QAS Ambulance Limited

QAS Ambulance Limited

Quality Report

Unit 4
Cornishway Industrial Estate
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Website: www.qasambulance.co.uk

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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
Patient transport services (PTS)	**Inadequate**

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 23 and 24 April 2019.

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

QAS Ambulance Limited is operated by QAS Ambulance Limited. The service opened in April 2013. It is an independent ambulance service in Manchester that serves several local NHS hospital trusts and local authorities. However, the service also transports patients across the country when required.

We rated it as Inadequate overall.

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

- Although the service had a safeguarding policy for adults and children, it was unclear if there was an effective system to protect patients from abuse. This was because although the service had a designated safeguarding lead, it was unclear if they had completed the correct level of training and the service had not planned to access a suitably qualified professional when needed.
- The service undertook Disclosure and Barring Service checks for all new staff. However, we found that there was no documented evidence of how the service had assessed the suitability of staff who had previous criminal convictions to undertake their role.
- We did not see documented evidence that the service had completed basic risk assessments for each patient and removed or minimised risk. This was because this had not been documented as part of the booking process or patient record forms.
- Staff had not always kept detailed records of patient's care and treatment. We reviewed 18 patient records, finding that they had not been fully completed on eight out of 18 occasions. In addition, the service had not kept patient records on occasions that patients had been transferred from an event to hospital.
- The service did not have processes to manage medicines safely. This was because they did not have a medicines management policy, despite staff regularly transporting patient's own medicines as well as providing medical gasses to patients. Additionally, not all staff had received training to administer medical gasses.
- The service had not always managed patient safety incidents well. Although there was an incident reporting policy, not all staff knew about the process to report incidents. Records indicated that there had no reported clinical or non-clinical incidents between April 2018 and April 2019.
- The service did not have a policy or standard operating procedure covering mental capacity, consent or best interest. This was important as it meant that there was no clear process for staff to follow when documenting a best interest decision or if a patient had refused transport.
- Although managers informed us that the service took account of individual needs and preferences on reviewing patient records, there was no documented evidence that the service had considered other complex needs such as if patients were living with dementia or had learning disabilities.
- The service did not have a formal vision and strategy. However, managers could tell us about the service and what they were aiming to achieve moving forward.
- The service did not have a formal system to assess, mitigate and control both clinical and non-clinical risks. This meant that we were not assured that all risks had been identified or that controls were in place to reduce the level of risk when needed.
- The service had not always monitored compliance against national guidance or policies. We found areas of poor compliance, such as record keeping, which the service was not aware of.

However, we found the following areas of good practice:

Summary of findings

- The service provided mandatory training in key skills and made sure that all staff completed it. This included important topics such as basic life support.
- The service had controlled infection risk well on most occasions. There were sufficient amounts of personal protective equipment available for staff to use and all ambulances were visibly clean.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. The service had a system to report faults and had acted to fix faulty items when needed.
- The service had enough staff to provide the right care and treatment. Records between March and April 2019 indicated that there had been the planned number of staff available to undertake all patient journeys.
- We reviewed eight patient record forms when feedback had been received by patients, finding that all feedback had been positive, with comments such as 'staff were great' and that a 'comfortable journey' had been provided.

During the inspection, we visited the service at Unit 4, Cornishway Industrial Estate, Austell Road, Manchester, M22 0WT unannounced on 23 and 24 April 2019. Due to an incorrect registration, this location was not registered as a separate location with us. The provider has submitted an application for the service's new location, under which this report is now published.

Following this inspection, we issued enforcement action, telling the provider that they must make significant improvement. We also told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North Region), on behalf of the Chief Inspector of Hospitals

QAS Ambulance Limited

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Background to QAS Ambulance Limited

QAS Ambulance Limited is operated by QAS Ambulance Limited. The service opened in April 2013. It is an independent ambulance service in Manchester and service primarily serves several local NHS hospital trusts and local authorities. However, the service also transports patients across the country when required.

The service provides patient transport services for mainly adults. Although the service had not transported any children between the 1 April 2018 and 24 April 2019, this service was available if required.

Additionally, the service provides medical cover at events and undertake medical repatriation. However, these are not regulated activities so we did not look at these as part of the inspection.

The service is registered to provide the following regulated activities;

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

QAS Ambulance Service was last inspected in January 2018, but the service was not rated at that time.

The service has a registered manager in post.

Our inspection team

The team that inspected the service was made up of a CQC lead inspector along with one other CQC inspector. The inspection team was overseen by Judith Connor, Head of Hospital Inspection (North West).

Our ratings for this service

Our ratings for this service are:

Detailed findings

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

Patient transport services (PTS)

Safe	Inadequate
Effective	Requires improvement
Caring	
Responsive	Requires improvement
Well-led	Inadequate
Overall	Inadequate

Information about the service

QAS Ambulance Service was established in 2013 by the current managing director. The provider offers patient transport services 24 hours a day, seven days a week from its ambulance station in Manchester. They currently undertake patient discharges and hospital transfers for several local NHS trusts and local authorities.

During our inspection, we spoke with two members of the management team as well as two members of staff who were employed by the service. We were unable to speak with any patients. We reviewed information that was provided by the service before, during and after the inspection. We also reviewed a sample of 18 patient records.

The CQC has not completed any special reviews of the service between April 2018 and April 2019.

Track record on safety (1 April 2018 to 24 April 2019);

- There had been no never events reported by the organisation.
- There had been no serious incidents reported by the organisation.
- There had been no complaints.

Summary of findings

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

- Although the service had a safeguarding policy for adults and children, it was unclear there was an effective system to protect patients from abuse. This was because although the service had a designated safeguarding lead, it was unclear if they had completed the correct level of training and the service had not planned to access a suitably qualified professional when needed.
- The service undertook Disclosure and Barring Service checks for all new staff. However, we found that there was no documented evidence of how the service had assessed the suitability of staff who had previous criminal convictions to undertake their role.
- We did not see documented evidence that the service had completed basic risk assessments for each patient and removed or minimised risk. This was because this had not been documented as part of the booking process or patient record forms.
- Staff had not always kept detailed records of patient's care and treatment. We reviewed 18 patient records, finding that they had not been fully completed on eight out of 18 occasions. In addition, the service had not kept patient records on occasions that patients had been transferred from an event to hospital.

Patient transport services (PTS)

- The service did not have processes to manage medicines safely. This was because they did not have a medicines management policy, despite staff regularly transporting patient's own medicines as well as providing medical gasses to patients. Additionally, not all staff had received training to administer medical gasses.
- The service had not always managed patient safety incidents well. Although there was an incident reporting policy, not all staff knew about the process to report incidents. Records indicated that there had no reported clinical or non-clinical incidents between April 2018 and April 2019.
- The service did not have a policy or standard operating procedure covering mental capacity, consent or best interest. This was important as it meant that there was no clear process for staff to follow when documenting a best interest decision or if a patient had refused transport.
- Although managers informed us that the service took account of individual needs and preferences. However, on reviewing patient records, there was no documented evidence that the service had considered other complex needs such as if patients were living with dementia or had learning disabilities.
- The service did not have a formal vision and strategy. However, managers could tell us about the service and what they were aiming to achieve moving forward.
- The service did not have a formal system to assess, mitigate and control both clinical and non-clinical risks. This meant that we were not assured that all risks had been identified or that controls were in place to reduce the level of risk when needed.
- The service had not always monitored compliance against national guidance or policies. We found areas of poor compliance, such as record keeping, which the service was not aware of.

However, we found the following areas of good practice:

- The service provided mandatory training in key skills and made sure that all staff completed it. This included important topics such as basic life support.
- The service had controlled infection risk well on most occasions. There were sufficient amounts of personal protective equipment available for staff to use and all ambulances were visibly clean.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. The service had a system to report faults and had acted to fix faulty items when needed.
- The service had enough staff to provide the right care and treatment. Records between March and April 2019 indicated that there had been the planned number of staff available to undertake all patient journeys.
- We reviewed eight patient record forms when feedback had been received by patients, finding that all feedback had been positive, with comments such as 'staff were great' and that a 'comfortable journey' had been provided.

Patient transport services (PTS)

Are patient transport services safe?

Inadequate

We rated safe as inadequate because;

Mandatory training

All staff were required to complete mandatory training which was delivered through an accredited course. Manual handling was delivered face to face, while staff were required to complete e-learning for all other modules.

Induction training was provided to all new members of staff and covered key topics such as data protection, consent to care, Human Rights Act, Equality Act, confidentiality, data protection and anti-bribery. Records indicated that all staff had completed this at the start of their employment.

Additionally, all staff were required to complete annual training updates. Records indicated that at the time of inspection, all staff were up to date with this.

Mandatory training completion was monitored by members of the management team to make sure that staff completed all required training in a timely manner. The management team were implementing an electronic monitoring system at the time of inspection which would support managers in recognising when training for individual staff members was due for renewal.

Safeguarding

The service had safeguarding policies for adults and children which were available for staff to access. This included how to report a safeguarding and highlighted who safeguarding referrals should be made to. Additionally, details of who to contact at the local authorities were included. However, the policy only specified the details for two local authorities that the service would potentially be required to make referrals to.

Members of the management team informed us that if safeguarding concerns were identified, the details would be passed to the provider who work had been undertaken for. We noted that there was no formal process outlined for this or key contacts for each organisation available.

In addition, we had concerns that there was an increased risk that the service would not be aware of, or follow the most up to date guidance. This was because on reviewing the policy for safeguarding children, the most up to date 'working together to safeguard children' guidance was published in 2018 while the guidance that was referenced in the policy was from 2006.

Records indicated that the service had made no safeguarding referrals between the 1 April 2018 and the 24 April 2019.

All staff had completed safeguarding training for adults as well as safeguarding level two training for children. Safeguarding was completed via e-learning and included important topics such as female genital mutilation and child sexual exploitation.

The service had a designated safeguarding lead for adults and children. During the inspection, we saw evidence that they had completed role specific training for this, which had been completed electronically. However, it was unclear what level of training had been completed. This was important as the Intercollegiate Document (Safeguarding Children and Young People), 2018, states that the designated safeguarding lead should be trained to a minimum of level four and should undertake face to face training.

Additionally, the service had not planned for the designated safeguarding lead to seek advice from an appropriately trained member of staff if needed.

The safeguarding policy and training included topics such as Female Genital Mutilation and child sexual exploitation. However, members of the management team and staff who we spoke with were unaware of Female Genital Mutilation which was important as reporting any incidents of Female Genital Mutilation is a legal requirement for all healthcare staff. Additionally, we noted that 'prevent' training was not available for staff to complete. Prevent training is a government strategy to help identify and prevent terrorism.

Although the service had a recruitment policy, the management of Disclosure and Barring Service checks was unclear. This was because it did not state what action should be taken to make sure that staff who had previous criminal convictions were appropriate to undertake their roles.

Patient transport services (PTS)

Although a member of staff had previous criminal convictions on one occasion, there was no documented evidence of how the service had reviewed this information to make sure that the member of staff was suitable for their role.

Cleanliness, infection control and hygiene

The service had an infection prevention and control policy. This covered important topics such as staff education, However, it did not provide guidance for staff to follow when managing, for example, a needlestick injury and did not reference best practice guidance, such as hand washing between patient contact or 'bare below the elbow'. Additionally, there was no guidance for staff to follow when washing their own uniforms.

There was no guidance of how to manage an infectious patient. This meant that there was no formal procedure for staff to follow when transporting an infectious patient or when cleaning a vehicle before transporting another patient.

All staff were required to complete infection prevention and control training. Records indicated that all staff had completed this.

Personal protective equipment was available on all vehicles for staff to use when needed. This included items such as clinical gloves and aprons.

The service had not planned during the booking process to identify if a patient was infectious or if any special arrangements were required during a patient's journey. This meant that there was an increased risk that infectious patients would not always be managed appropriately when required. However, staff informed us that they would ask nursing staff about this when collecting patients from hospital.

Records indicated that deep cleans had been undertaken monthly. The service had implemented a checklist for staff to follow when completing this. In addition, records also indicated that staff had completed monthly audits which had included the cleanliness of vehicles.

We noted that all ambulances, as well as garage and staff areas were visibly clean ant tidy.

Cleaning equipment was available in the ambulance station and was kept appropriately. Mops were colour coded and there was clear guidance which detailed what equipment should be used to clean different areas. This meant that the risk of spreading infection was reduced.

Spill kits (to clean bodily fluids) and disinfectant wipes were available in all but one ambulance to clean the vehicles and equipment correctly when needed.

Environment and equipment

The service had a fleet of five ambulances and a response car which were all equipped with blue lights. In addition, four vehicles had suitable equipment for transporting bariatric patients. Bariatric equipment is specially designed to carry larger weights than normal equipment.

Arrangements had been made for vehicles to be serviced on a regular basis. This included making sure that MOTs for all vehicles had been renewed in a timely manner. The service operated a system to monitor this.

Records indicated that all equipment such as stretchers and wheelchairs had been serviced in a timely manner. This meant that the risk of these items becoming faulty when being used was reduced.

Documentation was available for staff to complete so that faulty equipment could be reported. We saw evidence that these had been completed and dealt with when needed. In addition, documentation was also available for staff to complete if they had been involved in an accident which had caused damage to the ambulance.

We found that the ambulance station and all vehicles were visibly tidy and free from clutter.

The ambulance station had a key coded door to gain entry, reducing the risk of unauthorised access. All ambulances were kept inside the station securely when not being used, apart from an ambulance car that was kept in the car park outside. We found that the car had been kept locked. Vehicle keys were kept in the main office, but were not secured in a locked cabinet.

All controlled substances that are hazardous to health were kept in a locked cabinet in the garage. This was in line with the controlled substances hazardous to health legislation.

We found that medical gasses were stored securely. Medical gasses were kept in a locked cage in the ambulance station and were stored securely on ambulances.

The management had implemented an inventory which detailed what equipment was required to be available on each vehicle. We found that there was enough disposable equipment were available on all vehicles and records indicated that staff had completed daily checks to make sure that all equipment was available before the start of every shift.

The services had made sure that appropriate waste bags were available for the storage of clinical waste and that this was separated from domestic waste. All clinical waste was kept in sealed bags in a designated clinical waste bin. The management team informed us that this was emptied by an external provider when needed.

In addition, appropriate storage for used sharps was available on all vehicles. We found that these had been emptied at the time of the inspection.

The service had made sure that each vehicle had two fire extinguishers available for use in the event of an emergency. However, we found that that the service dates for these were overdue, which meant that there was an increased risk that they would not work if needed. We raised this with the management team who arranged for these to be serviced before the inspection had finished.

Uniforms, including shirts, trousers and coats were provided to all staff. We also found that identification badges were issued to staff at the start of their employment. However, there was no guidance for staff to follow when purchasing their own footwear. This meant that there was an increased risk that staff would not have appropriate footwear to undertake their role.

We had concerns that there was no system to make sure that uniforms, identification badges and station keys were reconciled if a member of staff left the service. This meant that the management team were unable to provide assurances that staff who no longer worked at the service had returned these.

Managers informed us that satellite navigation systems were available on two vehicles and staff were required to provide their own navigation system when using other vehicles. However, the service did not have a system to make sure that these had been updated regularly. This meant that there was an increased risk that staff would not always be able to find the correct destination in a timely manner.

Assessing and responding to patient risk

We had concerns that the service did not have an effective system to make sure that patient transport was only provided for suitable patients. This was because the service did not have a clear inclusion or exclusion criteria. Additionally, all work that was undertaken for local NHS trusts and local authorities was ad-hoc, meaning that it was unclear how the service had made sure that transport was only booked for suitable patients.

Members of the management team informed us that basic risk assessments were completed for all patients during the booking process. However, there was no documented evidence of this as only basic information had been recorded, such as a patient's name, date of birth and where the patient was to be collected from, as well as their destination. This meant that there was an increased risk that staff would not be aware of any special requirements that a patient had, for example if a do not attempt cardiopulmonary resuscitation order was in place.

There was a standard operating procedure which outlined actions for staff to take in the event of a patient becoming ill during a journey. However, we had concerns that patients would not always be managed appropriately in the event of an emergency. This was because although the standard operating procedure stated that staff must stop immediately and dial 999, it also stated to consider contacting a member of the management team to ascertain if it was appropriate for them to travel to hospital under emergency conditions, despite staff not having the correct skills to undertake this safely.

Members of the management team informed us that there had been no recorded occasions when a patient had become unwell during a journey between April 2018 and April 2019.

We were also informed about a small number of occasions between April 2018 and April 2019, when patients had been transferred from an event to hospital, requiring immediate medical treatment. Members of the management team informed us that when this had happened, the service

provided transport only and other medical professionals had travelled with the patient to provide care and treatment. However, the service was unable to provided us with documented evidence to confirm this.

All staff had received training in first aid at work, which included basic life support training and how to use an automatic external defibrillator (a portable electronic device with simple audio and visual commands, which through electrical therapy allows the heart to re-establish an organised rhythm so that it can function properly).

Records indicated that three members of staff had undertaken additional training which included taking patient observations such as blood pressure and pulse as well as an electrocardiogram (a picture of the heart's rhythm).

Defibrillators were available on all vehicles and records indicated that these had been checked regularly. We found that adult defibrillator pads were available, in date and packaged correctly on all vehicles. However, we noted that the service did not provide defibrillator pads for children. Guidance from the Resuscitation Council (2010) states that child defibrillator pads should be used in the event of a paediatric emergency.

The service had a policy covering do not attempt cardiopulmonary resuscitation orders. Staff who we spoke with understood their responsibilities to carry the appropriate paperwork with patients.

Staff had not received training in conflict resolution or de-escalation. This was important as we were informed that the service regularly transported patients with a cognitive impairment such as dementia.

Staffing

The service employed seven patient transport staff, six of whom had worked for the service for several years. There were no vacancies for patient transport staff at the time of the inspection.

All staff were employed substantively by the service and worked on a rota system, covering 24 hours a day, seven days a week. Staff were not routinely based at the ambulance station and were called in when there was a patient journey to complete.

Members of the management team were responsible for co-ordinating all patient journeys. Records between January and April 2019 indicated that there had been sufficient numbers of staff available to undertake all journeys that had taken place.

A member of the management team was always available on the telephone in case staff needed to contact them. Staff who we spoke with were aware of how to contact them if needed.

Records also indicated that sickness rates were low. For example, between April 2018 and February 2019, there had only been a total of nine days of sickness recorded for all staff.

Records

Patient records were all paper based. The type of patient records that staff were required to complete varied, depending on which provider transport was provided for. For example, a basic running sheet was completed for one NHS trust while the service's own patient record forms were completed for all other journeys.

The service had recently updated the patient record template so that staff were encouraged to document all aspects of a patient journey. The management team informed us that they had updated the patient record forms as they felt that not all parts of a patient's journey was being documented.

During the inspection, we took time to review 18 patient record forms that had been completed between 1 March 2019 and 24 April 2019, finding that they had not been fully completed on eight occasions. This was because information such as risk assessments and a patient's GP details had not been completed.

However, members of the management team informed us that staff had not completed patient records on occasions when patients had been transported from an event to hospital. It was unclear what the responsibilities of the service were when providing this type of transport.

The service had not planned to review compliance with the correct completion of patient record forms. This meant that we were not assured that the management team had full oversight of whether patient record forms had always been completed correctly, meaning that there was an increased risk that improvements would not always be made in a timely manner when needed.

Staff informed us that any additional documentation, such as hospital records or do not attempt cardiopulmonary resuscitation orders were transported as part of the patient records. This had been added to the updated patient record form so that staff could document when additional patient information had been transported and if this had been handed over at the end of the patient journey.

Patient records were stored securely at the ambulance station. Staff were required to post all completed patient record forms into a secure box at the end of every shift. Staff who we spoke with understood their responsibilities to maintain patient confidentiality.

The management team informed us that patient record forms were transported to a different address off site on a weekly basis so that they could be stored. However, we had concerns that the service had not stored records securely as the records and information governance policies did not state how this should be done safely so that patient confidentiality was maintained.

Medicines

The service did not have sufficient procedures in place to make sure that medicines were managed safely. The service did not have a medicines management policy detailing the responsibilities of staff when handling the service's or patient's own medicines.

We also had concerns that only three out of nine staff had received training in the administration of medical gasses, including oxygen and nitrous oxide (a medical gas used for pain relief). We also reviewed the standard operating procedure for the storage of medical gases, finding that there was no reference to how to make sure that they were administered safely, in line with best practice.

We raised this with the management team at the time of inspection, who informed us that they had made plans for all staff to be trained in the administration of medical gasses. However, the service had not set a date for training to be delivered, meaning that we were not assured that this would be completed in a timely manner.

We were informed by staff that nitrous oxide was not used during patient transport services. However, members of the management team informed us that staff could use it if a patient was in pain during a journey. However, on reviewing patient records, there was no documented evidence that pain relief had been administered during any patient journeys.

There was documented evidence in patient records of when patients had self-administered their own medicines during a journey.

Incidents

The service had an incident reporting policy which was available for staff to access and had implemented incident reporting forms to be completed if a clinical or non-clinical incident had occurred. However, staff who we spoke with did not know about the incident reporting policy and were unclear about how to record an incident if there had been one.

The service had not reported any serious incidents or never events between 1 April 2018 and 24 April 2019. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at national level and should be implemented by healthcare providers. Each never event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

The service had not reported any clinical or non-clinical incidents during the same period. Members of the management team informed us that on occasions when issues had arisen, they had made required improvements straight away.

Not all staff who we spoke with knew how to report an incident and were not always able to give us examples of what type of incidents that they were required to report. This meant that there was an increased risk that incidents would not always be recorded correctly and that there would be no documented evidence of what actions had been taken to reduce the risk of similar incidents happening again.

The service had not planned to investigate incidents with other providers when needed. This meant that there was a risk that improvements would not always be made so that the risk of similar incidents happening again was reduced.

Patient transport services (PTS)

The management team were aware of when to make statutory notifications to the CQC and this was detailed in the incident management policy.

The service had a Duty of Candour policy which was in line with the appropriate regulation and the management team understood the requirement to apply this when needed. The Duty of Candour is a regulatory duty that relates to open and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Duty of Candour should be discharged if the level of harm to a patient is moderate or above.

Between the 1 April 2018 and 24 April 2019, there had been no incidents reported when there had been a requirement for the Duty of Candour to be discharged. However, there was an increased risk that this duty would not be discharged when needed as the service had not planned to record the level of patient harm when incidents had been reported.

Are patient transport services effective?

Requires improvement

We rated effective as requires improvement because;

Evidence-based care and treatment

All staff had access to guidance from the Joint Royal Colleges Ambulance Liaison Committee, which covered key topics such as the management of different conditions and the administration of medical gasses. Staff who we spoke with confirmed that they had access to this on their mobile phone and would be able to access it when needed.

Additionally, some policies and procedures had some reference to best practice guidance outlined by the Joint Royal Colleges Ambulance Liaison Committee and the National Institute for Clinical Excellence. However, the service had not planned to monitor compliance against this. This was important as there was an increased risk that areas that required improvement would not always be identified in a timely manner.

Although the service had previously undertaken journeys for patients who were receiving renal dialysis, there was no evidence that best practice guidance outlined by the National Institute for Clinical Excellence had been followed or that compliance against this had been monitored. In addition, members of the management team were unaware of this guidance. This was important as the guidance states that services must ensure that 'adults using transport services to attend dialysis are collected from home within 30 minutes of the allotted time and are collected to return home within 30 minutes of finishing dialysis'.

Nutrition and hydration

Staff who we spoke with informed us that they would plan long journeys in a way that met the needs of patients and that this would include stops to make sure that patients had opportunity to eat and drink.

However, we found that on reviewing patient records completed between 1 April and 24 May 2019, there was no documented evidence that nutrition and hydration had been considered on all four occasions when patient journeys had taken between three and seven hours.

Response times / Patient outcomes

The service had not set out how quickly that they would respond to requests for patient transport journeys once a booking had been received. Additionally, the management team had not planned to monitor if the service had responded to bookings in a timely manner.

We reviewed 18 patient records, taking time to review how quickly the service had responded to bookings for patient transport services, finding that there was no documented evidence of what time the booking had been received or what time the patient was due to be collected on 14 out of 18 occasions.

However, in four records when the agreed collection time had been documented, there was evidence that the ambulance crew had arrived to collect patients in a timely manner.

Members of the management team informed us that there had been no occasions between 1 April and 24 May 2019 when the service had cancelled a patient journey due to not being able to meet demand. We were informed that this was because of the ad-hoc nature of the work that they undertook, and that they would not take a booking that they were unable to complete.

Competent staff

The service had an induction programme that was followed for all new staff. Records indicated that all staff had completed the induction programme at the start of their employment. Staff files included relevant training certificates for the parts of the course that they had completed.

The management team informed us that currently, six out of nine staff, including members of the management team had completed basic first aid at work training as well as training to use an automated external defibrillator. We were also informed that there were plans to make sure that all staff had received more advanced training, so that they were able to undertake skills such as monitoring patients' basic observations during a journey. However, there was no indication of when this would be completed by.

All staff were required to complete driving assessments at the start of their employment to make sure that they were competent to undertake their role. Driving assessments included basic skills such as parking and manoeuvring. In our last inspection of January 2018, we identified that one member of staff had not completed this. During this inspection, we had similar concerns.

The service had a driving policy for staff to follow and that there was a section in the policy which stated that all staff could claim exemptions under emergency conditions if needed. However, we had concerns that only three members of staff had completed an assessment to evidence that they were able to undertake this safely.

The management team had not made plans to undertake ongoing driving assessments. We were informed that if concerns were raised about driving competencies, refresher training would be provided.

The service undertook driving licence checks for new members of staff and personnel files that we checked indicated that this had been completed on all occasions. However, we noted that the driving policy did not state how many endorsements a member of staff could have before being unsuitable for the role and there was no process to risk assess members of staff if they had endorsements on their driving licence. This was important as records indicated that two members of staff had driving endorsements.

All staff were required to complete an annual appraisal and records indicated that most staff had completed this.

Records also indicated that during appraisals, the performance of staff had been reviewed and staff had been given an opportunity to discuss areas where extra training was needed.

However, we identified during our last inspection in January 2018 that the service had not arranged for the managing director to undertake an appraisal. Although the management team informed us during the last inspection that they would arrange for this to be done, this had not been completed at the time of this inspection.

Multi-disciplinary working

Due to the nature of the ad-hoc work that was undertaken, the service had not identified direct contacts in the organisations that they undertook work for.

Staff who we spoke with informed us that they worked well with staff from other providers. However, we were informed of occasions when information had not always been shared appropriately prior to a patient journey. This meant that there was an increased risk that staff would not always be aware of important information.

Staff understood their responsibilities to hand over all relevant information to other providers when needed. The service had recently implemented a new patient record form which included a section for staff to complete that handovers with other providers had been completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service did not have a policy or standard operating procedure covering mental capacity, consent or best interest. This was important as it meant that there was no clear process for staff to follow when documenting a best interest decision or if a patient had refused transport.

However, the service had recently implemented a revised patient record form which included a section for staff to complete if a Mental Capacity Assessment was required but there was no process in place to guide staff on how to complete this.

In addition, although the service had a Deprivation of Liberty safeguards policy, it was unclear if all the information in the policy was applicable to the service that was being provided. This was because, for example, the Deprivation of Liberty safeguards policy stated that the service could apply for a Deprivation of Liberty safeguard

despite managers confirming that they did not have the responsibility for this (Deprivation of Liberty safeguard applications are made when extra restrictions are needed to deprive someone of their liberty).

We were informed that best interest decisions, consent, the Mental Capacity Act and Deprivation of Liberty safeguards training was delivered as part of safeguarding training which all staff had received.

Gillick competence was not outlined in any of the policies or included in the safeguarding training. This was important as the service were able to transport children. Gillick is a term used if a child under 16 years of age can consent to their own medical treatment without the need for parental permission or knowledge.

Are patient transport services caring?

There was insufficient evidence to rate caring. However, we noted the following practice;

Compassionate care

We were unable to observe patient care during the inspection which meant. In addition, we were unable to speak to any patients or relatives who had used the service as the management team were unable to facilitate this. This meant that we were unable to fully assess how well the service had cared for patients.

All staff who we spoke with were committed to delivering the best possible care to patients.

Staff showed an awareness of the importance of maintaining patient's dignity during transport, particularly when transporting patients to and from an ambulance, especially in public areas.

We reviewed eight patient record forms when feedback had been received by patients, finding that all feedback had been positive, with comments such as 'staff were great' and that a 'comfortable journey' had been provided.

Most ambulances had CCTV at the front and rear of the ambulance as well as inside the main saloon. This meant that if activated, it filmed what was happening when care and treatment was being delivered. However, we noted that the service did not have a CCTV policy stating how and when this would be used appropriately. This meant that there was an increased risk that a patient's privacy could be breached.

The management team informed us that they had planned to introduce a policy regarding this in the future, however, it was unclear when this would be completed by.

Emotional support

The service had a policy which had been implemented to support staff if a patient had passed away during a patient journey, which stated to proceed to the nearest emergency department or hospice if this had already been booked. However, we had concerns that there was insufficient guidance for staff to follow in order to meet the individual needs of patients with cultural differences.

Understanding and involvement of patients and those close to them

Staff demonstrated an understanding about making sure that information about care and treatment was communicated with patients.

Are patient transport services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because;

Service delivery to meet the needs of local people

The main service was patient transport services which provided transport for those attending hospital outpatient clinics, being discharged from hospital wards, as well as transfers from other places of care including nursing homes. The service also provided these services to patients who were self-funded. Additionally, the service also transported patients from an event to hospital.

All patient transport journeys were ad-hoc at the time of the inspection. Managers informed us that they had planned patient journeys at short notice as best as possible, although this had sometimes been difficult as not all information had been provided by the organisations who had booked patient transport.

Patient transport services (PTS)

In our last inspection, we found that the service had regular meetings with senior managers of the service who work had been undertaken for. However, during this inspection, members of the management team informed us that they no longer had similar meetings, and were unaware of who the main contact was for each provider.

Meeting people's individual needs

Managers informed us that individual patient's needs were taken into consideration during the booking process for each patient journey. For example, standard questions asked included the patient's presenting condition and what their mobility was. Any information received was communicated to the crews before they undertook patient journeys.

However, on reviewing patient records, there was no documented evidence that the service had considered other complex needs such as if patients were living with dementia or had learning disabilities. This was important as staff had transferred patients with these conditions.

The service did not provide any additional training to support staff when providing care and treatment to patients with complex needs, such as those living with dementia.

The management team informed us that they did not provide transport services to patients who were suffering with mental health problems or those who had been detained as they had recognised that they did not have the correct vehicles and equipment as well as trained staff to undertake this safely.

The service had suitable equipment to provide services to bariatric patients. This was because four out of five ambulances had equipment which were larger and could carry larger weights than standard equipment. Staff had been trained how to use these when needed.

The service had not considered patients from different cultures, different faiths or those who spoke different languages. Although the management team informed us that staff would use the internet when needed, there was no access to translation services, either by phone or face to face. This meant that it was unclear how staff would support patients who spoke a different language.

Access and flow

Records indicated that the service had undertaken a total of 276 patient journeys between April 2018 and March 2019. However, it was unclear on how many occasions the service had transported a patient from an event to hospital as this had not been formally recorded.

The service provided patient transport 24 hours a day, seven days a week, Duty managers were responsible for taking bookings and managers informed us that if there was insufficient staff or vehicle availability, a patient journey would not be booked.

There had been no occasions recorded between April 2018 and March 2019 when a patient journey had been cancelled.

Members of the management team informed us that they monitored whether ambulance crews had picked patients up at the correct time. However, there was no formal system for this.

We sampled 18 patient records that had been completed in March and April 2019, finding that the time of pickup had not been documented on 14 out of 18 occasions. We noted that on the four occasions when this had been documented, the ambulance crew had arrived on time. However, we had concerns that on 14 occasions, that there was a risk that patients had not been collected in a timely manner.

Learning from complaints and concerns

The service had a complaints policy which outlined staff responsibilities when managing complaints and the timescales in which a complaint should be managed. Managers could tell us about how they managed complaints.

However, we found that the complaints policy did not have reference to the Parliamentary and Health Service Ombudsman or other external bodies such as the Independent Sector Complaints Adjudication Service. These are independent bodies that can make final decisions on complaints that have been investigated by the provider and have not been resolved to the complainant's satisfaction.

The service had not planned to investigate complaints with other providers if needed. This was important as the service undertook patient journeys for other providers, such as NHS hospital trusts.

Patient transport services (PTS)

Records indicated that between April 2018 and May 2019, the service had not received any complaints.

Are patient transport services well-led?

Inadequate

We rated well-led as inadequate because;

Leadership of service

The leadership team consisted of the managing director, two other directors, as well as a general manger who was registered with the CQC. The service also employed a team leader who had additional responsibilities. For example, making sure that staff adhered to a professional code of conduct.

The service employed a clinical director, who was an accident and emergency department consultant. The management team informed us that their main responsibilities included providing clinical advice to the service. However, we were informed that they did not currently input into the provision of patient transport services as they had focussed on other aspects of the service, such as the provision of events.

Members of the management team had undertaken qualifications to undertake patient journeys, but did not have any formal management qualifications. This was important as they were responsible for undertaking all aspects of management, including risk management, as well as developing policies and procedures.

Staff who we spoke with informed us that managers were visible and approachable.

Vision and strategy for this service

The service did not have a formal vision and strategy. However, managers could tell us about the service and what they were aiming to achieve moving forward. Managers also informed us that they were committed to making sure that they provided the best patient care possible.

Although the management team informed us that they had plans to develop the service further., there were no timeframes in which this would be completed.

Culture within the service

The culture of the service was positive and there was a willingness from all managers and staff who we spoke with to be open and honest.

Both managers and staff informed us that there was a positive working relationship between all staff who worked in the service. Staff informed us that they felt supported and felt comfortable to raise concerns when needed.

The service had implemented a whistleblowing policy which identified that staff could raise concerns with the managing director. Members of the management team informed us that if staff felt that concerns raised had not been dealt with appropriately, they would direct them to the CQC.

Between April 2018 and March 2019, the service had reported low levels of staff sickness as well as low staff turnover rates.

Governance

In our last inspection of January 2018, we identified concerns that the service did not operate an effective recruitment process. Although the service had implemented a revise recruitment policy since our last inspection, we identified similar concerns during this inspection.

This was because we reviewed personnel information that had been received following the inspection for a newly recruited member of staff. Although the service provided evidence of an application form, references and a health questionnaire, there was no documented evidence of the member of staff having completed an interview or providing other important documents such as a proof of identification or a driving licence check.

We reviewed the personnel file for a member of staff who was employed by a local NHS Trust, finding there was no documented evidence that the service had completed all appropriate checks, such as requesting evidence of qualifications or completing a Disclosure and Barring Service check. This meant that it was unclear if the member of staff was suitable to undertake their role.

The management team informed us that they made sure all staff had read all policies and procedures that the service had. Each policy had an associated register which all staff had signed confirming that they had read and

understood the content. However, staff who we spoke with did not always know about these. For example, staff were not clear on how to report incidents, in line with the incident reporting policy.

We found policies that had been implemented did not always reflect the service that was currently provided. For example, a policy stated that the service could apply for a Deprivation of Liberty safeguard, despite members of the management team informing us that this was not the case.

The service had implemented monthly team meetings since our last inspection. We saw documented evidence of this and found that a range of topics had been discussed. However, there were no documented actions following the meeting, meaning that it was unclear who was responsible for actioning these in a timely manner.

Managers were aware of their responsibilities to make sure that staff had to have sufficient rests in between shifts. We were informed that this was monitored daily.

The service had arranged for appropriate insurance policies to be in place. This included employer's liability insurance as well as motor insurance which covered all vehicles.

Management of risk, issues and performance

The service did not have a formal system to assess, mitigate and control both clinical and non-clinical risks. This meant that we were not assured that all risks had been identified or that controls were in place to reduce the level of risk when needed. For example, the service had recognised the need to update clinical and operational policies, however, the service had not considered the need for actions to be implemented to mitigate the potential risk while this was being undertaken.

The service had implemented several health and safety risk assessments for the service. This included risk assessments covering manual handling. We found that all risk assessments had been completed, scored and were in date.

We were not assured that incidents would be recognised, recorded or investigated so that the risk of similar incidents reoccurring would be reduced. Not all staff knew about how to report incidents and there had been no clinical or non-clinical incidents reported between April 2018 and April 2019.

There was a system in place to monitor compliance against the completion of daily vehicle checks and monthly vehicle deep cleans. However, the service had not routinely monitored other areas of the service. On reviewing all operational and clinical policies, there was no requirement to monitor compliance against them on a regular basis. This was because all policies stated for monitoring 'as and when'.

We identified some areas of poor performance, such as compliance against the completion of records. This was important as patient records had not been fully completed and members of the management team had been unaware of this, meaning that we had concerns that improvements would not be made.

In addition, the service had not always recorded when a patient was to be collected, meaning that they were unable to monitor if patients had been collected on time. There was also no formal review process in place between the service and the organisations who work was undertaken for.

The service had implemented a business continuity plan which included actions to take in the event of a power cut of the ambulance station not being accessible. For example, if there was a fire at the ambulance station, an alternative location could be used to store ambulances and equipment.

Information Management

The service had not always kept up to date information which reflected the service that had been provided. This was because although managers confirmed that there had been occasions when patients had been transported from an event to hospital, there was no formal record of this and managers were unable to confirm the exact number of patient journeys that had been undertaken.

The service made sure that all policies and procedures were available in the ambulance station for staff to access. In addition, staff could access electronic copies of these as well as being able to access an electronic version of the Joint Royal Colleges Ambulance Liaison Committee.

Managers informed us that they had begun to transfer all information such as training records and personnel files to an electronic system so that these could be monitored effectively. We saw evidence that this process had already commenced.

Patient transport services (PTS)

Public and staff engagement

The service sought feedback from staff on a regular basis as well as supervision meetings.

In addition, staff encouraged patients or relatives to complete a patient satisfaction section at the end of every patient journey. We reviewed 18 patient record forms that had been completed between March and April 2019, finding that this had been completed on eight occasions. Although all comments made were positive, managers informed us that they were committed to making further improvements to the service in the event of negative comments being left.

Managers informed that they reviewed all patient record forms for feedback, and action would be taken to make improvements if negative feedback had been left.

Innovation, improvement and sustainability

The service employed a consultant to assist them with the inspection process, introduce IT systems and to develop clinical and operational policies.

Managers informed us that they had recently recruited an additional member of staff to the management team who would be responsible for training so that the registered manager had more time to focus on other tasks such as compliance with CQC fundamental standards and associated regulations.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the service MUST take to meet the regulations:

- The service must ensure that there is access to a suitably trained member of staff who is able to give advice about safeguarding concerns when needed. This was a breach of Regulation 13(1).
- The service must ensure that there is a system in place to assess the suitability of staff who have had previous criminal convictions to undertake their roles. This was a breach of Regulation 19(1)(a).
- The service must ensure that they have an effective system to make sure that only suitable patients are transferred. This was a breach of Regulation 17(2)(a).
- The service must ensure that basic risk assessments are completed for all patients. This was a breach of Regulation 17(2)(a).
- The service must ensure that an up to date, contemporaneous record is kept for all patient journeys that have taken place. This was a breach of Regulation 17(2)(c).
- The service must ensure there are systems and processes in place to support staff when managing medicines. This was a breach of Regulation 17(2)(a).
- The service must ensure that staff who administer medical gasses have the correct competencies to do so. This was a breach of Regulation 18(2)(a).
- The service must ensure that the system used for reporting incidents is effective and that all staff know how to use it. This was a breach of Regulation 17(2)(b).
- The service must ensure that full recruitment processes are undertaken for all new staff, in line with policy. This was a breach of Regulation 19(1)(b).
- The service must ensure that there are monitoring systems in place so that areas for improvement are identified in a timely manner. This was a breach of Regulation 17(2)(b).

Action the hospital SHOULD take to improve

- The service should ensure that all policies reference and reflect up to date legislation and national guidance, for example, 'working together to safeguard children guidance, 2018'.
- The service should ensure that all staff receive 'Prevent' training.
- The service should ensure that there is a clear system for staff to follow if patients become unwell during a patient journey.
- The service should ensure that paediatric defibrillator pads are available for staff to use if required.
- The service should ensure that there are effective processes in place to support staff with consent, best interest decisions and Mental Capacity.
- The service should ensure that there are processes in place to manage CCTV cameras that are used in patient areas.
- The service should consider ways to make sure that all staff are aware of how to manage infectious patients safely.
- The service should consider implementing a system to make sure staff return all items such as uniforms and keys if they leave the service.
- The service should consider introducing training to support staff when managing patients who have individual needs, such as those who are living with dementia.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met;** Staff did not always have the correct level of knowledge, experience and training to undertake their role and the service had not planned to access people with the correct level of training when needed. Regulation 13(1)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met;** The service did not have an effective system for reporting clinical and non-clinical incidents. Staff were not always aware of how to use this. Regulation 17(2)(b)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met;** Staff had not completed competencies to ensure that they were able to deliver medical gasses to patients safely. Regulation 18(2)(a)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met;** The service must ensure that a full recruitment process is undertaken for all we staff, in line with policy. The service did not have an effective system to make sure that all staff who had a criminal conviction were suitable to undertake their role. Regulation 19(1)(a)(b).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met;** The service did not have a medicines management policy in place and did not operate an effective system to support staff with the administration of medical gasses. The service did not have effective systems to monitor the service provided so that improvements could be made when needed. The service did not have an effective system to make sure that only suitable patients were transported by the service. The service had not kept an up to date patient record for every patient journey. Regulation 17(2)(a)(b)(c)