

Mrs Valerie Ellen Price

# Medicmart999 Uk

## Quality Report

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

## Ratings

### Overall rating for this ambulance location

Patient transport services (PTS)	
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# Summary of findings

## Letter from the Chief Inspector of Hospitals

Medicmart 999 UK operated by Mrs Valerie Ellen Price. The service provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 30 January 2017, along with an unannounced visit to the provider on 3 February 2017 and a further planned visit on 9 March 2017.

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

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

We found the provider to be in breach of several regulations of the Health and Social Care Act 2008 Regulated Activities regulations (2014), inclusive of regulation 7 (requirements relating to registered managers), regulation 17 (good governance), regulation 13 (safeguarding service users from abuse and improper treatment), regulation 16 (receiving and acting on complaints), regulation 18 (staffing), and regulation 12 (safe care and treatment).

We considered the risk and potential impact of these breaches, suspended the providers registration for a period of three months from 8 February 2017 to enable them to make the necessary improvements.

The provider put the necessary improvements in place prior to the end of their suspension. After a re-inspection on 9 March 2017, the provider applied to have their suspension lifted and this was granted, with the service becoming operational again on 23 March 2017.

### Services we do not rate

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

We found the following areas where the service provider needs to improve:

The provider did not have sufficient oversight of the safety, effectiveness, caring, responsiveness or governance and leadership of the service.

The provider did not have robust policies and procedures in place for the running of the service and we were not assured that the existing documents were current in content and guidance. This included but was not limited to an incident management policy or process and a patient deterioration policy or process.

There were no systems in place to identify and assess risks to the service or the health, safety and wellbeing of its service users.

The provider did not provide certain statutory and mandatory training for its staff including but not limited to safeguarding, infection control and manual handling training.

There was no process in place to identify and raise safeguarding concerns, or to escalate concerns of a service user who deteriorated in the care of the service.

The provider did not have a robust system in place for obtaining recruitment checks such as validation and disclosure and barring service checks.

The provider did not adequately manage its storage, supply or administration of medicines including a category four controlled drug.

# Summary of findings

There was no audit and improvement processes and we were not assured that the leadership had an understanding of the safety and effectiveness of the service.

There was no system or process in place for gaining service user feedback or enabling service users to complain.

The provider did not have a system in place to ensure that stock in the vehicles intact and in date.

The provider was storing compressed gases unsafely and in an inappropriate location which presented an explosion risk.

The provider was not able to provide a service that met the needs of service users with different needs such as learning disabilities, dementia or some bariatric service users.

However, we also found the following area of good practice:

The provision of Medicmart 999 UK branded teddy bears to children being transported was a positive demonstration of meeting the needs of children using the service.

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

**Professor Edward Baker**

**Deputy Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Patient transport services (PTS)

### Rating Why have we given this rating?

Patient transport services were the main activity of the service.

The service was in breach of several regulations of the Health and Social Care Act (2014), such as requirements relating to registered managers, good governance, safeguarding service users from abuse and improper treatment, receiving and acting on complaints, staffing, and safe care and treatment.

This resulted in the service having their registration suspended for a period to make the required improvements. The provider applied for the lifting of the suspension in March 2017 and this was granted.

# Medicmart999 Uk

## Detailed findings

### Services we looked at

Patient transport services (PTS)

# Detailed findings

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### Detailed findings from this inspection

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## Background to Medicmart999 Uk

Medicmart 999 UK operated by Mrs Valerie Ellen Price is an independent ambulance service based in Yaxley, Peterborough. The service primarily provides patient transport services on behalf of a local NHS Trust to the communities of Peterborough and Cambridgeshire. This includes home to hospital, hospital to home, and hospital-to-hospital high dependency and critical care transfers.

The service also provides first aid cover to sporting events, although the Care Quality Commission does not regulate this activity.

The service was last inspected in November 2013. No action was required from that inspection to ensure compliance.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, and four other CQC inspectors. Fiona Allinson, Head of Hospital Inspection, oversaw the inspection team.

## How we carried out this inspection

The provider delivers a patient transport service from its base in Yaxley, Peterborough. This includes the picking up and dropping off of service users from their homes to local NHS Trusts, and the transport of service users, including critical care and high dependence service users, to and from a local NHS Trust to other hospitals in the country. The provider also provides cover to events, including sporting events, although the Care Quality Commission (CQC) does not regulate this activity. There were four cars and three ambulances in the service.

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the base of the service in Yaxley, Peterborough. We spoke with six staff including; emergency medical technicians, first aiders and management. We did not speak with any patients or relatives as there were none available on the days of our inspection. During our inspection, we reviewed 30 sets of patient record forms.

The CQC had been reviewing two separate complaints about the service during the 12 months before this

## Detailed findings

inspection. The CQC has inspected this service twice, and the most recent inspection took place in November 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (1 November 2016 to 28 January 2017)

- The service undertook 206 patient transport journeys between 1 November 2016 and 28 January 2017 as part of their contract with a local hospital trust.

The service subcontracted four registered paramedics, three emergency medical technicians, one emergency care assistant and one first aider to work at the service. The service did not have an accountable officer for controlled drugs (CDs).

The service did not have a track record on safety as they did not have any processes in place to recognise record or monitor never events, clinical incidents, serious injuries nor complaints.

## Our ratings for this service

Our ratings for this service are:

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

# Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

## Information about the service

The service primarily provides patient transport services on behalf of a local NHS Trust to the communities of Peterborough and Cambridgeshire. This includes home to hospital, hospital to home, and hospital-to-hospital high dependency and critical care transfers.

## Summary of findings

We do not currently have a legal duty to rate independent ambulance services.

### Are services safe?

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

- There was no formal process for staff to report incidents. We did not see any evidence of any incidents that staff had reported.
- There was a lack of knowledge of safeguarding. None of the staff were given accredited safeguarding training at the time of our inspection on 30 January 2017.
- The provider did not adequately manage its storage, supply and administration of medicines, including a category four controlled drug.
- Oxygen cylinders were stored unsuitably, creating a risk of fire or explosion.
- Equipment on ambulances was unsuitably stored, out of date and improperly documented.

However, we also found the following areas of good practice:

- On our visit on 9 March 2017, all staff had received mandatory and statutory training including infection prevention and control, manual handling and safeguarding.

### Are services effective?

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



# Patient transport services (PTS)

- Policies had no creation or review dates so we were not assured they contained current guidance. Policies were not based on up to date National Institute for Health and Care Excellence (NICE) or Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.
- The provider did not have sufficient evidence, such as qualification and skills checking, that staff were competent for the roles they were undertaking.
- Staff did not have sufficient knowledge of consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

## Are services caring?

- Staff we spoke with demonstrated a caring attitude to patients and their relatives.

## Are services responsive?

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

- Staff received no specific training for dealing with patients with complex needs, for example those with learning difficulties, older patients, or patients living with dementia.
- The service did not proactively seek nor act on feedback from patients and their families.
- The service did not have a policy or process in place for the management of complaints.
- Neither the provider, service manager, nor any of the staff we spoke with could recall any changes to the service or learning arising from feedback or complaints.

## Are services well-led?

- The provider did not have an overall vision or strategy for the service.
- The provider had no governance structures for ensuring oversight of the service, and improving practice.
- Procedures for ensuring fit, proper and competent staff were not robust.
- The provider did not have oversight of practices within the organisation.

## Are patient transport services safe?

### Incidents

- Medicmart 999 UK had no incident monitoring system or policy in place. This meant we were not assured that staff understood how to recognise, report, escalate and categorise incidents. Due to this, there were no reported never events, serious incidents, incidents or near misses recorded by the service. Neither was there any effective investigation or learning taking place to improve service provision and safety.
- We spoke with two members of staff, both of whom told us that if they were involved in or witnessed an incident they would report it to their supervisor. However, they were unable to give an example of a notifiable incident. There was no evidence that any incidents had been reported and the staff told us they had not reported any incidents.
- We asked two members of staff how they recorded any incidents that occurred, and they informed us that incidents would be recorded on patient report forms. We later asked the provider how incidents were reported and they stated that they would be written into an office diary. During our inspection on both 30 January 2017 and 3 February 2017, we found no evidence of incident reporting on patient report forms.
- By our inspection on 9 March 2017, the provider had developed an incident reporting policy that was produced in February 2017 and was due for review in February 2018. An example incident report form was kept in the folder. Copies of the incident reporting form were kept in folders on the ambulances for staff to use when required.
- During our inspection on 9 March 2017, we found some patient identifiable information left in the front cabin of an ambulance. This was raised with the provider who removed the information and raised this as an incident for investigating. We followed this up with the provider and found that their new incident management system had worked well, with the senior staff members holding a meeting to discuss what had happened and how to prevent it occurring again.
- We spoke with three members of staff about duty of candour. None of these staff had an understanding of

# Patient transport services (PTS)

their responsibilities of being open and honest under the duty of candour. The duty of candour is a regulatory duty that relates to openness 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.

- On 9 March 2017, the service had produced a duty of candour policy that all staff had signed to confirm they had read and understood.

## **Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)**

- Medicmart 999 UK did not have any process or system in place to monitor the clinical quality and safety of the service. This meant we were not assured that the service was provided in a safe and effective way.

## **Cleanliness, infection control and hygiene**

- Staff told us it was their responsibility to clean vehicles after each patient had been transported and at the end of each shift. However, no policy or records were provided to evidence this process.
- There was also a 'deep clean' cleaning schedule for all vehicles to be deep cleaned at least once a week or as necessary, for example after attending an event. We observed this cleaning taking place on one ambulance and one car during our inspection. The provider presented copies of completed, dated cleaning schedule sheets for the deep cleans in two folders. However, the documents were not kept in chronological or vehicle order so it was not possible to confirm that the provider was maintaining the cleanliness of vehicles or if any cleaning sheets were missing. There was no designated infection control lead at the time of our inspection.
- Staff were well presented and had visibly clean uniforms.
- Hand cleansing gel and gloves were available on all vehicles.
- Clinical waste was found in the 'domestic waste' bin, which was full; and domestic waste was found in the 'clinical waste' bin in one ambulance. Incorrect disposal of clinical waste presents a risk of infection to staff and patients.

- Reusable equipment such as splints, in two vehicles were found to be dusty and one splint was dirty with a dried red liquid. This was escalated to the service manager and office manager on 9 March 2017 who removed the splint immediately.
- We found a mattress in one vehicle was not intact. The mattress was ripped and therefore it was not possible to adequately clean the mattress for infection control purposes. The mattress was removed from the vehicle at the time of the inspection.
- After our inspection on 9 March 2017, we requested the provider send us proposed cleaning schedules for the vehicles once they were operational again. The proposed schedule showed that vehicles would be regularly cleaned for patient use.

## **Environment and equipment**

- During our unannounced inspection on 3 February 2017, we inspected two Medicmart 999 UK vehicles. In one vehicle, we found 28 items past their expiration date. The items included 12 oral airways, which are medical devices used to maintain or open a patient's airway that ranged from four months to two years past their expiration date, four syringes that expired in June 2016, and a paediatric nebulizer mask that expired in November 2015. We found three single use items that had their sterile packaging breached and were not suitable for use. This meant we were not assured that vehicles were replenished of stock in a timely way. On 9 March 2017 all out of date stock had been replenished and no further out of date items were found at the time of the inspection.
- We also found an automated external defibrillator (AED) in each vehicle that needed to be secured in six directions but were not stored securely and were at risk of being a falling hazard to patients and staff in the back of the vehicles. On 9 March 2017, the AEDs were being stored in a cabinet on the ambulances to ensure they were no longer a falling hazard for patients or staff when the vehicle was moving.
- The station environment was not organised or hygienic in parts. A stray cat stayed in the station and was fed during the day. The training room carpet had a marked amount of animal fur on it, as did the sofa in the same room. Equipment for use on vehicles was also stored in the training room.

# Patient transport services (PTS)

- On our inspection on 9 March 2017, we found that the resident cat had been removed from the station along with the sofa on which it slept. The station was visibly cleaner and less cluttered.
- The service provided evidence to demonstrate that all vehicles had received annual MOT's. Vehicle keys were stored securely at the location office. On 30 January 2017, one ambulance vehicle was being repaired in a local garage. This indicated that the service had a system for managing faulty vehicles.
- The service manager stated that nebulizer masks were not stored in any vehicles and that Emergency Medical Technicians (EMT's) carried their own masks in grab bags, which risks the equipment not being present when required.
- Two grab bags on two separate vehicles contained adult and infant sized bag valve masks (BVM's) but no child size BVM's were present. Correct BVM's is an essential piece of equipment for use in airway management. We escalated this with the provider who ordered the correct BVM's.
- Between two ambulance vehicles, there were two trolleys, a harness and a carry chair without any evidence of servicing. This was escalated to the provider who arranged for the servicing of vehicle equipment and informed us of the date this was completed.
- medicines to pre-defined groups of patients, without a prescription. This form meant that two of the subcontracted paramedics to the provider could obtain prescription only medications on behalf of the provider.
- The service manager stated that emergency medical technicians (EMT's) were trained in, and were administering a prescription only medication under a patient group direction. Only a registered professional may administer these types of medications. This meant that we were not assured that staff had adequate knowledge of what medications they were and were not qualified and permitted to administer. This was escalated to the service manager on 3 February 2017, who stated that EMT's would cease administering these medications and only the paramedics would do so.
- On 3 February 2017, we found that the service was storing cylinders of compressed oxygen and Entonox in a sealed safe next to a working gas boiler. This presented an explosion risk and disregarded the British Compressed Gases Association guideline on safe storage of cylinders (2016). This issue was escalated to the service manager immediately, who took action to move the cylinders to an outside area. However, this demonstrates a fundamental lack of knowledge of the risks associated with storage of compressed gases. On 9 March 2017, the cylinders were correctly stored in a locked outside area away from the main location.

## Medicines

- The provider did not adequately manage its storage, supply and administration of medicines. The provider was storing and administering medication, including controlled drugs without a medication management policy in place. They were not monitoring or recording medication stock. We reviewed all the medication held in the medicines safe during the inspection on 30 January 2017 and found the provider was holding a Schedule 4 controlled drug, 'Epistatus' midazolam, which it was not legally permitted to store. We escalated this to the provider who disposed of the drug immediately. The lack of medicines management meant that patients were at risk of receiving incorrect medications or medications that were out of date
- The provider had a Patient Group Direction (PGD) signed by a doctor, which was in date. PGDs allow healthcare professionals to supply and administer specified

## Records

- Patient Transport Service (PTS) drivers had printed work sheets at the start of a shift. This included collection times, address and patient specific information such as relevant medical conditions. The forms relating to dates of inspection were accurate and legible.
- Records were not stored in a suitable format at the location, because they were kept in a large plastic box with no filing system, which meant it was not possible to select a specific record or review them in a chronological order.
- Records were stored in the station, which was locked when staff were not at the premises.

## Safeguarding

- The provider had a safeguarding policy in place. However, this lacked an issue or review date and provided no process for the identification and reporting

# Patient transport services (PTS)

of safeguarding concerns. The policy referred to the training of staff, which had not taken place. There was also no process to feedback to staff or enable learning from safeguarding concerns. We were not assured that staff knew how to recognise potential signs of abuse, and there was no clear and structured process in place to escalate concerns to ensure that patients received the support and help necessary.

- Despite providing a service to both vulnerable adults and children, the provider had not undertaken any risk assessment for the transportation of these patient groups.
- Staff told us they would speak to the appropriate person in charge and if they were not available then go to someone more senior if they had safeguarding concerns. However, staff were unable to explain how safeguarding referrals would be made and to what body they would be escalated.
- There was no named individual who had overall responsibility for safeguarding. However, the service manager stated that they were considering appointing a “child safety officer”. On 3 February 2017, there was no indication that the appointment of a child safety officer was underway.
- The provider did not provide staff training in safeguarding vulnerable adults or children. There were no training certificates present in any of the four staff files we reviewed. On 30 January 2017, the service manager confirmed staff had not completed this training but that he had made enquires to an outside organisation to source this training.
- On 9 March 2017, 100% of staff that were employed by the provider had completed a one-day safeguarding course and online training modules in Safeguarding of Children and Safeguarding of vulnerable adults. Three senior members of staff had also completed an online module in Safeguarding of Children Practice Level 3.
- On our inspection on 9 March 2017, the provider had implemented a new safeguarding policy. All staff had signed to confirm they had read and understood the policy.

## Mandatory training

- We reviewed four staff files that were available at the time of the inspection and found that these staff had

not received training which they were required to have undertaken, for example in manual handling, safeguarding or infection control and there was no evidence of staff spot checks having taken place on their training or continuous professional development.

- Medicmart 999 UK had a limited overview of training across the service, for example, the service manager and staff we spoke with confirmed there had been no statutory training given to staff on infection control, health and safety and safeguarding. The provider was not able to provide an overview or percentage of staff training compliance.
- On our inspection on 9 March 2017, 100% of staff had completed the following online mandatory training: infection control, moving and handling, health and safety. The provider had also employed an officer manager, who was responsible for arranging and monitoring staff training. The office manager told us that further mandatory training will be rolled out to staff.

## Assessing and responding to patient risk

- The service manager confirmed there was no policy or procedure in place that described the responsibilities of staff in the event a patient should deteriorate.
- There was no policy for dealing with violent or challenging patients and no evidence that staff had received training in conflict resolution of dealing with violent patients.
- We were not assured that patient transport staff knew the safest way to manage a deteriorating patient in their care. The service manager told us that in the event a routine transport patient deteriorated, staff would head to the nearest emergency department with their blue lights on. However, if the patient became that unwell that it went “above the level the EMT could care for” they would call the NHS ambulance provider who would provide a paramedic response vehicle to join the patient on route. Staff we spoke with confirmed they would determine how far they were into patient transport journey before deciding where to take a patient whose condition was deteriorating.
- Staff were not aware of their responsibilities should a patient become seriously unwell. This was because there was no guidance on how patient deterioration would be identified and monitored, how the staff would

# Patient transport services (PTS)

identify a seriously unwell patient which was “above the level” they could care for and in what circumstances a transfer to hospital would be required or an ambulance be called. Delays in recognising and responding correctly to deteriorating patients can negatively affect patient outcomes. On our visit on 9 March 2017, the provider had produced a deteriorating patient policy, which included a pre-hospital sepsis screening tool and red flag observation sheet, which were placed in individual ambulance folders for staff to use when transporting patients that were at risk of deterioration. It was not possible to ascertain if staff understood or were following the policy at the time of the inspection.

- For high dependency and critical care hospital-to-hospital transportations, the local NHS Trust provided a clinical staff member to accompany the patient on their journey. This means that Medicmart 999 UK staff members were not solely responsible for the clinical care of these patients.
- The service did not have systems or processes in place to enable the identification and assessment of risks to the health, safety, or welfare of people who use the service. There was no way for the service to report, record or monitor risks. Risk assessments were not taking place and a risk register or similar model was not being used at the time of our inspection.

## Staffing

- There were poor processes in place for ensuring that staff were fit and proper for the roles they carried out. For example, the provider did not routinely undertake or require staff to undertake Disclosure and Barring Service (DBS) checks, but relied on older DBS checks from an individual's previous employment. Therefore, the service could not assure itself staff were suitable to work with vulnerable people. The provider obtained one reference for each employee, which they took over the phone from a previous employer prior to staff starting his or her employment.
- Staff records were disorganised and incomplete when we inspected the service on 30 January 2017. By the time of our inspection on 9 March 2017, all staff had completed DBS checks or their checks were in process.
- The service did not use any bank or agency staff.

## Response to major incidents

- There was no training in respect of major incidents.
- There were no business continuity arrangements.

## Are patient transport services effective?

### Evidence-based care and treatment

- We were provided with a folder containing policies and procedures, which were available in the location office. Policies had not been reviewed in line with the stated review dates. Policies were not based on up to date National Institute for Health and Care Excellence (NICE) or Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.
- By the time of our visit on 9 March 2017, all policies and procedures had been reviewed and had implementation and review dates, which included a deteriorating patient policy, incident management and safeguarding. However, it was not possible to confirm that staff understood and used the policies at the time of the inspection.

### Assessment and planning of care

- Staff were made aware of patients' conditions on the form provided by the local hospital referring team. However, there was no evidence that staff took any action as a result of information provided by the hospital.

### Response times and patient outcomes

- The provider did not measure patient outcomes or the timeliness of its service, which meant they had no way of measuring the quality of their performance. On 9 March 2017, the new office manager told us he was in the process of developing an auditing procedure for measuring the effectiveness of the service.
- The service did not participate in any national audits or benchmarking.

### Competent staff

- On our inspection on 30 January 2017, neither the provider nor service manager had oversight of recruitment requirements regarding training, competence, registration and revalidation.



# Patient transport services (PTS)

- There was no assessment of drivers' ability to drive, aside from them showing their driving licence at the beginning of their employment. The provider did not check driving licences periodically.
- Staff told us there was no system for routine appraisals, but they felt confident to raise any issues with the supervisor or manager if they had any problems or training needs.
- The provider had not completed revalidation checks at the time we reviewed staff files on 30 January 2017. However, the service manager did rectify this during our inspection by sourcing and saving the membership and up to date revalidation details of its registered paramedics from the Health and Care Professionals Council website.
- There was no formal induction process. Staff said they received an informal introduction to the organisation, introduction to other staff and location of equipment including vehicles where relevant.
- At our visit on 9 March 2017, the office manager had arranged for online training for staff in equality and diversity, Mental Capacity Act and Deprivation of Liberty Safeguards, dementia training, mental health awareness and dignity and respect. The office manager told us staff would be offered this training over the coming months. The office manager told us that revalidation checks would take place annually with copies of evidence kept in staff files.
- At our visit on 9 March 2017 the provider had not established a standard staff induction or routine appraisal process. However, the office manager told us this would be implemented over the coming months.

## Coordination with other providers and multi-disciplinary working

- There were no service level agreements with other providers. The service provided a PTS service as requested by a local NHS Trust for patients requiring transport to and from hospital from home, as well as transfers to other hospitals. This was not an established contract and was not subject to performance or quality management by the NHS Trust requesting the service.

## Access to information

- Staff told us that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders would be included in the information provided on the booking form from the local NHS Trust. Staff told us if they required any further information before or during a patient transport, they would contact the relevant ward at the local hospital.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service manager said that staff were not provided with any training in the Mental Capacity Act 2005 (MCA). None of the staff we spoke with were aware of the provisions of the MCA or of Deprivation of Liberty Safeguards (DoLS).
- On 9 March 2017, the office manager had accessed online training in MCA and DoLS and he told us that he would allocate modules to complete over the coming months.

## Are patient transport services caring?

### Compassionate care

- There were no patients or relatives available for us to speak with during our inspection. However, staff we spoke with demonstrated a caring, compassionate attitude when talking about patients and their relatives.

### Understanding and involvement of patients and those close to them

- There were no systems in place for collecting or acting on feedback from service users. The service manager and provider confirmed that Medicmart 999 UK did not gather formal patient feedback.
- On 9 March 2017, the provider had placed feedback cards into each vehicle in anticipation of being operational again.

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

### Service planning and delivery to meet the needs of local people

# Patient transport services (PTS)

- The provider offered patient transport services around Cambridgeshire for patients conveyed to and from the local hospital, as well as country wide hospital-to-hospital transfers as requested by a local NHS Trust.
- The service was not formally commissioned by any organisation, therefore it was not possible for the provider to plan ahead, for example for staffing levels and training requirements.

## Meeting people's individual needs

- There was no policy for dealing with patients with complex needs.
- Staff received no specific training for dealing with patients with complex needs, for example those with learning difficulties, older patients, or patients living with dementia.
- There were no arrangements in place for accessing translation services if required.
- The service provided Medicmart 999 UK branded teddy bears for children using the service to provide distraction and comfort whilst being transported in an ambulance.

## Access and flow

- The service manager was responsible for the management of bookings. The local hospital faxed copies of journeys required, which the service manager allocated to a crew. The provider did not collect data on delayed or cancelled journeys at the time of our inspection.

## Learning from complaints and concerns

- The provider had not established a system for the raising of complaints or investigation of complaints. The service manager confirmed that service users were not provided with information on how to raise a complaint or concern.
- Neither the provider, service managers, nor any of the staff we spoke to could recall learning being shared because of a complaint or concern.
- During our inspection on 9 March 2017, the office manager showed us patient feedback cards that they will provide to all patients that used the service in the future. There was also a complaints policy in place and

staff had been informed of this and had signed to say they had read it. However, there was no evidence at the time of the inspection of the policy being used or followed.

## Are patient transport services well-led?

### Leadership / culture of service

- One person led the service as the registered provider, who had overarching responsibility for all aspects of the business. However, the provider was not involved in the day to day running of the service and had not delegated responsibility to a suitable person.
- Under the provider, leadership was provided by a service manager who was an emergency medical technician (EMT) who worked alongside a service supervisor who was also an EMT. The service manager was responsible for managing the service on our announced and unannounced inspections and he referred to himself as a "Partner" and "Director" of Medicmart 999 UK. However, he did not have regulatory responsibility for the service. The service manager informed inspectors that the provider attended the office on an ad-hoc basis, but that he was responsible for the day-to-day running of the service.
- Staff we spoke with spoke positively about the management of the service.
- After our inspection on 30 January 2017, the provider employed an office manager to manage the governance and administration elements of the service.
- During inspections on 30 January and 3 February 2017, inspectors found that the provider was not in charge of the day to day running of Medicmart 999 UK, that they did not have sufficient oversight to ensure effective governance and that they had not appointed a suitable person to manage the regulated activities.
- We were not assured that provider had sufficient knowledge or oversight of the service. When asked what the provider's role in Medicmart 999 UK was they confirmed that their main role was to "look after the CQC side of things". We asked the provider to clarify what that entailed and they responded that they "ensured that policies were up to date and that staff were up to date with training". The provider also stated they

# Patient transport services (PTS)

undertook staff one to one spot checks on a monthly basis. When asked if they undertook any formal auditing or monitoring in relation to their responsibilities as the registered person, they confirmed that they did not. The provider stated that they were assured about the safe operating of the business based on verbal confirmation from staff that tasks had been completed.

- There were no formal processes in place for the provider of the service to gain assurance. The provider had a full time working position outside of the service and had limited time to dedicate to the service, stating that they gained informal assurance of issues such as safeguarding and mandatory training by asking staff. However when we checked staff files, there was no recorded evidence of any statutory or mandatory training. The provider confirmed that no audits of the service took place.

## **Vision and strategy for this this core service**

- There was no documented vision or strategy for the service, which meant there was no robust, realistic strategy for achieving any priorities and delivering good quality care
- We spoke with three members of staff regarding leadership of the service. No members of staff we spoke with were able to explain a vision or strategy for the service.

## **Governance, risk management and quality measurement**

- The service had no governance processes in place. There was no risk register or key performance indicators in place, and the service did not hold governance meetings. This meant that neither the service leaders nor we were assured that the service being provided was safe and there was no forum to discuss service improvements.
- The service manager also told us that he was very rarely in the office as he preferred to be “out on the ambulances”. The service manager acknowledged that the paperwork was not his “strong-point”.

- There were no auditing or improvement systems. When asked if routine audits such as record keeping, infection control and medicine management were taking place the service manager confirmed they were not taking place. We later asked the provider if any auditing of the service took place and they stated that this had not occurred. There was no system for the provider to identify and act on risks to people who use the service.
- During our inspection, we asked the service manager if there were policies and procedures in place in relation to deteriorating patients, risk management and incident management. The service manager stated that these policies were not in place. Further, we found that the policies the service had in place, such as the “Employee vetting and screening policy”, and the “Harassment and bullying policy” had no date of implementation or review identified on them. This meant that we were not assured that the policies contained current information.
- On our inspection on 9 March 2017, the new office manager had taken on responsibility for the updating and implementation of policies and procedures. We saw the following documents that the service had produced in February 2017, which were all due for review in February 2018; Human Resources Policy Manual, Personal Protective Equipment Policy, Duty of Candour Policy, Safeguarding Policy, Infection Prevention and Control Policy, Incident Reporting Policy, Company Complaints Policy, Prevent Policy, Data Protection Policy, and a Deteriorating Patient Policy. All staff had signed the policy folder confirm they had read and understood the new policies.

## **Public and staff engagement**

- The provider did not engage the public or its staff in the planning and delivery of its service.

## **Innovation, improvement and sustainability**

- The provider did not engage in any innovation, service improvement or sustainability plans.



# Outstanding practice and areas for improvement

## Outstanding practice

## Areas for improvement

### Action the hospital **MUST** take to improve

- The provider must take action to ensure that the registered provider has oversight of the service and assurance that the service is operating in a safe and effective way.
- The provider must ensure there is an incident reporting and management system in place.
- The provider must ensure that there is a system of auditing and service improvement in place to ensure the effectiveness of the service.
- The provider must ensure there is a system in place for management of risks, including the completion of risk assessments and the creation and management of a risk register.
- The provider must ensure that policies and processes are up to date and contain current guidance.
- The provider must ensure that staff are trained and supported to recognise potential signs of abuse and neglect, including the escalation of safeguarding concerns.

- The provider must ensure there is a complaints management policy and process in place.
- The provider must ensure that staff have appropriate disclosure and barring service clearance, and that there is an appropriate employment checking system in place for new starters.
- The provider must ensure that staff receive both statutory and mandatory training in a timely manner to carry out their roles effectively and safely.
- The provider must ensure that all stock and equipment used by the service is in date, intact, and serviced as appropriate in a timely manner.
- The provider must ensure that any appropriate medications kept by the service are subject to appropriate medicines management, including but not limited to secure storage and regular stock checking.
- The organisation must ensure staff know about the duty of candour and understand its principles.
- The provider must ensure that vehicles and equipment are clean, and properly maintained.

### Action the hospital **SHOULD** take to improve

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.

## 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	<p>Regulation 4 HSCA (RA) Regulations 2014 Requirements where the service providers is an individual or partnership</p> <p><b>How the regulation was not being met:</b></p> <p>The registered provider did not demonstrate their competence, because they had insufficient oversight of the service and did not effectively supervise their management.</p> <p>Regulation 4(5)</p>
Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>How the regulation was not being met:</b></p> <p>The provider did not conduct any audits to assess the effectiveness or safety of the service.</p> <p>Regulation 17(1)(2)(a)</p> <p>The provider did not have a system in place to monitor or mitigate risks to the service, service users or staff.</p> <p>There were no systems were in place to maintain oversight of vehicle or equipment cleanliness or maintenance.</p> <p>Regulation 17(1)(2)(b)</p> <p>The provider did not have any systems or processes in place to obtain feedback or oversight of the service and therefore did not engage in any service improvement activities.</p>

This section is primarily information for the provider

## Enforcement actions

Regulation 17(1)(2)(e)

### Regulated activity

Transport services, triage and medical advice provided remotely

### Regulation

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

**How the regulation was not being met:**

The provider did not have any policy or processes in place for the safeguarding of children or vulnerable adults.

Systems and processes were not operated effectively because staff were unsure of safeguarding procedures.

Staff were not consistent in their knowledge of how to make a safeguarding referral.

Staff did not receive appropriate safeguarding training.

Regulation 13 (1) (2)

### Regulated activity

Transport services, triage and medical advice provided remotely

### Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

**How the regulation was not being met:**

The provider did not have any policy or process in place for service users to formally complain, nor for the management of complaints.

Regulation 16 (2)

### Regulated activity

Transport services, triage and medical advice provided remotely

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

**How the regulation was not being met:**

This section is primarily information for the provider

## Enforcement actions

The provider did not provide its staff with training, supervision or regular appraisals to enable them to carry out their duties effectively or safely.

Regulation 18 (2) (a)

### Regulated activity

Transport services, triage and medical advice provided remotely

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met:

The provider did not have any stock control processes in place for the effective and safe management of medicines.

Regulation 12 (1) (2) (g)

The service's emergency medical technicians were administering a prescription only medication inappropriately as they are not registered professionals.

Regulation 12 (1) (2) (g)

The service was storing a category four controlled drug despite having no controlled drug officer or licence.

Regulation 12 (1) (2) (g)

The provider had no stock management process in place and as a result, some items of stock were out of date or missing, such as paediatric bag valve masks.

Regulation 12 (1) (2) (e)

### Regulated activity

Transport services, triage and medical advice provided remotely

### Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

How the regulation was not being met:

This section is primarily information for the provider

## Enforcement actions

Staff did not know or understand their responsibilities under the Duty of Candour Regulation.

Regulation 20 (1)