Medevent Medical Services Ltd

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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 know to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	

Summary of findings

Letter from the Chief Inspector of Hospitals

Medevent Medical Services Limited is operated by Medevent Medical Services Limited. They are an independent medical transport provider based in Maidstone, Kent. The service provides medical cover at events such as music events, aviation events, and rugby matches for both adults and children. Trained paramedics, emergency care technicians, and ambulance care assistants are used to staff the services. The service has undertaken three emergency transfers in the last 12 months from events; it is these journeys that fall within the scope of registration with the CQC.

In England, the law makes event organisers responsible for ensuring safety at the event is maintained, which means that medical cover comes under the remit of the Health & Safety Executive (HSE). Therefore, the Care Quality Commission (CQC) does not regulate services providing ambulance support at events and this is not a regulated activity. The main service was event work, which the CQC does not regulate. Therefore, these services were not inspected.

The policies, procedures and expectations on staff including completing of patient report forms, administration of medicines, are the same for both the regulated activity and non-regulated activity. Therefore, we used these as evidence for this report.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 5 December 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.

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 issues that the service provider needs to improve:

- There was an incident reporting system but a culture of incident reporting was not embedded in the service. Staff reported incidents verbally, but there was no formal recording of incidents or their severity, or how learning from incidents had been shared.
- There were limited governance arrangements to monitor or evaluate the quality of the service and improve delivery.
- The service did not have a business continuity plan. This meant the provider could not be assured that staff knew what to do in the event of an emergency, such as phone or radio system failure.
- The service did not have a risk register, so they might not have identified, assessed, and mitigated key risks and issues.
- The service did not have an effective system to ensure staff were up to date with competencies necessary to perform their jobs.
- The service did not have an effective system to ensure staff were up to date with their mandatory training. Following the inspection the service sent us a structured mandatory training plan for all staff.
- We found intravenous fluids stored on vehicles outside of recommended safe temperatures. The registered manager removed the fluids immediately from the vehicles and stored them in an appropriate location.

Summary of findings

However, we found the following areas of good practice:

- The registered manager demonstrated a dedication and motivation to improve the service. They spoke openly and honestly about the introduction of new systems and processes being implemented, or in their infancy and needing further development.
- Patient report forms were fully completed and legible in line with guidance from the Joint Royal Colleges Ambulance Liaison Committee clinical practice guidelines. From review, we saw the service had adapted the patient report forms to include additional information, such an additional check for pain.
- Staffing levels and skill mix was reviewed, planned and appropriate to ensure patients received safe care and treatment.
- Emergency equipment was available, maintained, and serviced. Staff assessed and responded appropriately to potential risks to patients.
- Medicines were well managed by the service. We saw there were effective systems to ensure medicines, including controlled drugs, were checked in and out at the beginning of an event.
- The service was aware of national guidance relating to the provision of medical cover at an event. This was reflected in the services policies and procedures. However, we found some policies lacked some of the latest guidance and best practice references.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Amanda Stanford

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		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. As there was only one core service, please see summary of findings below.

Medevent Medical Services Ltd

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to Medevent Medical Services Ltd

Medevent Medical Services Limited is operated by Medevent Medical Services Limited. The service opened in 2006. It is an independent ambulance service in Maidstone, Kent. The service primarily serves the communities of Kent.

The service has had a registered manager in post since 2011. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is managed.

Medevent Medical Services Limited provides non-emergency ambulance medical cover at events, such as music concerts, aviation shows and rugby matches, for both adults and children. However, the service has undertaken three emergency transfers in the last 12 months from events.

Medevent Medical Services Limited fleet consists of three vehicles; however, at the time of inspection one vehicle was off the road. The ambulances were fitted with a stretcher, three seats, and a wheel chair. There are no additional employees at this service. The service employs staff to help at events on a casual contract basis.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in emergency ambulance services.

Catherine Campbell, Head of Hospital Inspection, oversaw the inspection team.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the registered address. We spoke with the registered manager and one registered paramedic. At the time of the inspection, there were no patient transport journeys, so we did not speak to other casual contract staff, patients or review clinical practice. We looked at five patient feedback surveys, which patients had completed before our inspection

There were no special reviews or investigations of the service on going by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in 14 January 2014, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (December 2016 to November 2017)

- In the reporting period December 2017 to November 2017 there were three emergency and urgent care patient journeys undertaken.

The registered manager was the only employed staff for the service. They had access to casual contract staff, all of which helped at events.

Track record on safety:

- No reported never events
- No serious injuries reported
- No formal complaints received

Emergency and urgent care services

Summary of findings

We found the following areas of good practice:

- The registered manager understood of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was meeting the requirements of the act.
- The registered manager demonstrated a dedication and motivation to improve the service. They spoke openly and honestly about the introduction of new systems and processes being implemented, or in their infancy and needing further development.
- Patient report forms were fully completed and legible in line with guidance from the Joint Royal Colleges Ambulance Liaison Committee clinical practice guidelines.
- The service had adapted the patient report forms to include additional information, such an additional check for pain. This meant the service had gone over and above the best practice Joint Royal Colleges Ambulance Liaison Committee clinical practice guidelines to ensure patient comfort and safety.
- The vehicles we inspected were clean, tidy and in good condition. They contained personal protective equipment for staff. The vehicles were up-to-date with servicing, tax, and Ministry of Transport testing.
- Staffing levels and skill mix was reviewed, planned and appropriate to ensure patients received safe care and treatment.
- Emergency equipment was available, maintained, and serviced. Staff assessed and responded appropriately to potential risks to patients.
- Medicines were well managed by the service. We saw there were effective systems to ensure medicines including controlled drugs were checked in and out at the beginning of an event.
- During our inspection, we found the service did not have an effective system in place to ensure staff were up to date with their mandatory training. Following the inspection, the service sent us evidence of a structured plan for mandatory training for all staff. In addition, we received email showing that staff had been written to, and requested that this training was a requirement to work for the service and was expected to be completed, March 2018.
- We found intravenous fluids stored on vehicles outside of recommended safe temperatures. The registered manager removed the fluids immediately from the vehicles and stored them in an appropriate location.

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

- The service was aware of national guidance relating to the provision of medical cover at an event. This was reflected in the services policies and procedures. However, we found some policies lacked some of the latest guidance and best practice references.
- An incident system was in place but a culture of incident reporting was not embedded in the service. Staff reported incidents verbally, but there was no formal recording of incidents or their severity, or how learning from incidents had been shared.
- The service did not have a business continuity plan. This meant the provider could not be assured that staff knew what to do, in the event of an emergency, such as phone or radio system failure.
- The service did not have an effective system in place to identify, mitigate, and control clinical and non-clinical risks. We found the service did not have a risk register in place.
- The service did not have an effective system in place to ensure staff were up to date with competencies necessary to undertake the role they were employed for.
- The registered manager was in the early stages of developing systems and procedures to monitor the safety, quality, and performance of the service against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- The service had a paper-based system for staff to report accidents, incidents and near misses (referred to as incidents for this report). We saw there was an 'Incident Information Report' form for staff to complete in the event of an incident. The form was available in folders on the service vehicles.
- The form included, but was not limited to, the incident date and time, location, names and contact details for those involved. The form was separated into information for accidents to the person, such as any injuries sustained and medical treatment required, or damage to property, such as to the vehicles or equipment.
- At the time of inspection, the service reported no incidents within the reporting period of December 2016 to November 2017. There were no serious incidents reported within this period. Therefore, we were unable to assess the effectiveness of the system.
- However, we briefly spoke with one of the casual contract staff during our inspection, who told us that if he had any concerns and had raised them with the registered manager he received feedback on the outcome. When we asked about how they reported incidents, they told us it was verbally, and not via the incident report form. We informed the registered manager of this at our feedback session at the end of the inspection.
- The service had reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The duty of candour is a regulatory duty that relates to the 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.
- Although the registered manager did not understand the term 'duty of candour', they were able to described the actions they would take if something went wrong and that they would apologise to the patient.
- As incidents were not formally recorded, we were not able to assure ourselves that there had been no incidents since the introduction of the legislation, where the provider had been required to follow the process.

Mandatory training

- At the time of inspection, there was no clear evidence that all staff had undertaken mandatory training. We spoke with the registered manager, who acknowledged this was an ongoing issue with trying to obtain assurance from staff. The registered manager informed us that in order to correct this, they were in contact with an outside provider to ensure staff compliance with mandatory training.
- Following our inspection the registered manager sent the CQC a structured mandatory training plan for all staff. This included, but was not limited to, cleanliness and hygiene, hand hygiene, basic life support, equality and diversity, dementia awareness, fire safety, moving and handling, medicines management, information governance, safeguarding adults (level 2) and safeguarding children (level 3).
- We were also supplied an email that showed that the registered manager had written to all staff and had stated this training was a requirement to work for the service, and gave a clear time line for when this training was expected to be completed, which was March 2018.
- All new staff completed induction training specific to company procedures and equipment, and we saw completed induction records.
- If there was an unexpected or unplanned emergency, we saw records, which showed required staff were appropriately trained to 'drive under blue lights'.

Safeguarding

- The service had up to date 'Child Safeguarding Protection Document' version 1 (dated September 2017) and 'Vulnerable Adults referral policy' version 1 (dated July 2017), with defined responsibilities, basic principles, types of abuse and immediate actions staff should take if abuse was suspected.

Emergency and urgent care services

- There was a system to ensure the registered manager was made aware of any concerns about a patient seen at an event. The registered manager was aware of the process to report a safeguarding concern to both the local authority and the Care Quality Commission (CQC).
- The service reported that no safeguarding concerns had been raised in the reporting period between December 2016 and November 2017.
- The registered manager was the safeguarding lead for both adults and children for the service. We saw they were trained for both safeguarding vulnerable adults and safeguarding children to level three.
- The 'Intercollegiate Document; Safeguarding Children and Young People (2014), says that all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers, should be trained to level two. However, the document goes onto say 'clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns' should be trained to level three. During our inspection, there was no clear evidence that staff had undertaken safeguarding training to an appropriate level. The registered manager acknowledged there was an on going issue of obtaining assurance around casual contract staff compliance with safeguarding training. The registered manager informed us that in order to correct this, they were in contact with an outside provider to ensure staff are up to date with mandatory training.
- Following our inspection, the registered manager sent us confirmation that Safeguarding Adults (level 2) and Safeguarding Children (level 3) training had been purchased and was mandatory for all staff who worked for the service. We also saw the service has given staff a clear timeline in which to complete this training. This meant the service would be assured all staff were up to date with safeguarding training to keep patients safe from abuse and harm.

Cleanliness, infection control, and hygiene

- The service had an up-to-date 'Infection prevention and control document' V1 (dated May 2017). A paper based version of this policy was kept in a folder on the vehicles and at the medical base during an event, and was available to staff.
- The registered manager provided us with evidence of up to date training they had undertaken.
- We saw that alcohol-based hand sanitising gel was available in all vehicles. We did not undertake any patient journeys with staff, during our inspection, and were therefore unable to observe if staff were compliant with hand hygiene. However, we saw the service had a 'Hand hygiene procedure for Medevent Medical Services Limited' V1 (dated May 2017), which outlined when and how staff should clean their hands, for example we saw staff were expected to clean their hands in line with the World Health Organisation ' five moments for hand hygiene. In addition, following inspection, we received confirmation from the service that hand hygiene training package had been purchased and was considered part of their mandatory training.
- Casual contract staff were provided with adequate numbers of uniforms that they washed themselves. There was an expectation that staff would be properly dressed when on duty. This was clearly laid out in the 'operational medical plan' for an event.
- Personal protective equipment, such as disposable gloves in a range of sizes, was readily available for staff to ensure their safety and reduce the risk of cross contamination. All personal protective equipment we checked was within date and stocked on the vehicles we inspected.
- During our inspection, we looked at two vehicles. We found them to be visibly clean and tidy inside. We saw decontamination wipes were readily available for use to clean equipment. We saw there was a vehicle-cleaning log in the ambulance. During our inspection, we looked at the records for one of the vehicles we inspected and saw these had been completed.
- We reviewed three casual contract staff folders and saw that before commencing employment with the service, they had to complete a medical questionnaire. The medical questionnaire included vaccination history,

such as hepatitis B virus and tuberculosis, and history of any communicable diseases such as chicken pox or shingles. This meant the service had procedures to protect staff and patients from preventable illnesses.

- There was a schedule for deep cleaning of all vehicles, which took place every six weeks. A deep clean involves cleaning a vehicle to reduce the presence of certain bacteria. The service cleaned the inside of the vehicles, and then used a 'fogging' machine to ensure a through clean. 'Fogging' is ideally suited for use in healthcare due to its rapid, flexible, and 'residue-free' nature. The use of a 'fogging' machine has extensive, proven biological efficacy against a wide range of environmentally associated pathogens. We looked at the records for one of the vehicles we inspected and saw deep cleans had been completed.
- We found the outside of the vehicles we inspected to be visibly clean. The service took the vehicles to a local car wash for an external clean. The exterior of vehicles should be kept clean, as clean vehicles will help staff keep their hands clean when opening and shutting doors.

Environment and equipment

- The service ran from a residential address and the vehicles were parked on the front driveway.
- The service told us they had three vehicles, two ambulances and one 4x4. However, at the time of our inspection, one of the ambulances was off the road, but the remaining two vehicles were available to us to look at.
- The service used a local garage for mechanical repairs, servicing, and Ministry of Transport testing. Records showed that vehicles were compliant with Ministry of Transport testing and vehicle servicing scheduling. There were also appropriate records of insurance and road tax. Vehicle keys were safely securely stored.
- We saw there were radios and mobile phones available for staff to use during events to communicate with the medical base or the NHS Ambulance service, if required. We saw the radios were checked before and after an event to make sure they were safe to use.
- Disposable single use equipment was stored on both vehicles we looked at. The registered manager refilled the stock. However, we found items that were out of date and we brought this to the attention of the registered manager at the time of the inspection, who removed the out of date equipment immediately.
- We saw there were items such as face masks used for delivery of oxygen, in various sizes, including those meant for children. This meant the service would be able to respond and have the correct equipment available in the event of a patient collapsing and requiring additional support.
- There was a checklist for staff to complete before removing the vehicle from the residential address. The checklists we reviewed confirmed the vehicle met basic safety standards such as functioning lights, windscreen wipers, seat belts, fuel level, warning lights and tyres were of an appropriate safe standard and all identified equipment was available.
- The service used lap belt restraint on stretchers and wheelchair restraints to ensure patients were safe during transit. The ambulance we looked at was not equipped with a child safety harness, and therefore it was not clear how children would be transported safely. The paramedic we briefly spoke with told us they would ask the parents to hold the child on their laps. We reviewed the three patient transfers within the reporting period and saw that none of them related to children.
- The vehicles had access to up to date satellite navigation systems. Due to the small size of the service, the registered manager had recently started to complete an asset register spread sheet for all the equipment within the service. This would be used for all equipment within the vehicles, which was updated as the items were replaced, updated, or changed.
- We saw equipment on board the ambulance was serviced and tested for electrical safety.
- We saw the vehicles had emergency resuscitation equipment on board, such as automated external defibrillators (AED) and portable suction units. We saw that regular checks had been carried out to ensure these were ready for use in an emergency.

Medicines

- The service had an 'Administration of Controlled Drugs Policy' version 1 (dated June 2017).

Emergency and urgent care services

- Controlled drugs were kept securely in suitable double locked cupboards, which were bolted to the wall, and access to them was restricted. We saw that controlled drugs were signed in out of the cupboard using a record book, this included the medicine, amount to be taken out, and amount left, expiry date and signatures of both members of staff. We checked the controlled drugs and found the correct amounts in line with the record book. All were in date. Controlled drugs are a group of medicines that require special storage and recording arrangements due to their potential for misuse.
- We saw medicines were stored securely and handled safely. Medicines were stored in a double locked cabinet, and access to them was controlled. We saw two members of staff, one being the registered manager, signed medicines in and out of the cupboard.
- The keys to both the medicines and controlled drug cupboards were kept in a separate key safe that only the registered manager had access to. The key safe was locked and kept in an alarmed area.
- We saw there was a secure and locked area on the services vehicles where medicine could be safely kept, whilst at an event.
- We found intravenous fluid stored on the vehicles. This fluid should be stored within a specific temperature range to make sure the intravenous fluids remain safe to use. At the time of the inspection, the outside temperature was cooler than the recommended safe range. We bought this to the attention of the registered manager, who removed the fluid immediately to a suitable storage area.
- Staff could administer different medications depending on their role. For example, paramedics worked to the guidelines contained within the Joint Royal Colleges Ambulance Liaison committee and Schedule 17 and Schedule 19 of the Human medicine Act 2012 in relation to the administration of medicines.
- The service held an account with a single supplier for the supply and disposal of medicines. There was a system to make sure that medicines that had been requested were received, this meant the service had safe systems in place to ensure medicines were accounted for.

Records

- If a patient received treatment, staff completed patient report forms. This included patient information such as name, date of birth and past medical history, along with any treatment given and observations. These forms were based on the Joint Royal Colleges Ambulance Liaison Committee clinical practice guidelines. From review, we saw the service had adapted the patient report forms to include additional information, such an additional check for pain. This meant the service had exceeded best practice guidelines to ensure patient comfort and safety.
- Staff completed duplicate paper report forms and gave the top copy of the paperwork to the patient, if not transported to hospital.
- During our inspection, we reviewed the three patient report forms of patients who had been transported to hospital. We found them to be fully completed, and legible. Due to the small sample of patients transported to hospital, we reviewed another four patient report forms of patients who had not been transported to hospital. The records included observations and a record of treatment and sign posting advice for patients if required. We saw from patient report forms that staff routinely recorded assessments and findings. Staff also used diagrams that clearly showed physical assessments and results.
- There was a lockable cupboard on the vehicles where patient report forms were stored securely. We saw records were kept securely in a locked filing cabinet; keys to the filing cabinet were kept in a locked key safe.
- The registered manager undertook regular audits of the patient report forms, and told us they would speak to staff if they found any non-compliance in completion of the paperwork. We looked at the audit for July 2017, during our inspection, and saw that all records that had been included in the audit had been completed fully. This was in line with our review of the patient report forms during our inspection.
- We reviewed three casual staff folders during our inspection and saw one member of staff had completed information governance training. The registered manager told us they had difficulty in obtaining assurance around staff training compliance, and was in the process of buying a package of training for the service. Following our inspection, the registered manager sent us confirmation that information

governance training had been purchased and was mandatory for all staff who work for the service. This meant the service was compliant with the commercial third parties information governance toolkit published by the Department of Health which says, says all staff should have training on information governance requirements.

Assessing and responding to patient risk

- We reviewed seven patient report forms and found assessments were being completed in line with Joint Royal Colleges Ambulance Liaison Committee and Health and Care Professions Council standards.
- We saw from our review of the patient report forms, that a series of observation monitoring was undertaken, such as pulse, blood pressure, and respiratory rate. In addition, we saw in all seven patient record forms we looked at, that a very detailed history was taken, this included the nature of the injury and events leading up to the injury and a past medical history.
- We saw the service used the national early warning score system in line with the National Institute of Health and Care Excellence guidance 51. The national early warning score system is a simple scoring system for physiological measurements, such as blood pressure and pulse and identifies patients at risk of a sudden deterioration in their condition. If a patients national early warning score increased, staff were alerted to the fact and a response would be prompted. The response varied from increasing the frequency of the patient's observations, to urgent review and transfer to hospital.
- We looked at seven national early warning scores during our inspection and found all seven had been completed and scored correctly. This meant this documentation allowed staff to make an assessment to be aware early enough to take preventative action and keep patients safe.

Staffing

- The registered manager was the only employee for the service. The service employed staff on a casual basis, such as paramedics, doctors, and technicians. Therefore, work would only be accepted based on the availability of the correct staff for the event.
- There was a validated staffing tool, called a 'Risk and Resource Assessment Form'. This form was used to decide how much support was required at an event based on the expected number of public attendees. All events had a paramedic in attendance, and some included a doctor. We saw from the 'operational medical plans', that a paramedic always attended every event.
- During our inspection, we looked at three casual contract staff files. We saw a check with Disclosure and Barring Service (DBS), and driving licence check had been carried out prior to staff commencing duties. This meant the provider had taken appropriate steps to protect patients from receiving care and treatment, when staff started employment with the service.
- We saw an up-to-date 'Certificate of Employers Liability Insurance'; this is in line with the Health and Safety Executive requirements of Employers' Liability (Compulsory Insurance) Act 1969.

Anticipated resource and capacity risks

- During our inspection, we did not gather evidence for this as part of the inspection.

Response to major incidents

- The provider was not part of the NHS major incident planning. However, if a request to provide services was made, they tried to meet those demands, the service also told us took part in major incident training. A major incident is any emergency, which requires the implementation of special arrangements by one or all of the emergency services and would generally include the involvement, either directly or indirectly, of large numbers of peoples, for the initial treatment, rescue, and transport of a large number of casualties.
- The service was part of the 'safety advisory group' for the southeast. Safety advisory groups are made up of agencies, such as the Police, and NHS Ambulance trusts and fire service. Their purpose is to look at events taking place in the region, and to fully discuss suitable arrangements that organisers have been made to minimise the risk to public safety, relating to the planning and management of a specific events.
- We saw the service took part in regular table top exercises with event organisers, to ensure a cohesive and appropriate response in the event of a major incident.

Emergency and urgent care services

- The service did not have a business continuity plan, which outlined how they would function in the event of an emergency. The registered manager confirmed there was not a plan, but would look into developing one. This meant the provider could not be assured that staff knew what to do, in the event of an emergency, such as phone or radio system failure.

Are emergency and urgent care services effective?
(for example, treatment is effective)

Evidence-based care and treatment

- The service had a range of policies and protocols in including infection prevention and control, consent, administration of controlled drugs and vulnerable adult referral. The policies we reviewed gave clear instructions for staff on their roles and responsibilities, were dated and version controlled. We saw not all the policies were fully referenced; we informed the registered manager of this at the time of the inspection. However, we saw the policies reflected and included national guidance. For example, we saw the hand hygiene policy included the World Health Organisation, five moments for hand hygiene, which gave clear guidance when staff are expected to clean their hands.
- Medical staff and paramedics assessed patients using The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. Staff also referred to The National Institute for Health and Care Excellence (NICE) guidelines in providing emergency and urgent care.
- The service undertook regular audits of the patient record forms, but did not formally audit patient safety issues such as hand hygiene. The registered manager told us they highlight compliance with Medevent Medical Services Limited policies, which are available for staff whilst on site at an event.

Assessment and planning of care

- Staff followed relevant national and local medical protocols in assessing patients and planning their care for their role, when assessing and providing care for patients. They made effective use of protocols, supporting guidance and pathways in their assessment of patients. For example, we looked at patient report forms for patients treated at the scene, and saw there were various referral pathways such as, advising to visit their general practitioner, or a minor injuries unit.
- We saw assessments of patients, which followed the Joint Royal College's Ambulance Liaison Committee (JRCALC), and Health Care Professions Council (HCPC) standards. There were pathways for assessing and responding to the risk of patients deteriorating.
- We saw staff recorded administration of any medicines on patient report forms. For example, we saw that pain relief medicine was administered to one of the patients who were transferred to hospital. We saw the medicine was recorded as well as a before and after pain score, to establish the effectiveness of the medicine. This meant there was a record of which member of staff administered medicines to which patient and who was accountable for administration.
- Staff were able to contact the registered manager for clinical advice if needed. We spoke with one paramedic during our inspection who confirmed this is the action they would take.

Response times and patient outcomes

- The service did not benchmark itself against other providers. The services' main work was to provide medical cover at private events, and had only completed three patient transfers during the reporting period.
- The service monitored response and turnaround times if a patient was taken to hospital. The service monitored information on patient outcomes, such as treat on scene, use of admission avoidance pathways or advice to attend minor injury units, rather than admit to hospital. The registered told us that they only did one patient journey at a time, so they could then spend as much time as they needed in order to transport the patient safely, and comfortably. The service did not benchmark itself against other providers.
- The registered manager told us they were proud of their treat on scene response, and use of admission avoidance pathways, rather than admit to hospital. This information was discussed with all team members at debrief.

Competent staff

- Staff had the appropriate qualifications and experience for their role within the service. The registered manager was the only employee of the service and qualified paramedic and was on the Health and Care Professions Council register. The casual contract staff were registered paramedics, doctors, and emergency care support workers.
- All new casual contract staff were required to undertake a set induction programme on how to use the equipment that was available on the ambulance, and we saw completed induction records.
- We looked at three staff folders during our inspection and saw prior to starting their role in the service they were required to provide evidence of their qualifications certificates, and driving licence. They were also asked to complete a medical questionnaire to ensure they were fit to work. In addition, the service checked any register that a healthcare professional may be on, for example, Health Care Professions Council. We saw the registered manager took separate checks to ensure their membership remained current.
- There was a system for on going checks for driver competence. Driving licences were checked on a yearly basis. We reviewed three staff files for casual contract staff, which showed that all had a driving licence check in the 12 months prior to our inspection.
- The registered manager attended operational duties during events with staff to check competencies and ensure they were delivering a good standard of care. However, the service did not complete formal competency checks for the registered professional they employed via the casual contract. The service told us that it was their own responsibility to keep up to date with their skills and knowledge as part of their clinical registration.
- We saw each member of staff group had a job description, which outlined the job's roles and responsibilities. This meant the service ensured staff had clear guidelines and expectations of the role they have been employed to do within the service.

Coordination with other providers

- We saw the service had admission avoidance pathways. Patients seen and treated at the scene were advised to seek further medical attention from their general practitioner, 111, or other service if symptoms persisted. We saw the service had a series of leaflets they would give to patients, for example 'head injury leaflet, which included tips and general advice, symptoms to be aware of, and advice to seek medical attention. Patients were taken to the emergency department for continuation of their care if this was required. Three patients required transfer to hospital during the reporting period.

Multi-disciplinary working

- During our inspection, we did not see any patient journeys or interactions between staff. Therefore, we did not gather evidence for this as part of the inspection.

Access to information

- Each vehicle was fitted with satellite navigation and tracking systems. Staff had radios for communications between the medical base, and each other during events. In addition, staff had mobile phones if they needed to communicate with the NHS Ambulance service.
- Staff had access to policies and standard operating procedures, which were located at the providers address and at the medical base during events. In addition, staff had access to the 'operational medical plan' for the event. This included, but was not limited to estimated crowd numbers, and risks associated with the event, such as uneven ground, weather, potential drug misuse, and sanitation risks.
- Staff obtained information about patients at presentation; this may be in the medical base or at another location if the patient was unable to get there. Staff completed a patient report form, which included all details required to treat the patients, including, but not limited to, the patients name, and date of birth, and past medical history. In addition, there was a section, which could be completed if a patient had a do not attempt cardiopulmonary resuscitation (DNACPR) order. The registered manager confirmed this section would only be completed if the staff saw the DNACPR order, and not just on being informed verbally.
- A copy of the patient record form was provided to the hospital if a patient required transfer, and the original was retained by the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had 'Principles of Mental Capacity Act in relation to healthcare treatment' Version 1 (dated January 2017), for staff to refer to. The policy included clear guidance that included the Mental Capacity Act 2005 legislation and set out procedures that staff should follow if a person lacked capacity.
- The 'Consent Protocol' version 1 (dated October 2017), outlined the principles for obtaining consent from patients, including those under 18. The registered manager told us that verbal consent was obtained prior to treatment, such as prior to fastening their seatbelts. However, as we were unable to witness any patient interactions on the day of inspection we were unable to corroborate this.

Are emergency and urgent care services caring?

Compassionate care

- Although not all patients that provided feedback were transported, their comments showed staff provided compassionate care. We reviewed five comment cards. Patients wrote that staff were, "Polite and welcoming [with a] lovely manner". Another patient wrote they were, "Very, very well treated", describing staff as, "Wonderful", "Friendly" and "Very helpful". All five patients said they were very satisfied with the overall experience.
- Staff ensured both dignity and privacy for patients in public places. The registered manager and the paramedic told us they took patients to the ambulance for treatment. Where this was not immediately possible, staff used partitions to examine their patients.
- The service had a 'Chaperone policy and protocol' version 1 (dated July 2017). We saw from records that we looked at staff made patients feel as comfortable as possible during intimate care. Staff completed intimate assessments, in private, away from the public. The registered manager told us they still tried, wherever possible, to make sure female staff carried out intimate assessments for female patients.
- Although the service had not transported children in the previous year, they did describe a caring and respectful attitude to relatives and carers of children. The registered manager told us when tending to children they always considered parents' views and respected their wishes. Staff would not discharge a child from their care unless the parent felt confident they were back to their normal self.

Understanding and involvement of patients and those close to them

- We saw from our review of the patient report forms that staff made thorough assessments of their patients and involved them in their care. We saw that staff documented discussing options with patients; this shows patients were involved in their care.
- Staff respected patient's decisions. The registered manager told us about caring for a patient who had fallen and had significant pain in their hip. The patient declined further pain relief because they already took a lot of medication daily and did not like the idea of taking more. The crew respected this and transported the patient to hospital while exploring other ways to manage the pain. We saw this example detailed in patient records.
- Staff used a variety of tools to understand and support their patient. The service ensured staff had access to an internet connection.

Emotional support

- Staff supported patients during distressing times. The registered manager told us about an example when staff cared for a patient who became distressed and anxious with their surroundings. The patient sat down on the floor outside in the cold and refused to move. The paramedic sat on the cold floor next to the patient and gently encouraged them to get into the warm ambulance. While the patient resisted initially, the paramedic gained their trust and transported them safely.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The service provided private event first aid medical cover for local and national events within the area. The

service used recognised 'risk and resource' assessment criteria. The assessment included the type of event (water sport, aviation event), venue of event (indoor, outdoor), standing or seated, audience and crowd mix, expected attendance numbers, and proximity to an emergency department. This information generated a risk score, which will then made recommended minimum resource requirement. This meant the service ensured they had the right resources in order to meet the needs of the people it provided a service for.

- The service worked with the event organisers and the safety advisory group to identify potential risks an event generated, and the management of such risk.
- The registered manager completed risk assessments prior staff being sent to an event. This included the type of event, potential hazards, estimated crowd size, and time of year, this would be used to determine the amount of staff required to undertake the event safely. This meant the service assessed risk and made sure they had the correct skill mix of staff and correct resources in place to keep patients safe.
- The service had a 4x4 vehicle to be able to get to some of the casualties that were in difficult places for an ambulance to access such as on uneven muddy terrain.
- We also saw a 'post event debrief', was held to review the service provision at events. This included number of casualties treated, types of injuries or medical conditions and suggestions for areas of improvement at future events. We reviewed two post event debrief and saw sections included, numbers of staff needed, and facilities at the medical base such as improved lighting.

Meeting people's individual needs

- The service only transferred one patient at a time meaning that the service could be tailored to meet the patient's needs.
- We saw from our review of the patient report forms staff responded in a timely and appropriate way to patients experiencing physical pain. We saw evidence in records that staff assessed pain both twice before pain relief and twice after.
- Patients who had communication difficulties or whose first language was not English, we were told the service had two picture books, which were used to aid communication. In addition, the service had a handheld personal tablet, which was used to look up words, and phrases to help communicate with the patient.
- The paramedic we spoke with told us about a time they cared for a patient who did not speak English. They communicated through drawing pictures until they could understand their patient's needs. This meant staff could provide care, support and advice the patient understood.
- Ambulances had different points of entry, including sliding doors, steps, and tailgates so that people who were ambulant or in wheelchairs could enter safely.

Access and flow

- The service predominately provided initial assessments and treatment of people requiring first aid during events. Emergency treatment or transfers were predominantly provided by the local NHS ambulance trust, however between December 2016 and November 2017, the service had transported three patients to local emergency departments.
- Anyone requiring first aid at an event would be seen on a first come, first seen basis following a self-referral. However, staff would assess each patient individually and determine the priority of the patients' treatment based on the severity of their condition.
- There was an up-to-date website, which gave full contact details and the details of work undertaken by the service.
- Due to the size of the service, there were limited facilities for multiple bookings. The registered manager agreed all bookings for events in advance and allocated adequate time.

Learning from complaints and concerns

- The 'Concerns and Complaints Procedure' version 1 (dated July 2017), outlined the process for making a complaint and how it would be handled.
- The registered manager had overall responsibility for responding to all complaints. All complaints were acknowledged with either an email or telephone call

within three working days. The aim was to have the complaint reviewed and completed within 25 working days. The services website did not detail the complaints process.

- There were comment cards available on the ambulances and at the medical base during events.
- From December 2016 to November 2017, the service had not received any complaints.
- The CQC received no enquiries relating to this service in the last 12 months.

Are emergency and urgent care services well-led?

Leadership/ culture of service

- The registered manager was the owner of the business and the only employee of the company. This meant the leadership structure was flat, with the registered manager working alongside any casual contracted staff.
- The registered manager was a qualified paramedic and was on the Health and Care Professions Council register. The registered manager was fully aware of the scope and limitations of the service, based on the size, numbers and type of staff, and type of work booked for.
- During our inspection, we spoke very briefly with one of the casual contracted staff who spoke positively about the leadership of the service, and they were proud to work for the service. The registered manager was clearly passionate about the service they provided and was dedicated to the business.
- The service had a CQC registered manager in post to carry out the day-to-day running of the service. Health and Social Care Act 2008 requires the CQC to impose a registered manager condition on organisations that requires them to have one or more registered managers for the regulated activities they are carrying on. This meant Medevent Medical Services Limited complied with their registration conditions.
- We found the registered manager understood the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014, and there was evidence in place to demonstrate how the provider was meeting the requirements of the act. For example, we saw in the safeguarding policies, the service recognised the need to notify the CQC in the event of a safeguarding concern. However, they could not demonstrate they had full oversight for the service in terms of risk, for example, as there was no risk register in place and the incident reporting system was not embedded with staff.

Vision and strategy for this this core service

- Medevent Medical Services limited had a clear mission statement and focus "to provide compassionate, comprehensive, event medical healthcare that exceeds customers and patients expectations". There was a set of core values that underpinned the mission statements; these were respect, integrity, accountability, compassionate care, and stewardship.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- Due to the size of the service, there were limited governance frameworks to support the delivery of high quality care.
- The registered manager was in the early stages of developing systems and procedures to monitor the safety, quality, and performance of the service against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our inspection, the registered manager was open and honest that the governance system was in the early stages of development.
- We saw the service had policies and procedures for staff to follow to keep patients safe. We saw the policies were dated and signed by the registered manager and version controlled. This meant that staff could be confident they were referring to the most up to date policy for the service.
- The service was in the process of completing an asset register for all their equipment and vehicles. The registered manager told us he did not have a risk register at the present, but once the asset register was completed this would be developed. We saw the service undertook comprehensive risk assessments prior to an event. These included the event type, estimated crowd size, review of event past history, time of year, distance to the nearest hospital with an emergency department and onsite facilities. This allowed the service to

determine the level of risk and the resources required in order to provide the correct level of medical first aid safely. The registered manager told us they would not take on an event, unless they were fully able to resource correctly and safely.

Public and staff engagement (local and service level if this is the main core service)

- We saw the service had a website with accurate and current information for the public about the services they provides and contact details.
- The registered manager told us they do not hold formal meetings with their casual contract staff, but talk to them informally when working alongside them. In addition, they sought feedback form them during the debrief staff following an event.
- We saw patients were asked to complete a satisfaction survey. During our inspection we looked at patient feedback forms and saw in out of patients responded with their overall all experience of the service, and one responding .

Innovation, improvement, and sustainability (local and service level if this is the main core service)

- We asked the registered manager about any areas of development or improvement they were proud of. They told us they were proud of the work they are doing with the civil aviation industry when undertaking an event at an air show.
- The service demonstrated a willingness to develop and improve the service provided, and took prompt action to rectify issues identified at the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve
Action the provider SHOULD take to improve

- The provider should ensure there are effective governance arrangements to evaluate the quality of the service
- The provider should ensure all staff receive mandatory training to enable them to effectively carry out their roles, and that this is regularly monitored.
- The provider should consider how it asses, records and mitigates to patients, staff and others.
- The provider should consider a structured system for carrying out routine audits to confirm safe practice and adherence to policy.
- The provider should consider ways that would give assurance that all incidents are formally reported in a timely manner, investigated and learning shared.
- The provider should consider how it assures itself that staff had the competencies necessary to undertake their jobs.
- The provider should review their business continuity plan.
- The provider should ensure that all staff are aware of the duty of candour regulations.
- The provider should ensure vehicles are equipped child safety equipment.