

Trailmed Limited

TrailMed

Inspection report

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

This was the first time we inspected this service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff provided good care and treatment and gave patients pain relief when they needed it. The service met stakeholder and patient expectations. Managers made sure staff were competent and monitored patient and stakeholder satisfaction. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their immediate health needs. They provided emotional support to patients and relatives.
- The service planned care to meet the needs of people in different circumstances, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- The registered manager ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's values, and felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with their stakeholders to plan and manage services well. They used feedback from patients to improve the service.

However.

- They did not manage storage and stock control of medicines well. This was rectified immediately after our inspection.
- Managers did not routinely use clinical audit to monitor the effectiveness of the care they provided.
- Although substantive staff had daily meetings with the medical director to plan their work and assess risks, they did not hold formal governance meetings with staff. This was rectified immediately after our inspection.
- Although new staff had their skills and competency checked during induction, there was no formal record of this. The registered manager planned to add this to the electronic monitoring system.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Good 	

Summary of findings

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Summary of this inspection

Background to TrailMed

TrailMed is operated by TrailMed Limited and is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of service, and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC regulates the emergency and urgent care service provided by TrailMed Limited. The other services provided by TrailMed, are not regulated by CQC as they do not fall into the CQC scope of regulation. The areas of TrailMed Limited that are not regulated are provision of first aid treatment at sporting events and health and fitness testing for athletes. However, where TrailMed convey a patient from an event to hospital, this activity falls into the remit of CQC and is regulated activity.

TrailMed Limited is an independent ambulance service based in Leicestershire and operates across the country. They provide first aid treatment and advice for people attending events, such as sporting events across the country and abroad. This activity is not regulated by CQC.

They have been registered with CQC since May 2020 to provide the following registered activities;

- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder and injury.

They provide regulated activity for people over the age of 18 years.

TrailMed also provide a phlebotomy service from their base in Leicestershire where patients can book appointments directly and on behalf of an independent company who provide phlebotomy services in various locations.

This was the service's first inspection.

The service has a registered manager in post who is also the director/owner and nominated individual

The service employs 3 substantive staff who provide management, emergency and urgent care at events and the phlebotomy service. A fourth person is subcontracted as an account's manager and personal assistant to the medical director. Ambulance crew including paramedics, ambulance technicians, doctors and student doctors are employed on an ad-hoc basis to support events when there is a possibility emergency or urgent care work will be required.

How we carried out this inspection

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in paramedic services. The inspection team was overseen by an inspection manager and Charlotte Rudge, Interim Deputy Director of Operations.

Summary of this inspection

We spoke with 7 members of staff including the registered manager, office staff, paramedic staff and trainee paramedic, and obtained feedback from stakeholders who commission this service. We also looked at feedback provided by patients who had used the service and reviewed patient records.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Outstanding practice

We found the following outstanding practice:

- The registered manager was committed to providing opportunities for doctors and other clinicians to experience delivering 'wilderness medicine' in sporting events and regularly volunteered their services at events abroad.
- The service supplied and funded a medical lead and medical supplies for some international events where only a nominal fee was charged to cover basic costs, such as paying medical staff for volunteering their time.

Areas for improvement

Action the service **SHOULD** take to improve:

- The service should continue to monitor adherence to the revised medicines management policy (Regulation 12).
- The service should ensure comprehensive oversight of policies and procedures through maintaining improved governance processes (Regulation 17).
- The service should consider a wider programme of audit to assess the effectiveness of the care they provide.
- The service should consider formalising the competency and skills assessments of staff during the induction process.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Emergency and urgent care

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Is the service safe?

Good 

This was the first time we had inspected this service. We rated it as good.

Mandatory training

The service provided mandatory training in key areas to all substantive staff and made sure everyone completed it. They checked all ambulance crew members were up to date with mandatory training prior to each booking.

Staff received and kept up-to-date with their mandatory training. Substantive staff were 100% compliant. A new member of the team was progressing through their mandatory training and was expected to be fully compliant soon.

The mandatory training varied according to role and met the needs of patients and staff. Mandatory training was comprehensive for clinical staff and included health and safety, information governance, blue lights training, as well as relevant clinical updates for paramedics and clinical staff. Crew members received their mandatory updates through their NHS roles and were required to provide evidence of this before booking an events shift.

Managers asked staff to provide evidence of mandatory training compliance. When crew members were booked onto an event, their mandatory training compliance was automatically checked by the manager and if this was not up to date, they were not allowed to work at the event.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

As an events medical service, staff did not enter people's homes and their contact with individuals was brief. However, they knew how to recognise a concern and how to report it. Staff received training specific for their role on how to

Emergency and urgent care

recognise and report abuse. The Safeguarding Children and Young People: roles competencies for health care staff intercollegiate document (2014) states that clinical staff who contribute to assessing, planning and evaluating the needs of a child or young person should be trained to level 3. Additionally, all clinical and non-clinical ambulance crew members who had contact with young people should be trained to level 2.

Office staff were trained to level 2 whilst clinical staff were trained to levels 2 and 3 according to their role. The lead clinician onsite was a qualified doctor or paramedic who were trained to level 3. The registered manager who was also a clinician was trained to level 3.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They knew how to make a safeguarding referral and who to inform if they had concerns. Office staff informed the registered manager and ambulance crew informed the team leader at the event.

Cleanliness, infection control and hygiene

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

All areas at the main office and clinical area used for phlebotomy were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The phlebotomy service was held in a clinical area which was separate to other services provided. They used an app whereby a short cleaning audit was performed prior to each patient episode and again when finished. They were also able to record the final cleaning check at the end of each day. The information was captured on the service's computer system and monitored by the medical director.

There was an infection prevention and control (IPC) policy in place which included the chemicals and methods for cleaning the vehicles. We saw that ambulances had clear IPC posters in them which detailed cleaning processes, relevant IPC procedures to protect patients and staff, and a QR code which linked to their IPC policy.

We found the ambulances to be generally visibly clean. Staff used a QR code within the vehicles to confirm they had completed their cleaning checks. The QR code provided a checklist survey which linked to the provider's computer system. The provider was able to monitor remotely that the checks had been carried out and was able to quickly manage any cleaning issues reported by staff. The provider told us that all vehicles received a deep clean every 8 weeks during the main events season by an external cleaning company. We saw that the most recent deep clean was in September 2022.

There was a washing area on site with appropriate cleaning products to clean vehicles.

Staff followed infection control principles, such as the use of personal protective equipment (PPE) Staff told us there was always an adequate supply of PPE on vehicles.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Emergency and urgent care

The design of the environment was appropriate for its use. There was a separate clinical area for the phlebotomy service with suitable equipment. Needles and blood containers we checked were all in date. Patients brought their own blood containers and patient labels when booked through another provider. Completed blood samples were then placed in sealed, pre-addressed envelopes which were handed to the patient to post. The flooring, handwash facilities and patient couch were all appropriate for their use.

The main service provided was first aid and medical advice at events and the service would transport patients to hospital from events if required and had the use of blue lights. Only those crew members who had up to date training on blue lights driving were used to transport patients. The service undertook a *Driver and Vehicle Licensing Agency* check as part of their recruitment procedure ensuring they had the correct categories on their licence. They checked this on a regular basis to ensure compliance.

Staff carried out daily safety checks of specialist equipment in all vehicles. Crew staff checked equipment each day and reported any issues via a QR code in each vehicle. Staff had enough suitable equipment to help them to safely care for patients. There was a good supply of stock to support multiple events.

Equipment was suitable and clean and stored safely with easy access for staff. The service had a system to ensure the safety and maintenance of equipment. All equipment on vehicles was checked by the lead paramedic at the start of each event. The service had recently introduced an electronic check system through a QR code which fed into a central compliance system. This recorded checks for all vehicles and equipment each time the vehicle was used. However, we did not see a standard equipment list for vehicles.

All equipment had a sticker in place to show it had received an annual clinical engineering maintenance check. The next check was due in September 2023.

We found all consumable items to be in date clean and packed correctly. There was clear evidence of good labelling and content lists for bags with clear expiry dates.

The vehicles were parked in a secure compound to the side of the office building and on charge. The vehicles were locked, and the keys were kept in a secure location in a locked key box with restricted access.

The service were compliant with Ministry of Transport (MOT) testing and servicing of the vehicles. We saw evidence all vehicles had a current MOT, service and insurance. The service had an agreement with a local garage who maintained the vehicles. The 3 vehicles we checked had appropriate checks for roadworthiness.

British Compressed Gases Association guidance was followed in respect of medical gases, and these were stored securely and safely.

Staff disposed of clinical waste safely. They used a private contractor to collect waste. Sharp bins were signed and dated to show when started. There was a policy to guide staff on the use of sharps which included what to do in the event of a sharps injury to staff.

Assessing and responding to patient risk

Staff completed risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Emergency and urgent care

Staff knew about and dealt with any specific risk issues. Risks to patients were assessed, and their safety monitored and managed. The service had a conveyance of patient's policy. This was based on national guidance and explained clearly under what circumstances patients could be transferred to hospital. This policy also outlined what assessments and actions should be taken to convey a critically unwell patient and what actions to be taken if a major critical incident were to happen on site.

Risk assessments specific to events were conducted before each event. Details of events were discussed well ahead of the event to enable the service to undertake risk assessments and to help minimise risks.

Staff carried out risk assessments during the transfer of patients. When treating patients, staff assessed individual risks by asking about past medical history, current medicines being taken and whether the patient had any allergies. These were documented in the patient's electronic record and were shared with relevant medical staff when they arrived at hospital. There was appropriate equipment on board ambulance vehicles to provide monitoring and assessment of patients during patient transport journeys. For example, patients could have oxygen saturations, non-invasive blood pressure, temperature and blood sugar levels recorded. Patient records showed staff monitored patient's health and wellbeing during patient transport journeys and recorded their findings.

Staff shared key information to keep patients safe when handing over their care to hospital staff on arrival.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave new staff a full induction.

The registered manager, an office manager and an exercise physiologist were the only substantive staff. All events and ambulance crew were ad hoc staff from a bank of staff who had been recruited for the service. There was also an international operations manager who managed events abroad and one of the experienced paramedics who regularly led clinical teams at events in the UK.

Managers accurately calculated and reviewed the number of staff and skill mix for each event ensuring there was always an experienced senior clinician to lead each team at events.

Teams were a mix of qualified doctors, junior doctors, paramedics, emergency care practitioners, ambulance technicians and student paramedics and doctors. The service employed crew staff on an ad hoc basis according to the team requirements at events. There were some staff who worked regularly at events throughout the events season.

The provider told us that crew staff were booked from the large bank of staff who had been recruited for the service and were booked on an ad hoc basis. Staff had access to the events schedule and upcoming work and were able to book to work at events. There were some senior qualified staff who were used regularly and had gained experience of working at events. The most experienced qualified staff were used as team leaders and provided induction, supervision, assessment and mentorship for newly recruited staff and non-qualified staff.

Staff told us they received a 2-day induction when they were first recruited and continued to receive mentorship and support at each event until they had gained experience and were fully competent. All staff told us they felt very supported, and the induction had been beneficial. The service used an electronic matrix system to record and track staff through recruitment and induction process but did not record skills competency checks completed by everyone.

Emergency and urgent care

Staff told us they were aware their skills and competencies were being assessed during induction and mentorship but that there was no formal sign-off process. The registered manager planned to provide a QR code for lead clinicians to record assessment of skills and competencies for new staff soon. The records would then be available on the services electronic monitoring system.

The service followed recruitment practices that ensured all staff had the relevant qualifications, skills training and experience to carry out their role. Our review of staff records confirmed the registered manager followed this process when recruiting staff. This included confirmation of completed checks against the Disclosure and Barring Service, driving licence, and staff references before staff commenced employment. There was a staff selection process which included a scoring system based on qualifications and experience.

The service did not use agency staff.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. When the service treated a patient at the treatment hubs, staff recorded the relevant details and used information about the patient's illness or injury to ensure they were sent the right medical help. For example, where a patient required hospital treatment, the event facilitator would contact the ambulance crew nearest to where the patient was located so that they could attend to the patient quickly. Records of treatment or first aid initially provided at the treatment hub was easily accessed by the ambulance crew to use during their transport to hospital.

Records were stored securely on the services computer system. Patient names were redacted prior to storing the record. Our review of 5 patient records showed staff were thorough in detailing the care provided during transport to hospital.

Medicines

The service used systems and processes to safely prescribe, administer, and record and medicines, but did not always store them safely.

The service had a medicine management policy in place to support individuals dealing with medicines. It provided a framework of processes for all aspects of medicines management including supply, administration, storage, disposal and adverse incident reporting. The registered manager took responsibility for day-to-day management of medicines and devolved some responsibility to an experienced paramedic and the office manager for stock takes. Storage of medicines on vehicles was the responsibility of the lead clinician for each vehicle.

We found that the medicines management policy was not always robustly followed in respect of storage and auditing of medicines.

The service tracked medicines carried by paramedics by allocating a log number to each medicines pack which was then allocated to a vehicle. This was recorded on the services electronic system. The registered manager told us they knew which medicines bag was assigned to which vehicle and could easily trace any missing medicines problems back to individual paramedics if needed.

Emergency and urgent care

There was a process for allocating medicines to clinical staff. The medicines were placed into a container along with the list of medicines and clear instructions as to its legal use. The medicines container was then placed inside the paramedic kit bag which was prepared before the start of each event. After the event, kit bags were returned to the head office where medicines were returned to stock.

However, we found there was sometimes a delay in removing the medicines from the kit bags and returning them to the locked medicines cabinet at the end of an event. This meant that medicines were left unsecured for more than 24 hours. The registered manager had not conducted any recent medicines audits after events but told us there were not usually any issues with missing medicines.

Paramedics told us this system worked well for them. They were required to check medicines when they received them and if there were any issues, they would escalate this to the senior clinician on site. There was a safe on each vehicle for the storage of controlled drugs (CDs)

Immediately following our inspection, the registered manager made changes to strengthen their processes and improve management of medicines. They added specific survey questions relating to medicines checks to the vehicle and kit checks system which used a QR code linking directly to the services electronic system. This enabled the registered manager to monitor issues identified on site.

Most medicines were stored securely at the main office in a suitable locked cabinet. There was a secure office with a security code in place. Access was restricted to appropriate persons. However, there were many kit bags containing medicines in the office waiting to be checked and dismantled on the day we inspected.

There was an electronic system where the service recorded the stock level of each medicine for stocktaking and reordering purposes. We checked 10 medicines in the cabinet against the numbers recorded in the system and found that only one medicine corresponded correctly.

We brought this to the registered manager's attention, and they made immediate changes to improve their system and level of governance and accountability for managing medicines and to ensure that all medicines in the service's possession can always be accounted for.

The provider had taken the following actions;

- Reconciled all medicines from paramedic kits back into stock.
- Revised the medicines management policy to reflect improved governance and accountability of medicines.
- Conducted a full comprehensive stock take verified by 2 people and updated the electronic system to accurately reflect current stock.
- Purchased an additional lockable cabinet to store pre-packed medicine packs when prepared for events.
- Made improvements to sign in and sign out processes which is monitored on their electronic system via a QR code.
- A senior clinician has been appointed as a medicine's management lead.
- Any errors in medicines management will be documented on the incident reporting system and all incidents reviewed by the medicines management lead.
- Rapid assessment document is being modified to reflect the changes in process.
- Formal monthly governance meetings commenced in March 2023, which included medicines management and review of incidents as a standard item on the agenda.
- Plan in place for 100% of medicines records to be audited initially until new processes have embedded.
- Communication to all staff regarding adherence to new processes and revised medicines management policy.

Emergency and urgent care

The registered manager provided us with a copy of the revised medicines management policy, evidence and assurance of the improvements made, along with plans to conduct audits to ensure compliance.

The service had a licence to hold CDs. These were stored securely in a locked safe and appropriate records were made of their use. We checked stock numbers and found these to be accurate and in date. The keys to the CD safe were held securely with access limited to the registered manager and a designated paramedic. CDs were stored in a safe on each vehicle when in use.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff administered medicines according to the advice detailed in the Joint Royal Colleges Ambulance Liaison Committee's (JRCALC) Guidelines. This was used by all trained ambulance staff in the pre-hospital treatment of patients. These guidelines were easily accessible to all staff.

Medicines were prescribed by a doctor and administered by appropriate clinical staff with the relevant skills. The registered manager had recently introduced patient group directives so that a specific emergency medicine could be administered if required on route to hospital. This was awaiting sign off by a pharmacist at the time of our inspection. Staff were reliant on using a patient specific direction in the meantime which required a doctor to prescribe the medicine for each individual.

Staff recorded medicines administered to patients in the patient record and shared these with staff on arrival at the hospital. The electronic record was accessible on the services recording and monitoring system.

The medicines storage cabinet and safe were in a designated area next to the main office area which was accessible only to limited personnel using a key code. All 10 medicines we checked were in date. Medicines stored within the ambulance were also found to be all in date. Medicine incidents would be reported using an incident report form to the Medicines and Healthcare products Regulatory Agency. Medicine administration followed the advice detailed in the JRCALC Guidelines. This was used by all trained ambulance staff in the pre-hospital treatment of patients. The guide detailed the procedures for the use of medicines by trained and registered paramedics and in restricted circumstances by other staff. Most medicines used in the ambulance service were Prescription Only Medicines. (POMs) The ambulance paramedics were able to administer certain POMs due to the exemptions relating to their role. In addition, paramedics could also administer POMs and general sale list medicines under the directions of a prescriber, such as an advanced practitioner or doctor. The medical director followed the Medicines Act 1968 and ensured that certain injectable products were only administered by way of parenteral injection for saving life in an emergency.

Staff had ready access to numerous national evidence-based guidelines, such as those provided by the National Institute for Health Care Excellence and JRCALC. The medications management also followed these guidelines and relevant legislation. Staff told us that policies or guidelines they needed were the same as the ones they used in their NHS practice and could be easily accessed on the service's electronic drive.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents. Managers investigated incidents and learned from them. When things went wrong, staff apologised and gave patients honest information and suitable support.

Emergency and urgent care

The service had an incidents and events policy to support learning from incidents. There had been 2 incidents reported during in the last 12 months relating to events activity. Although the service had only been indirectly involved, they conducted a comprehensive investigation to understand what they could learn from it. However, this was not shared widely with staff. There were no incidents reported which related to any of the 14 patients who were transported to hospital in the last 12 months.

Staff knew what incidents to report and how to report them. Ambulance staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them where appropriate using the services electronic system. The registered manager planned to encourage staff to report more minor incidents in the future and discuss these at governance meetings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of what happened, as well as offering a written apology.

The service had no never events.

Is the service effective?

Good 

This was the first time we had inspected this service. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Lead clinicians checked to make sure staff followed guidance. Staff had access to national evidence-based guidelines, such as those provided by the National Institute for Health Care Excellence and Joint Royal Colleges Ambulance Liaison Committee's (JRCALC).

Policies were based on evidence-based guidance. Staff told us that policies or guidelines they needed could be easily accessed on the services electronic system.

When policies and guidelines were updated, staff were alerted to this via the services communications app which was a closed group where only recruited staff could access.

Staff had specialist mental health skills and received training as part of their NHS work, but these were not usually required at events work as the service did not convey patients subject to the Mental Health Act 1983.

Pain relief

Emergency and urgent care

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. These were recorded in patients' records. Pain relief medication was provided in response to pain levels and the effectiveness of this was reassessed. Ambulance staff were able to provide pain relief in line with legislation including controlled drugs.

Patients received pain relief soon after it was identified they needed it, or they requested it.

Over the counter pain relief medication, such as paracetamol were available on the vehicles.

Patient outcomes

Staff reviewed the effectiveness of care and treatment to achieve good outcomes for patients

The service undertook very few journeys which fell under regulated activities. However, they reviewed each care episode to check they had provided good care.

The provider did not have a formal system in place to allow them to determine whether they were delivering an effective service. The service was unable to benchmark itself against other independent ambulance services carrying out a similar service or build on their own performance based on patient outcome data. However, they routinely assessed each care episode within their multidisciplinary team.

All 14 patient transport journeys completed in the previous 12 months were discussed as a routine team debrief and staff discussed whether they could have done anything to improve patient experience.

The registered manager planned to carry out audits of pain relief using pain scores before and after administration of pain relief medicine.

Competent staff

The service made sure staff were competent for their roles. Managers assessed staff's work performance and provided mentorship, support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

The service had systems in place to manage effective staff recruitment processes. The service used an electronic dashboard system which held details of all staff who had submitted an application to work for the service. The accounts manager reviewed prospective applications and discussed them with the registered manager. Candidates were then asked to submit a copy of their qualifications, mandatory training, Disclosure and Barring Service status, driving licence, skills and competency updates and other documents relevant to their role. The system identified candidate's progress through the recruitment assessment and if they were thought to be suitable, they were invited to an event where they would undertake supervised activity and on-the-job assessment and supervision along with completing a full induction course tailored to their role. Once inducted, new recruits worked at future events as part of a team under supervision until the lead clinician was satisfied with their work. Further mentorship and onsite training was provided for as long as was needed.

Emergency and urgent care

Ambulance crew members told us that there was always a senior clinician, such as an experienced paramedic or consultant, on site for support and that mentorship had been extremely valuable. They told us that when training was provided, their competence was usually assessed.

Managers supported substantive staff to develop through yearly, constructive appraisals of their work and identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The registered manager was keen to provide development opportunities for staff. For example, office staff could develop skills in phlebotomy and events management. Student doctors and other health professionals were given the opportunity to experience 'wilderness medical care' abroad, and staff had the opportunity to develop their skills under supervision in different challenging situations at adventure sports events.

The registered manager had developed a 'scope of practice' document and matrix which was shared with staff and easily accessible on vehicles to remind staff of the limitations of practice for each role. Only qualified paramedics or consultant paramedics were able to provide care for patients being transported to hospital.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

The service worked with patients in a pre-hospital environment to decide the best course of action to minimise their discomfort, promote rapid recovery and avoid journeys to hospitals that were not required. For example, the service were able to signpost patients to their GP or walk in centre after successfully bringing their condition under control, whereas they would otherwise have presented to a local emergency department.

Staff held regular and effective multidisciplinary meetings with the onsite medical team to discuss the care provided to patients after every transport journey to hospital.

Staff worked with other agencies when required to care for patients. For example, when needing to identify the most appropriate care facility for the patient's specific needs.

Staff worked well with other disciplines and organisations, such as emergency paramedic crews, hospital staff and other event staff.

The service had a policy for the handover and communication with receiving hospitals.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Mental Capacity Act (MCA) training formed part of mandatory training for staff within their NHS roles. The nature and type of events they attended were usually adventure sports related and staff told us that patients were usually fit and well and so did not usually encounter patients who required MCA assessment. However, staff were knowledgeable about capacity and how to assess patients if required.

Emergency and urgent care

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service had a policy in place for gaining consent and staff were familiar with gaining consent before care and/or treatment. Records of patient care and treatment identified that staff asked for consent, and this was documented.

Is the service caring?

Good 

This was the first time we had inspected this service. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Due to the low number of care episodes which fell under regulated activities we were unable to observe any care provided to patients. However, when found that staff spoke about patients in a caring and compassionate way and described how they felt it was important to properly care for patients with foot problems after running a marathon as well as those patients who fell ill and needed urgent transport to hospital.

The service sought feedback on their service where applicable. Patients said staff treated them well and with kindness. The service was scoring 4.9 out of 5 on their social media platform feedback metrics. People and patients who had used the service described staff as “very professional”, “caring and really kind”, “seemed very knowledgeable”, “sorted me out in no time”. The 2 patients we spoke with who had attended the phlebotomy service told us they were extremely happy with the service they received, and that staff were kind and helpful.

Staff said they were discreet and responsive when caring for patients and took time to interact with patients and those close to them in a respectful and considerate way.

Staff followed policy to keep patient care and treatment confidential. Patients’ personal information was redacted from the record once treatment had been completed and the patients had been handed over to hospital staff.

The service asked staff for feedback after each event and had received hundreds of pieces of feedback on event related services for the 12-month period prior to the inspection. Staff reported they had really enjoyed working at the events and learned a lot. There were numerous comments about the excellent support they received from senior clinicians and team leads. Comments, such as ‘absolutely stunning’ “amazing”, “well organised” were typical comments left by staff. Any information relating to potential problems was used to improve the service.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Although we were unable to observe staff and patient interactions directly, we spoke with ambulance staff in the service about what they would do when transporting a patient who required additional emotional support.

Emergency and urgent care

All staff we spoke with demonstrated a consideration for the emotional wellbeing of patients and their relatives. They described how they reassured patients to reduce their anxiety.

Staff supported patients who became distressed and recognised that having a relative or friend there to support them was helpful if they were in pain or anxious. Staff allowed a family member or friend to travel with them to hospital in most circumstances.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff told us they were respectful and encouraged the input of family members and encouraged patients to be involved in decisions about their care. Staff gave clear explanation of what they were going to do with patients and the reasons for it. Staff told us they checked with patients to ensure they understood and agreed.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was QR code available on the vehicles and in treatment hubs.

Is the service responsive?

This was the first time we had inspected this service. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people. It also worked with stakeholders and local organisations to plan care.

The service provided medical care and advice at events across the country and abroad, so did not serve just their immediate locality. If communication was a barrier, they would consider the use of a translation app, or visual aids, or gain consent for a friend or relative to act as a guide.

The service completed a pre-event assessment with the event organisers prior to each event to ensure that the service they were providing would meet the needs of the local population.

This assessment included where the nearest local hospital was and details of local services where patients could be directed to if needed. The service would ensure that a list of local services, such as GP's, pharmacies and walk in centres was available on site so that they could effectively direct patients to the most appropriate service if needed. This ensured that undue stress was not placed on other local services, such as emergency departments.

Meeting people's individual needs

Emergency and urgent care

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

Staff had access to communication aids to help patients become partners in their care and treatment. Due to the nature of the service attending sporting events, such as ultra-marathons, staff encountered some patients on a regular basis and were often able to plan for people who had specific needs. For example, patients with diabetes, epilepsy or mobility problems.

The service assessed and planned for events and were prepared to meet the needs of people at different settings. For example, at ultra-marathons people were more likely to incur certain foot injuries, whereas cycling events and adventure sports brought different challenges.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The service had a complaints policy which was easily accessible to staff. The registered manager told us they had not had any complaints in the last 12 months but that if they ever received a complaint, they would ensure the complainant had a response within 48 hours and would conduct a full investigation into the issue. They would then seek to learn from the complaint and make any changes needed.

Staff understood the policy on complaints and knew how to handle them. Staff said they couldn't remember receiving any complaints but would seek to resolve minor complaints immediately in the first instance.

We found the provider to be extremely responsive to our feedback at this inspection. When we raised concerns about oversight and governance of medicines management, the registered manager made some changes on the day and submitted an action plan within 2 days outlining the planned changes to rectify the issues raised. Within 6 days after our inspection, they provided us with evidence that governance and medicines management had been strengthened and improvement plans had been actioned.

Is the service well-led?

This was the first time we had inspected this service. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The team was led by the provider and owner of the service who was also the registered manager and medical director and oversaw regulatory compliance, recruitment, clinical governance and the overall management of the service.

Emergency and urgent care

The medical director was supported by an office manager who coordinated events and a sports and exercise physiologist who was trained to provide the phlebotomy service.

There was also an accounts director who was also personal assistant to the medical director and looked after the accounts and coordinated recruitment checking processes assisted by a staff selection process which included a scoring system devised by the medical director.

A medicines management lead who was an experienced paramedic had recently been appointed to ensure adherence to the revised medicines management policy and strengthen governance and oversight of medicines management.

There were clinical leads appointed to lead teams at events who were senior, experienced clinicians, such as consultants, doctors and paramedics. The clinical leads were supported by the medical director either on site or via telephone.

All managers and leads who formed the leadership team reported directly to the medical director and on events, all staff reported to the clinical lead in charge of each team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a set of aims and objectives to help them achieve this.

The service had a vision which was to be the leaders in their sector and provide the finest and most progressive sporting event safety and medical cover. This was supported by a set of aims and objectives to help achieve this, which included giving patients the best possible care, exceeding patients expectations and to support staff growth and development. The staff we spoke with were aware of the vision for the service and could describe their overall aims.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service promoted an open culture where any team member could discuss concerns with either their clinical lead at events or the medical director if required. Staff confirmed there was a good culture and that they felt supported and valued. The working environment was inclusive, and equality and diversity were taken seriously. Staff reported they really enjoyed working for the service and felt respected. One staff member said they sought regular work with the service because they always had a great experience, the people were good to work with and the service was a well-run, professional operation.

Governance

Leaders operated governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from their peers.

Emergency and urgent care

The registered manager who was also the medical director and a trained anaesthetist was responsible for overseeing the clinical governance framework and was assisted by the clinical knowledge and expertise of the paramedics and doctors on the core team.

Clinical governance arrangements included medical and clinical policy sign off, clinician authorisation, and prescription medicine authorisation.

The service had an overarching governance structure in place which enabled the flow of information from the senior team to frontline staff and vice versa which was effective during events.

The structure also enabled effective planning of events, appropriate staffing, risk management, and maintenance of vehicles and equipment. However, we found that medicines management was governed less effectively than other aspects of the governance structure at the time we inspected.

The registered manager made immediate improvements to how medicines management was governed and provided documentary evidence to us within 6 days of our inspection which assured us that sufficient governance processes had been put in place to ensure safe management of medicines. This included appointing a dedicated medicines management lead to ensure the revised medicines management policy was quickly implemented, adhered to and monitored.

Governance meetings were not routinely held at the time we inspected. The registered manager told us this was because the core team met every day to discuss aspects of the business and planned activity. Immediately after our inspection, the registered manager put in place monthly governance meetings to review key areas, such as medicines management, risk, incidents and audits.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were processes in place to manage current and future activity. Data was collected and monitored. This was limited to vehicle and kit checks and patient record checks. The registered manager planned to conduct regular audits of medicines management and the effectiveness of pain relief which would be discussed at governance meetings.

The managers, clinicians and staff were clear about their roles and understood what areas they were accountable for. The registered manager had recently introduced a scope of practice policy which outlined what each role could do and the limitations to practice. A matrix outlining the scope of practice for different roles was made available in paramedic kit bags for staff to refer to.

The service had a formal risk register to record and manage risks. A risk register is a management tool, which enables an organisation to understand its risk profile, as risks are logged on the register and action taken to respond to the risks.

Where a risk was identified at the daily staff meetings, this was added to the risk register and list of actions recorded. Actions and outputs from risks were discussed at subsequent meetings. This meant they were able to notice trends and put systems in place to lower any risks to patients, premises or the business.

Emergency and urgent care

The service had a major incident plan in place in the event of a major catastrophe occurring at an event involving the public. The plan included working with other local stakeholders to safely manage treating large numbers of people if needed.

Information Management

The service collected reliable data and used it to monitor activity and compliance. Staff could find the data they needed, in easily accessible formats to assist them with decisions. The information systems were integrated and secure.

The service was aiming to reduce paper records and had invested in a comprehensive information technology system which collected data and information about every aspect of the business and activity including patient records, staff records, skills, qualifications, training, vehicle and equipment maintenance, and numerous checks made by staff including cleanliness checks and vehicle, equipment and medicines checks. The system presented data in the form of dashboards and was linked to QR codes which staff used to access policies and processes and to report incidents and record routine checks onsite.

Engagement

Leaders and staff actively engaged with patients, staff, and local organisations to plan and manage services and to help improve services for patients.

The service engaged with other professionals, such as event organisers, before events, to ensure that people's needs would be met in a safe way. We spoke with an event organiser who had used the service several times before. They said the service was "really, really good" and that they "always found the service to be approachable and professional in every aspect" and, "they always turn up on time and with the agreed number of medical staff, all of which represent the service in an exemplary way.". "The always give the same excellent level of service."

Staff felt very engaged and supported by the service and felt like they were a member of 'one big family'. One clinical staff member told us the service was well organised and prioritised safe practice and they felt "their professional registration was safe when working for the service".

Staff always knew what events were coming up and were able to book work through the services communication's portal.

The service encouraged staff to provide feedback and share their ideas for improving the service. The website had been redesigned with collaboration with office staff and the phlebotomy area had been reconfigured after a suggestion by a member of staff.

Ambulance crew made suggestions via their communications app. For example, changes had been made to the container infantry to include more individual boxes; vehicle parking method had been adjusted to enable more vehicles; and a larger supply of blister tape had been put in place.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Emergency and urgent care

Training days were provided for staff throughout the events season. For example, a recent training event was focussed on 'foot care' because this was most of the care provided at ultra-marathon events.

The provider was committed to helping student doctors and junior doctors improve their skills and provided a controlled environment for them to practice medicine safely in the 'wilderness experience' environment.

There was a staff competence pathway which helped staff develop skills as they gained different experiences.

Staff told us they learned continuously whilst working with experienced clinicians at events.