts to be 'on-call' throughout the week. Should a transfer be requested, those on-call staff would be contacted and asked to attend work. These staff were either drivers or escorts.

The service had a fleet of five vehicles including unmarked cars, an ambulance and minibuses.

Track record on safety: we did not review safety data.

There were no enquiries of concern made to CQC since the last inspection in May 2017.

The provider had given a provider return in June 2019. The provider was requested to send more up to date information for the inspection but asked us to use the existing information.

Summary of this inspection

Our inspection team

The team that inspected the service comprised one CQC inspector and a specialist advisor with experience in patient transport services. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

We inspected this service on 27 November 2019.

How we carried out this inspection

During the inspection, we visited the main office and vehicle cleaning area. We spoke with the registered manager.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	N/A	N/A	N/A	Inadequate	Inadequate
Overall	Inadequate	N/A	N/A	N/A	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	
Caring	
Responsive	
Well-led	Inadequate

Are patient transport services safe?

Inadequate

We rated safe as inadequate.

Mandatory training

The service did not always provide mandatory training in key skills to staff. Driver training was not always provided by an accredited provider. The provider could not provide assurance staff had received training in the use of hard handcuffs.

The service kept a log to monitor staff compliance with mandatory training. Mandatory training was shown as reviewed annually against the induction checklist of required training. However, during the inspection we could only speak with the registered manager, who could not provide training system data. Some data had been submitted as part of the pre-inspection provider return. Upon review of the data, we saw there was 100% compliance with mandatory training.

Topics on the mandatory training list included but were not limited to blue light driving, infection control, fire safety and manual handling.

Driver advanced training was not always delivered by an accredited trainer. Two drivers had received training from a recognised provider but two had received in house training from a non-accredited advanced driver. Under the Road Safety Act 2006, Section 19, exemption from speed limits is only given when the vehicle is being driven by a person who has satisfactorily completed a course of training in the driving of vehicles at high speed. The training given to two of the drivers by a person who had previously been an advanced driver did not have regulated content or assessment. The provider was not assured the training was sufficient to reduce the risk of a road traffic collision to the driver, staff and patients being transported at high speed.

The registered manager told us staff used hard handcuffs on patients but there was no evidence of handcuff training. Patients were at risk of avoidable harm from improper use of hard handcuffs by staff who were not trained.

Safeguarding

Staff had training on how to recognise and report abuse.

During the inspection we could only speak with the registered manager who could not provide training system data. Some data had been submitted as part of the pre-inspection provider return.

Staff received level two safeguarding training. The provider submitted data that stated all staff had completed the training. We could not assess if staff understood how to protect patients from abuse as we did not speak with any staff during the inspection.

The safeguarding lead was not trained to level three and there was no training planned. At the last inspection the provider received a requirement notice stating that the safeguarding lead was not trained to level three and did not have sufficient knowledge and qualifications to support their staff in safeguarding vulnerable adults and children. The same was found during this inspection.

There was a safeguarding policy for adults and children at risk. However, the policy was not clear on when to report potential safeguarding concerns and had the potential to confuse staff.

At the last inspection the provider received a requirement notice stating the provider must ensure all staff have

documented DBS checks. The registered manager told us during this inspection all staff should now have a DBS check in place. However, we did not see evidence to support this as the registered manager did not have access the systems.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff did not keep premises, equipment and vehicles visibly clean.

The areas used for cleaning vehicles and equipment were visibly dirty and did not ensure safe infection prevention and control. We inspected the unit where vehicles were cleaned. There was one sink which was extremely dirty which posed an infection risk to staff and patients. The sink was used for filling and emptying mop buckets. The sink was also used by staff for washing mugs for their use and there were mugs on the drainer. There was a used mop head on the shelf under the sink. There was also a bucket containing pieces of concrete on the shelf under the sink.

We saw a dirty mop head was still on a stored mop, used for cleaning vehicles. At the last inspection we found staff re-used disposable mop heads and we could not be assured this was not still the case.

The service did have adequate cleaning products. The service had a vehicle deep clean policy and vehicle cleaning schedule for staff. We saw templates of these but did not see completed forms.

We inspected two vehicles and found they were not visibly clean or fit for purpose. We inspected an ambulance which was visibly dirty inside the cabin and the main patient area. The stretcher had patient straps which were ripped and dirty. Several seats were ripped, and the arm of a seat was mended using bandage, increasing the risk of infection. There was dirt under the seats. There were pieces of food on the floor in the driver's cab.

Equipment was stored incorrectly and in a way which did not promote infection control or prevention. The overhead compartment in the ambulance we inspected contained several wet blankets suggesting water was entering the vehicle which increased the risk of infection. The registered manager also told us blankets should not be stored in vehicles.

We inspected a nine-seater minibus and found it was visibly dirty inside the patient seating area, increasing the risk of infection.

The registered manager told us they carried out spot checks on vehicles to make sure they were clean but we did not see records to support this.

Environment and equipment

The maintenance and use of the premises were suitable. However, the maintenance of vehicles and equipment put people at risk of avoidable harm.

Premises were appropriate and well maintained but were not clean. The premises were safe and secure and had out of hours' security arrangements.

The service did not have effective systems to ensure the safety and maintenance of equipment. This meant there was not always safe, ready to use, equipment for the vehicles.

We inspected an ambulance which contained a stretcher, wheelchair and a transit chair for transporting patients. These were not labelled to show when they had last been serviced and the registered manager was not able to provide any documentation to confirm when they had been. This posed a risk of harm to patients as it could fail whilst being used and cause physical harm to a patient, if the equipment had not been serviced regularly.

There was no equipment log to monitor where equipment was situated and when it was last serviced. There was no log of equipment requiring repair. This meant patients were at risk of avoidable harm from equipment that was not in service date and could fail whilst being used by staff.

There was no log to monitor where hard handcuffs were at any time and when they were last used, cleaned or checked. This meant the registered manager did not have oversight of when staff used hard handcuffs. Patients were at risk of avoidable harm from improper use of hard handcuffs that were not cleaned or maintained.

The patient straps on the stretcher, located in the ambulance we inspected, were ripped, dirty and not fit for purpose. Several seats in the ambulance were ripped. A seat belt buckle had been mended with sticky tape which placed a person using the seatbelt at risk of harm in the event of a road traffic accident. The fold out ramp used to

access the back of the ambulance did not have a sticker to confirm when it was last serviced and the registered manager could not provide this. This posed a risk to staff and patient safety, if it failed.

The fire extinguisher in the ambulance was due a test in March 2018 but there was no label to confirm it has been tested. The registered manager was unable to provide documentation confirming it had been tested. The registered manager told us they would replace the fire extinguisher with another which had been recently serviced. At the last inspection, the provider was asked to ensure all fire extinguishers had annual maintenance checks and so the lack of checks had not improved since the last inspection.

The vehicle used by the service to transport persons under the Mental Health Act 1983 was not equipped to safely transport higher risk patients. We inspected a nine-seater minibus which was used for this service. There were risks posed by high risk patients accessing the driver whilst in transit as there was no dividing screen between patients and the driver. The registered manager told us higher level restraint (such as several escort staff or hard handcuffs) was used for some patients suggesting some patients were high risk.

The two vehicles we inspected did have working lights and indicators. The heater in the back of the ambulance was working. Vehicles in use had an annual Ministry of Transport test (MOT).

Assessing and responding to patient risk

The procedures for assessing and responding to patient risk were unsafe.

We were not provided with any assurance staff were completing risk assessments for patients. The service had some generic organisation risk assessment forms for risks such as manual handling and infection control. However, the forms submitted by the provider as evidence were dated May 2016 and May 2018 respectively and so were out of date.

The service had a service user handling and transfer policy, but this was last reviewed in May 2018 and so had not been recently reviewed. This meant patients could be potentially at risk of avoidable harm as staff did not have up to date policies to follow.

Before booking a transfer, the registered manager spoke with the booking establishment, including whether the patient was detained under the Mental Health Act, to ensure the staff and vehicles were planned and used safely.

The booking establishment provided a summary of the booking for the patient transfer. The summary included brief details of the patient's history and current physical and mental health conditions. However, staff at the service did not then complete their own risk assessment to consider risks for transfer such as suitable vehicle arrangements, restraint or staffing mix and numbers. Risks to patients accessing the driver during transit in the absence of a diving screen had not been considered. This put staff, patients and the public at risk of avoidable harm.

The provider did not have a policy for any use of 'blue lights' which complied with national recommendations. The registered manager told us blue lights would be used if staff needed to get a mental health patient to a destination quicker.

Staffing

We did not review staffing.

Records

We did not review records as we could not gain access to them as the registered manager was unable to access them.

Medicines

Due to the nature of this service, staff did not carry or have access to on-board medicines. However, we saw a management of medication policy that covered the transporting of patient medicines. The policy had been reviewed in 2019.

Incidents

We did not review incidents

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

We have not inspected and rated this area.

Evidence-based care and treatment

We did not review evidence based care and treatment.

Inadequate

Patient transport services

Nutrition and hydration

We did not review nutrition and hydration.

Pain relief

We did not review pain relief.

Response times

We did not review response times.

Patient outcomes

We did not review patient outcomes.

Competent staff

We did not review competent staff.

Multidisciplinary working

We did not review multidisciplinary working.

Health promotion

We did not review health promotion.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

Are patient transport services caring?

We have not inspected and rated this area.

Compassionate care

We did not review compassionate care.

Emotional support

We did not review emotional care.

Understanding and involvement of patients and those close to them

We did not review understanding and involvement of patients and those close to them.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

We have not inspected and rated this area.

Service delivery to meet the needs of local people

We did not review service delivery to meet the needs of local people.

Meeting people's individual needs

We did not review meeting people's individual needs.

Access and flow

We did not review access and flow.

Learning from complaints and concerns

We did not review learning from complaints and concerns.

Are patient transport services well-led?

Inadequate

We rated well-led as inadequate.

Leadership

The leadership appeared to lack fundamental understanding of how to safely operate the service.

The service was led by the registered manager who was the director of the company. The registered manager lacked understanding of the basics of running the service such as equipment logging and servicing and holding a risk register.

The registered manager was safeguarding lead but was not trained to level 3 or qualified to lead staff in safeguarding practices.

There was previously an operations manager in post but they left the service a few months before our inspection and so the registered manager had taken over the role. The service had previously had a governance lead who worked one day a week but had recently finished working for the service. There were no other managers apart from the registered manager. The registered manager said there was not a need for another manager for the service.

We did not speak with any staff, so we did not know their views on leadership for the service.

Vision and strategy

The service did not have a clear vision for what it wanted to achieve or a strategy to turn it into action.

Inadequate

Patient transport services

There was no evidence of core values being shared with new or existing staff and there was no clear business strategy.

Culture

We did not review culture.

Governance

There was a lack of effective governance processes throughout the service which meant the leadership had limited to no oversight of risk, performance or safety issues within the service.

Training was not always provided by accredited providers. Two out of four staff had completed advanced driver training from a person who was unqualified, and the course was not accredited. The registered manager told us the drivers would sometimes use blue lights to get to their destination quicker. This lack of effective governance put patients, staff and other people at risk of avoidable harm.

Not all policies were reviewed within a year and were out of date, including the fundamental service user handling and transfer policy.

There was a lack of equipment logging and management of servicing schedules. Equipment in vehicles and stored for repair was not labelled with serial numbers and not labelled to show when it was last serviced.

There was a lack of oversight of vehicle cleaning as the two vehicles we inspected were visibly dirty inside. There was a lack of oversight of cleaning of the premises which was visible very dirty.

One administrator managed the unit. Their duties included vehicle storage, vehicle cleaning facilities, office space, reception area, equipment storage room, cleaning equipment cupboard, medical gases storage and toilet facilities. The registered manager rarely attended the unit to oversee its running. The administrator only worked three days a week.

We did not see evidence of staff meetings or how information and learning was shared with staff.

Management of risks, issues and performance

The service did not manage performance or risk.

At the last inspection the service received a requirement notice as it did not use a risk register or similar tool to assess and monitor their risks. At this inspection we found this still to be the case and so there was no improvement since the last inspection.

The service provided some generic organisation risk assessment forms for risks such as manual handling and infection control. However, the forms submitted by the provider were dated May 2016 and May 2018 respectively and so were out of date.

We did not see any management of performance of the service. The registered manager told us the booking organisations did not set performance targets for the service. The registered manager told us the service had service level agreements with booking organisations, but we did not see these.

The provider was not managing ongoing risks and so had not put into place mitigating actions to keep staff and patients safe from avoidable harm. Staff training in advanced driving and the use of hard handcuffs was not always completed or adequate but there had been no checks by the registered manager to ensure staff were competent. The premises, vehicles and equipment were not clean or maintained and the registered manager was unaware these risks were present. There were no plans to recruit a cleaner or to carry out an audit of vehicles and equipment to mitigate against these risks.

Information management

We could not review information management as we could not gain access to records due to the appropriate staff not being available.

Public and staff engagement

We did not review public and staff engagement.

Innovation, improvement and sustainability

We did not review innovation, improvement and sustainability.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
Action the provider MUST take to meet the regulations:

- The provider must ensure required training is provided through an accredited training provider (Regulation 12 (2) (c)).
- The provider must ensure staff using handcuffs are adequately trained (Regulation 12 (2) (c)).
- The provider must ensure that the safeguarding lead is trained to level 3 and have sufficient knowledge and qualifications to cascade safeguarding training to their staff (Regulation 13 (2)).
- The provider must ensure that all staff have documented DBS checks (Regulation 19 (1) (a) (2) (a)).
- The provider must ensure premises, vehicles and equipment are clean to protect patients, staff and others from infection (Regulation 12 (1) (2) (h)).
- The provider must ensure vehicles and equipment are maintained to protect people from avoidable harm (Regulation 12 (1) (2) (e)).
- The provider must ensure there are appropriate procedures were in place to assess and respond to patient risk (Regulation 12 (1) (2) (a) (b)).
- The provider must ensure there are up to date policies for staff to follow. These should include the use of blue lights and the used of high-level restraint such as hard handcuffs (Regulation 12 (1) (2)).
- The provider must ensure the service identifies, records and manages risks (Regulation 17 (2) (b)).
- The provider must ensure the service has a systematic approach to oversight and maintenance of effective policies and procedures (Regulation 17 (2)).
- The provider must ensure the service has a systematic approach to checks of cleanliness and infection prevention and control (Regulation 17 (2) (a)).
- The provider must ensure there is a systematic approach to checks of vehicle and equipment maintenance (Regulation 17 (2) (a)).
- The provider must ensure there is sufficient management of training to ensure staff received accredited and appropriate training for their roles (Regulation 17 (2) (a)).

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Enforcement actions

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 CQC (Registration) Regulations 2009 Fees

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