

Savoy Ventures Limited

Savoy Ventures

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Savoy Ventures is operated by Savoy Ventures Limited. They are an independent medical transport provider based in Stone, Kent. The service provides patient transport, and high dependency transfers.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection 31 October 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.

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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 of good practice:

- There was a system to ensure all incidents were recorded and monitored, with learning and outcomes shared with staff.
- Staff followed infection prevention and control procedures to reduce the spread of infection to patients. We found all vehicles were in good condition, well maintained and visibly clean and tidy.
- Staff focused on providing person centred care and enjoyed working for the company.
- Staff were caring, helpful, and respectful to patients.
- The staff planned journeys considering patient safety using information provided at the time of booking.
- Records were well maintained. Patient records were held securely and included appropriate information. The service regularly audited these.
- The service used its vehicles and resources effectively to meet patients' needs.
- The service had a system for handling, managing and monitoring complaints and concerns.
- Staff we spoke with had a good understanding of duty of candour.
- The service encouraged feedback from patients through satisfaction surveys.
- The service encouraged feedback from staff through staff engagement forums.

Summary of findings

- The service had effective processes for recruitment, recording disclosure and barring service checks, staff training, and competence.
- There was a positive culture within the organisation and staff told us leaders were approachable.
- There was a strong multi-disciplinary team approach across the service. We observed good collaborative working and communication from all members of the team.

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

- Although staff understood what their safeguarding responsibilities were and what constituted as abuse, we identified that staff were not trained to the correct level for safeguarding children. However, subsequent to our inspection, the service provided evidence they had since put the correct training in place.
- There was a risk register in place at the service, which was in its infancy and we had no assurances these were being tracked and managed to reduce risks.
- There was limited provision on ambulance vehicles to support people who were unable to communicate verbally or for whom English was not their first language.
- There was no information regarding how to make a complaint directly to the service on the vehicles.
- Staff were unclear on who would replace a sharps box once full, and where these would be kept until collected. In addition to this, the sharps boxes we looked at were not labelled correctly, in line with guidance.
- We found clinical waste that was not labelled in line with guidance.
- Although the defibrillator had a user test undertaken daily, the therapy cable was not checked daily, in line with manufacturer's guidance.
- There were no communication aids available for staff to use to support patients who were unable to speak due to their medical condition or who had complex needs.
- At the time of the inspection, there were limited formal processes to audit clinical practice of staff to monitor adherence to national guidelines and local policies.
- Following this inspection, we told the provider that it should take some actions to comply with the regulations, even though a regulation had not been breached, to help the service improve.

Professor Ted Baker
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?

We do not currently have a legal duty to rate independent ambulance services. However, we found the following areas of good practice:

- Patients were protected from the risk of abuse and avoidable harm. Staff knew how to escalate key risks that could affect patient safety. For example, after reporting a safeguarding concern, we saw evidence where the service had checked with the NHS trust to ensure they had raised the safeguarding alert.
- There were effective systems in place to report incidents. Incidents were monitored and reviewed, learning was shared with staff.
- Staff followed infection prevention and control procedures to reduce the spread of infection to patients.
- There were effective systems in place to ensure vehicles were well maintained to keep patients safe. All vehicles had an up to date MOT and tax.
- Patient feedback was consistently positive.
- Staff worked flexibly to meet the demands of the service.
- All staff were passionate about their roles and providing excellent care for patients.

However:

- Clinical waste was not disposed of in line with guidance.
- The risk register was in its infancy and therefore we had no assurances that risks were being tracked and managed, with plans to mitigate risks.
- There was no formal process to access interpreting services for patients whose first language was not English.
- There was a lack of information on the vehicles on how to make a complaint directly to the service.

Summary of findings

- Not all staff were trained to the correct level of safeguarding children training.
 - Not all sharps bins were labelled in line with guidance and staff were unclear who was responsible for replacing them once full.
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Savoy Ventures

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Background to Savoy Ventures

Savoy Ventures is operated by Savoy Ventures Limited. The service opened in 2007. It is an independent ambulance service in Stone, Kent. The service primarily serves the communities of the Kent and London area.

The service has had a registered manager in post since 2011.

Savoy Ventures Limited provides patient transport services and high dependency transport services as a subcontractor to two main contractors (identified as NHS trust in this report).

The journey types of patient transport included outpatient appointments, admissions and discharges

from hospital, hospital to hospital transfers, high dependency transfers and patients requiring treatment such as renal dialysis. This included transporting both adults and those under the age of 18.

Savoy Ventures Limited's fleet consisted of 119 vehicles, including high dependency ambulances, patient transport ambulances, cars, off road transport, and eight vehicles that could be used for bariatric patients. The service employed 72 staff, which included senior managers, administration, fleet staff, patient booking staff and high dependency (HDU), staff and patient transport drivers. The service also had 135 self-employed staff. The service provides cover seven days a week for its patient transport service.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, two CQC inspectors, and two specialist advisors with expertise in emergency ambulance services and non-emergency patient transport services.

The inspection team was overseen by Elizabeth Kershaw, Inspection Manager.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Savoy Ventures Limited is based in Stone, Kent. They are an independent ambulance service, which provides non-emergency patient transport for two NHS trusts.

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

During the inspection, we visited the base, located in Stone, Kent. We spoke with 12 members of staff including, directors, booking and fleet staff, a paramedic, and patient transport drivers. We spoke with two patients. We also reviewed 35 patient feedback surveys, which patients had completed before our inspection.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service was last inspected in September 2013 and was found to be compliant with the five outcomes inspected at that time. There have been no previous requirement notices or enforcement actions associated with the service.

We inspected this service using our comprehensive inspection methodology.

Activity (April 2017 to September 2017)

- In the reporting period, there were 102,029 non-emergency patient transport journeys, undertaken.
- In the reporting period, there were 674 high dependency patient transport journeys undertaken.

Track record on safety

- The service had reported no never events in the reporting period (October 2016 to September 2017)
- The service had reported 193 Incidents between October 2016 and September 2017.
- No serious injuries were sustained by patients in the reporting period (October 2016 to September 2017)
- Between October 2016 to September 2017, the service received 273 complaints, 65 (24%), were received directly to the service and the remaining 208 were received via the NHS trust Patient Advice and Liaison service, the service was contracted to work for.

Patient transport services (PTS)

Summary of findings

Are patient transport services safe?

Incidents

- Staff followed the 'Learning from untoward incidents, complaints and reporting policy' issue1 (dated July 2017), which included, but was not limited to, responsibilities, investigations, analysis, improvements and communication of learning points.
- We saw the service kept an incidents log, which included the date and time of the incident, incident details and comments and recommendations. We also saw the log separated incidents into antisocial behaviour, equipment fault/damage, patient ill health, patient injury, security (damage/loss/theft), vehicle damage/accident, safeguarding, driver injury, manual handling, passenger injury, other, and near misses. This meant the service could assess or analyse incidents to identify trends or themes, or areas for improvement.
- Between October 2016 and September 2017, the service report 193 incidents. The majority of incidents reported were for antisocial behaviour (45) and patient ill health (39) followed by near misses (30) and patient injury (30). The least were related to equipment fault/damage (4), security (3), driver injury (2), manual handling (2), and passenger injury (1). The incident reporting rate was variable throughout the year.
- During our inspection we looked at 20 incidents, we saw there was a clear description of each incident, who was involved and who reported it. We saw a person was designated to investigate, and actions taken. There were email attachments, which showed any follow up, and actions that had been completed.
- Staff told us they were encouraged to report incidents and they were confident about reporting issues and raising concerns. Staff were able to clearly describe the process for reporting incidents.
- Staff were aware of the type of incidents they needed to escalate and report. Staff also said there was a no-blame culture for reporting incidents. This meant the service could be confident all incidents including 'low risk' or near 'misses' were reported.
- The duty of candour is a regulatory duty that relates to the openness and transparency and requires providers

Patient transport services (PTS)

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 not all staff understood the term duty of candour, all staff were able to describe the actions they would take if something went wrong and that they would apologise to the patient. We also saw the duty of candour was included in the quality and governance section of the service's website. There had been no incidents since the introduction of the legislation where the provider had been required to follow the process.

Cleanliness, infection control, and hygiene

- The service had effective systems to ensure the cleanliness of equipment to maintain patients' safety and protect them from healthcare associated infections. This included pre and post-use cleaning regimes and random quality control checks, random swab testing, to ensure effectiveness of cleaning.
- During our inspection, we looked at five vehicles, including three ambulances and two cars. We found them to be visibly clean and tidy inside. We saw alcohol-based hand sanitising gel was available in all vehicles. We saw staff using the gel correctly. This was in line with National Institute for Health and Social Care Excellence (NICE) quality standard (QS) 61, statement three, which says people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.
- We looked at 35 patient feedback forms during our inspection. All responses to the question 'was the vehicle clean and tidy?' were 'yes'.
- All staff wore visibly clean uniforms and were observed to be bare below the elbow, which was in line with the service policy.
- We found the outside of all the vehicles we inspected to be visibly clean. The service provided evidence that they 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.
- Personal protective equipment (PPE), such as gloves and aprons, were available on each ambulance. We also saw that vehicles had a spill kit in place to manage any small spillages and reduce the infection and hygiene risk to other patients.
- Staff employed by the service undertook the deep cleaning of vehicles. We saw the service had a schedule of regular deep cleaning in place, which took place every 42 days, or sooner if a vehicle had been used to transport a patient with a known infection, or became contaminated with body fluids (such as urine or vomit). There was a clearly defined process for deep cleaning and how this would be done and what products to use. A deep clean involves cleaning a vehicle to reduce the presence of certain bacteria.
- We spoke with staff who undertook the deep cleaning process and were able to describe the process, including what products they would use and what PPE needed to be worn to protect themselves. We saw there was a 'Scheduled deep clean report / checklist', which staff completed for each deep clean. Additionally, we saw the service had introduced a 'swab test', after the deep cleaning process to confirm the clean had been effective.
- We reviewed the deep cleaning records for 87 vehicles, which showed that two had exceeded the 42-day deep cleaning process. One vehicle was at 49 days, and had been taken out of service, the second was at 44 days, and was scheduled to be deep cleaned 2 November 2017. There were another 15 vehicles, which were between 32 and 40 days post deep clean, all had scheduled dates for a clean. The remaining 70 vehicles were within date, between three to 29 days post deep clean.
- In the event of a significant contamination, a deep clean could be undertaken at short notice. The vehicle would be taken off the road whilst the deep clean took place.
- Staff reported they would be made aware of specific infection risks prior to transfer.
- Staff we spoke with told us all equipment should be cleaned between patients, and at the end of a shift. We saw there were 'cleaning standards for ambulances',

Patient transport services (PTS)

which outlined what needed to be cleaned, how often and with what. During our inspection, we saw staff cleaning equipment between patients, in line with the cleaning standards.

- The service, told us they produced minimal clinical waste, but did have a service level agreement with a contractor registered for disposal of healthcare waste, which we saw evidence of. Each vehicle had yellow bags for the safe disposal of clinical waste. Staff told us primarily clinical waste would be disposed of at hospitals throughout the day.
- There was a small bulk storage bin for clinical waste, which was locked and kept in the garage away from public access. However, we saw that clinical waste bags were not closed or labelled to indicate their origin. plastic tie closures should be used for healthcare waste bags; clearly labelled/tagged to identify them as the producer. We informed the management team of our findings when we fedback. Following the inspection, the provider submitted a 'Clinical Waste Management Procedure' to us, which showed the new procedure for the disposal of waste.
- We saw sharps bins were available on vehicles. We saw they were assembled correctly and not overfull; however, they were not signed and dated. This is not in line with HTM 07-01, which says 'sharps receptacles used during the course of ambulance/patient transport services should be correctly assembled, labelled, dated, and signed as appropriate'. In addition, staff were not aware of the process they would take to dispose of them. They were unclear who was responsible for removing them once full, and where they would take them. We informed the management team of our findings when we fedback to them at the end of the inspection. Following the inspection the provider submitted a 'Safe handling of sharps policy' issue 1 (dated November 2017), which included, but not limited to, ensuring sharps boxes were correctly labelled and the correct disposal.
- Infection control training was part of the 'Ambulance Care Skills' course, we saw 100% of staff had completed this course.
- Although the service did not have a formal programme for auditing against infection prevention and control standards, we saw that site supervisors undertook a

random visual observation of crews undertaking procedures such as cleaning equipment. Staff told us if they had not been compliant with standards they were informed at the time. In addition, they undertook random swab testing, to ensure the effectiveness of cleaning, the result, along with date and time are photographed and sent to the head office.

Environment and equipment

- The ambulance head office provided ambulance and car parking facilities, booking offices, management and administration offices, boardroom, chapel and facilities, such as a staff kitchen for managers and staff.
- There was also a training room, which was set up as a home environment and included a bed and kitchen. This was to facilitate teaching emergency procedures in an environment staff were likely to encounter.
- The service operated 119 vehicles, however they were not all kept on site overnight as some drivers took them to their home address. We inspected five vehicles during our inspection, found that all were in good condition, and well maintained.
- Staff completed a checklist when they were allocated a vehicle. The checklist 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. If the service was transporting children, they had child belt restraints and other child safety equipment, for example, car seat.
- Staff had access to a personal digital assistant (PDA) device while on shift. All of the vehicles were equipped with a tracking device. This meant the provider could locate the vehicles and could monitor driving activities in real-time, such as driving speeds, arrival and departure times, and routes travelled.
- In addition to this, there was a standard equipment list on each vehicle, therefore, it was possible for staff to check and identify missing items. For example, disinfectant spray, gloves, urine and vomit bowls and spillage kits, we saw all cupboards were labelled with the equipment or consumables, which were in it. This

Patient transport services (PTS)

meant staff could be confident all vehicles were set out in the same way, including the layout of equipment and consumables, and they would be able to locate items in the event of an emergency.

- Vehicle servicing was up-to-date with effective processes in place to ensure they were well maintained. We saw records for vehicle servicing, maintenance and Ministry of Transport (MOT) testing were in place. We saw mileage was recorded on various documentation, such as deep clean forms, which allowed the service to monitor the mileage and know when a service may be due. The information was recorded on the vehicle master and fleet master spreadsheet. The fleet department would produce a list each month of all vehicles that required either a service or MOT the following month. This meant the service had effective systems in place to ensure their vehicles were safe for patients to travel in.
- Patient transport vehicles carried a first aid kit in the event of an emergency. Vehicles used for high dependency 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. However, on the AED we saw only a 'user' test was undertaken daily but the therapy cable was not checked in line with manufacturer's guidelines. We informed the management team of our findings when we fed back to them at the end of the inspection. Following the inspection the provider submitted evidence that this was now part of the daily AED checks.

Medicines

- There was a 'Medicine Management Policy' issue 2 (dated October 2017), for staff to follow. The policy included but was not limited to, ordering, storing, and disposal of medicines, reporting losses and prescribing of medicines.
- The patient transport service did not carry medicines, with the exception of medical gases. Due to the nature of patient transport services carried out this was not required.
- Medical gases were carried on each ambulance vehicle. We found that oxygen cylinders were mainly secured safely and were in date. However, we observed that in one of the three patient transport ambulances we

inspected oxygen was not strapped down. This meant there was a risk that if there was a collision, the oxygen cylinder could fall onto an ambulance occupant and injure them.

- The high dependency service carried medicines, which were stored in a secure cupboard at the station. The cupboards were locked, with restricted access and were bolted to the wall. We saw staff had to sign the medicine packs in and out of the room.
- Medicine packs were carried on the two high dependency vehicles, which were mainly crewed, by two technicians and when required, by a technician and a paramedic. They were used to transport patients with more complex needs, who may have required support from trained staff during their journey.
- There was a tagging system in use for medicine packs. We checked the medicine pack and all medicines were in date. Medicine bag tags were kept in a secure location. This meant bags could not be tampered with and only authorised staff could access the bags.
- We saw staff recorded any medicines given on the patient report forms. This meant there was a record of which member of staff administered medicines to which patient and who was accountable for administration.
- The service did not store controlled drugs on site. A paramedic employed by the service had a limited supply of controlled drugs, which were stored under responsibility of the paramedic for which they were solely responsible. This was in line with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and Medicines and Healthcare Products Regulatory Agency (MHRA) guidance: Rules for the sale, supply, and administration of medicines for specific healthcare professionals, January 2014.
- The service held an account with the local pharmacy for the supply and disposal of medicines.

Records

- Information about the patients' health and circumstances was collected during the booking process. For example, any information about access to the patient's property, mobility, illness, such as diabetes, and if an escort was accompanying the patient. In addition to this, staff would contact the patient between

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9am and 7pm, the day before transport, to confirm the information was correct. If a booking were received after this time, that call would be prioritised, for the following day.

- Staff received their work via a secure 'app' on a personal digital assistant (PDA) device, the day before. This included appointment times, addresses and patient specific information, such as; mobility, access to property, medical conditions, and if an escort was accompanying the patient.
- The service kept a central electronic record for all patient journeys. This included relevant information about the patient, including their medical condition, contact details, and mobility issues. Staff told us; sometimes information about the patients' medical condition could be left off the booking form, during the booking process and if staff noticed this they would contact their trust and request the booking be reviewed. For example, if the patient was living with dementia, they would contact the trust and request the patient had an escort, if applicable. This meant the service had checks in place to maintain patient safety.
- During our inspection, we looked at the central electronic record and saw the records were fully completed. In addition, we saw booking staff checking the electronic record when booking for a patient they had transported before, to ensure they had all the correct information to safely transport the patient.
- Staff completed patient report forms (PRFs), based on the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) clinical practice guidelines, for all high dependency transfers. Completed PRFs were kept in a locked metal container at the station. This meant confidentiality was maintained and records could be reviewed retrospectively if necessary. However, we noticed the metal container was not secured to the wall. During our inspection, we reviewed five PRF; all were fully completed and legible.
- Staff were alerted at the time of booking or by hospital staff if a patient they were transporting had a 'do not attempt cardiopulmonary resuscitation' (DNACPR). Staff told us they used to request an original copy of DNACPR form prior to transportation. If they could not have the

original, they would ask to view it and contact 'control' who would document this on the central system. However, staff told us they had been told they could now accept a photocopy.

- Information Governance training was part of the 'Ambulance Care Skills' course, we saw 100% of staff had completed this course. This meant the service was compliant with the commercial third parties information governance toolkit published by the Department of Health, which says, all staff should have training on information governance requirements.

Safeguarding

- The service had a 'Safeguarding policy' issue 4 (dated October 2017), which included, but was not limited to, general principles, specific issues relating to safeguarding, and suspected abuse of vulnerable adults.
- From a review of the incident log, there were 10 safeguarding incident reports between October 2016 and September 2017. These included concerns over patients' homes, comments by relatives or carers and inappropriate behaviour of other patients.
- During inspection, we reviewed seven of the referrals made. We saw all referrals were made in line with the service's policy. However, there had been no safeguarding concerns reported to CQC since July 2013. The Care Quality Commission (Registration) Regulations 2009 require providers to notify CQC of any allegation or incident of abuse relating to patients using the service. This had not been done for any of the recorded incidents. We raised this at the time of inspection. Managers told us they had not been doing this as the trust they worked with informed them the safeguarding alert would be raised through their system. We saw evidence where the service checked with the NHS trust to ensure they had raised the safeguarding alert. This meant the service ensured any concerns about safeguarding were raised appropriately.
- All staff we spoke with had an understanding of safeguarding and when they would report an incident. Staff we spoke with knew the Quality Assurance manager was the lead for safeguarding, and could explain the actions they would take if they had a safeguarding concern; this was in line with the policy.

Patient transport services (PTS)

- All safeguarding concerns would be recorded on the electronic incident reporting system and we saw this was happening.
- We saw good levels of safeguarding vulnerable adults training among all staff groups. Data supplied to us showed that in the reporting period, 84% of patient transport staff (PTS), 71% of PTS owner-drivers, and 100% of office based staff and high dependency staff (HDU), had completed this training. Owner-drivers are staff who use their own vehicle to transport patients.
- During inspection, the service told us 0.71% (1412) of their patient journeys related to children. Data supplied to us showed 63% of PTS, 68% of PTS owner-drivers, 90% of office based staff and 100% of HDU staff had completed safeguarding vulnerable children training. The service told us they are aiming for all staff groups to be 90% to 100%, by the end of November 2017.

Mandatory training

- Mandatory training covered a range of topics including, but not limited to, safeguarding vulnerable adults, safeguarding children, data protection, equality and diversity, patient customer service and health and safety in the work place. In addition, staff undertook patient centred moving and handling, bariatric awareness and ambulance care skill, which included infection prevention and control training.
- The registered manager was able to review records to see the training staff had completed and training due for renewal.
- Staff completed a mixture of face-to-face and e-learning training as part of their induction process, upon beginning employment with the service.
- Staff were trained during their induction to provide the skills and knowledge required for their role.
- Information provided to us during the inspection showed that 100% of required staff had completed customer service, first aid at work, oxygen therapy, adult cardiopulmonary resuscitation (CPR) and automated external defibrillators (AED) training, and patient centred moving and handling, bariatric awareness and ambulance care skills. The remaining mandatory average training compliance for all staff groups ranged

between, 70% for safeguarding vulnerable children training and 90% for 'Barbara's Story', an awareness module about how it feels for a patient with dementia to be in unfamiliar surroundings.

Assessing and responding to patient risk

- Information about patients' needs was collected at point of booking and communicated to staff on their personal hand held electronic device. We observed staff recording details of risk factors when making a booking for transport.
- For high dependency transfers, assessments for patients were carried out using a recognised model based on the Joint Royal Colleges Ambulance Liaison Committee Patient Assessment Model 2016. Documentation assisted staff in undertaking a rapid assessment and indicating when a patient was deteriorating. The patient forms we reviewed were fully completed and base line observations, were well documented.
- High dependency staff, which transferred patients, followed medical protocols in assessing patients and planning their care. Records we looked at showed they were following the assessment process. We saw a series of monitoring observations such as blood pressure, pulse, and respiration.
- All patient transport staff were trained to First Aid at Work level 3 to enable them to provide emergency first aid, which included cardio-pulmonary resuscitation.
- Not all staff we spoke with were clear on the escalation process in the event of a patient becoming unwell during a journey. Staff told us they would contact 'control' who would escalate or advise as appropriate. For any clinical emergency, staff escalated using the 999 facility, and then would inform 'control'. We informed the management team of our findings when we fed back to them at the end of the inspection. The management team confirmed this was the correct process for staff to follow. Following the inspection the provider submitted an 'Escalation process' issue 1 (dated October 2017), which detailed both PTS and HDU escalation process.
- On high dependency transfers, we saw there was appropriate equipment on board ambulance vehicles to provide monitoring and assessment of patients. For example, patients could have oxygen saturations, and non-invasive blood pressure checks.

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- Staff we spoke with confirmed the process they would follow if their vehicle was involved in an accident or broke down. Staff told us they would ensure the immediate needs of any patient on board the vehicle were taken care of and then inform control. We saw evidence of this on the incident log. In addition to this, we saw the service provided high visibility jackets for staff.
- We were told that the service did not transfer patients who were detained under the Mental Health Act. However, the service did tell us they would transport a patient who had a history of violence or aggression.
- Staff we spoke with were clear on the protocols they would follow to meet the support needs of patients who presented with challenging behaviour. For example, staff told us they would escalate to the management team. When we spoke with the chief executive, they confirmed they had spoken with the commissioning NHS trust, about a patient who had challenging behaviour. They told us the NHS trust had spoken with the patient. If the patient continued to be abusive or aggressive, they would no longer provide a service for that patient.

Staffing

- Staffing for the service was made up of a mixture of employed and self-employed staff.
- There were 72 employed staff, which included senior managers, administration, fleet high dependency (HDU), patient booking staff and patient transport drivers.
- Data supplied to us, showed there were 135 self-employed staff working for the service; this was predominantly patient transport drivers (132), along with other staff working in patient bookings and fleet.
- The service worked with contracted partners to flex the start times of the shifts the following day to meet the demand of the service needs. For example, we saw a patient needed to be at their dialysis appointment for 7am, and needed to be picked up at 6.30am, this meant the driver would start their shift at 5am.
- The allocation of staff was arranged as per transfer booking. We saw that the service provided the appropriate number of staff for each booking. This was agreed prior to the transfer depending on the activity;

we saw codes on the booking form indicating the type of crew required. For example, we saw a code which indicated a request for a car, and another which indicated a request for a double crew.

- Skill mix was determined by the level of care required by the patient being conveyed. Paramedics and technicians undertook high dependency transfers. Patient transport staff undertook clinic work such as outpatient journeys and discharge to home addresses.
- Staff did not raise any concerns about access to time for rest and meal breaks.
- We saw the service had an 'employee induction checklist' and 'self-employed induction checklist'. Both checklists included, but were not limited to, proof of identification and right to work, criminal records checks through the Disclosure and Barring Service (DBS), and driving licence check. We reviewed five staff personal personnel files, all of which showed these checks had been carried out on the commencement of employment or working for the service. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

Response to major incidents

- As an independent ambulance service, the provider was not part of the NHS major incident planning. However if a request to provide services was made they would endeavour to meet those demands. 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 had an 'Outline Continuity Plan for the Continued Provision of Service' V3 (dated October 2017), which was specific to the head office. This outlined how the service would continue to function in the event of an emergency, such as electrical power failure or IT failure, phone system failure, flood or natural disaster and staff shortages. However, there were no defined roles and responsibilities, which meant the provider could not be

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assured that staff knew what to do. Following inspection, the provider supplied a Business Continuity Plan, V1 dated 2017. It clearly defined roles and responsibilities.

- Due to the scheduling of transport, by booking in advance, the service managed anticipated staffing resource risks. However, staff we spoke with were aware of the impact of different resource and capacity risks, and could describe action they would take. For example, staff in booking office sent traffic reports every two hours, between 7am and 7pm, to both trusts they provided services for. We saw this included the severity (severe or moderate), location (motorway or A road), and type of incident (accident, queuing traffic).
- We asked staff what would happen in the event of unexpected severe weather conditions, they told us they would work with the local trusts, and determine which clinic appointment would be cancelled as well as ones which, would still need to go ahead, such as patients requiring dialysis. One member of staff told us, on one occasion, the service hired 4x4 vehicles to ensure patients could get to their appointments.

Are patient transport services effective?

Evidence-based care and treatment

- The service had a range of guideline and policies, which were available electronically on the provider's electronic system and in paper versions, which were available in a folder in an office. We reviewed 10 policies, found that all were up to date, and had an issue number and review date. This meant staff could be confident they had access to the most up to date version of policies.
 - We saw policies and procedures referenced to current good practice, such as Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines.
 - The service had a 'Do not attempt cardio-pulmonary resuscitation (DNACPR) policy' issue 2 (dated October 2017), which was based on, and referred to the Resuscitation Councils (UK) guidance, 2016.
 - There was no formal process followed to monitor staff adherence to national guidelines and local policies, other than general conversations with staff. However, we saw minutes of a clinical governance meeting held in September 2017, which indicated audits were discussed and a list of audits or spot checks, which were being undertaken, was to be sent to the registered manager for review.
- ### Assessment and planning of care
- Water was not routinely provided by the service. However, the service provided water bottles within the vehicles, in case the journey was delayed so patients remained hydrated.
- ### Response times and patient outcomes
- From April to September 2017, there were 102,029 patient journeys, the level of activity fluctuated each month. We saw the most patient journeys were undertaken in May 2017 (17,713) and the fewest in April 2017 (15,504).
 - From April to September 2017, there were 674 high dependency journeys, the level of activity fluctuated each month. We saw the highest dependency journeys were undertaken in June 2017 (129) and the fewest in April 2017 (87). In the reporting period, we saw that 672 journeys were undertaken with a two-man ambulance technician crew, and an ambulance technician and a paramedic had undertaken two journeys. Both the high dependency journeys the paramedic had undertaken were in August 2017.
 - The service monitored pick up times, arrival times and site departure times either through the crew's personal hand held electronic devices or tracking devices.
 - We were provided with the services key performance indicators for both of the services commissioning bodies.
 - The key performance indicator for one of the commissioning bodies was 100% of patients out under 90 minutes. Performance data supplied to us for September 2017 showed the service met this 89% of the time.
 - The second commissioning body had two key performance indicators. One had a key performance indicator of 90% and the second 100%.
 - We saw for September 2017, the service had a key performance indicator of 90% of patients out under 90 minutes. Performance data supplied to us showed the service met this 67% of the time.

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- The second key performance indicator for the second commission body was 100% of patients out under 120 minutes. Performance data supplied to us for September 2017, showed the service met this 83% of the time.
- This performance was worse than the KPI for all elements, we spoke with the registered manager, who told us they were aware they were not meeting their KPI's. They told us they were looking at ways in which they could improve, and were working in cooperation with the two contracting NHS trusts. For example; they have been working with the discharge nurses, to improve their wait times, attending bed meetings, and having their own portering staff at the NHS trusts.
- Staff told us if they were running late that they would call the control, who would then inform the hospital.
- Standards and expectations of the service were outlined in the Service Level Agreement (SLA).

Competent staff

- All new staff completed a set induction programme. We saw there was a 'Self Employed Induction Checklist' and 'Employee Induction Checklist', which detailed the induction training staff needed to undertake. Their mandatory training then followed the induction.
- The service had systems in place to support learning and development. Data supplied to us showed 76% of permanent members of staff had an annual appraisal. The reason the remaining 24% had not had an appraisal was because there were new starters. We reviewed 16 appraisals during our inspection, and saw evidence of staff engagement and involvement in their role. We also saw areas for development were discussed. The staff member signed their appraisals.
- Driver and Vehicle Licensing Agency (DVLA) checks were conducted at the start of employment, and then every six months. During our inspection, we looked at five records and saw all records had been checked within the last six months, and included a copy of the photographic licence. All crew were aware of the need to notify the managers of any changes to their licence in line with the driving standards policy. We saw the check also included any penalty points.
- We saw records that showed all patient transport service (PTS) staff completed an extended first aid at

work course, before they went out on ambulances. The course included information on managing broken bones, bleeding, unconscious patient assessment, and cardio-pulmonary resuscitation.

- The service employed paramedics and ambulance technicians to provide care for patients during high dependency transfers. They were employed to make use of their enhanced monitoring skills, for example, the use of blood pressure and electrocardiogram (ECG) monitoring. Staff who undertook high dependency work had professional qualifications, such as BTEC Level 2 First Person on Scene (Intermediate) or QA Level 3 Cert in First Response Emergency Care (QCF)
- There was no person responsible for driving standards at Savoy Ventures Ltd. Initial driving checks were carried out on employment. These included, but were not limited to; hold a full and valid driving licence for at least two years, hold no more than six endorsement points, and have not been banned from driving. Once they have completed their initial induction, they were partnered with another driver. Part of the process involved the new employee to drive in areas, which are less congested, to familiarise themselves with the vehicle. There was no formalised driving re-assessment during the course of employment and they would re-assess a member of staff if concerns relating to driving were identified.

Coordination with other providers and multi-disciplinary working

- There was a strong multi-disciplinary team (MDT) approach across the service. We observed good collaborative working and communication from all members of the team. We saw staff worked together to ensure the safe transfer of patients. Staff we spoke with told us they worked well as a team.
- There were monthly contract meetings with the two NHS trusts who commissioned patient transport services from Savoy Ventures Ltd. This would include, but was not limited to, any issues relating to the delivery of the service.
- There were dedicated staff to coordinate for each of the NHS trusts who commissioned services from Savoy Ventures limited. The coordinator staff worked Monday to Friday 9am to 5pm. This allowed for good

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communication between the service and the NHS trusts. Any problems could be dealt with quickly and any questions regarding patient needs and requirement of crews could be discussed.

Access to information

- All patient details were collected at the booking stage. We saw the booking forms completed upon referral included patient demographics, medical history, location, and the journey planned. The details from the booking form were recorded on to an electronic system. This also included other important information such as, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) and infection status.
- Patient transport staff received information about their jobs via a personal handheld electronic device. These included appointment times, addresses and patient specific information such as relevant medical conditions, complex needs, mobility, or if an escort was travelling with them.
- All vehicles had accurate and up-to-date satellite navigation systems.
- Staff told us they felt they had access to sufficient information for the patients they cared for. If they needed additional information or had any concerns, they spoke with the staff at 'control'.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood their roles and responsibilities for gaining consent and staff told us that consent was obtained from patients prior to all interventions, treatments, and transfers. We saw this during our inspection.
- Records confirmed all staff had received training in the Mental Capacity Act (MCA) 2005 as part of their induction and mandatory training. The registered manager told us staff received face-to-face training about the Mental Capacity Act 2005 provided by an external company, within the safeguarding vulnerable adult's module.
- The registered manager told us they did not routinely convey patients with mental health problems.

- The service ensured that up-to-date 'do not attempt cardio pulmonary resuscitation' (DNACPR) orders and end of life care planning was appropriately recorded and communicated when patients were being transported.

Are patient transport services caring?

Compassionate care

- We looked at 35 patient feedback forms that the service had received from patients and their relatives. These included positive and grateful comments about the service they had received. For example, one patient wrote, 'my driver is very punctual, professional, and polite'. Another patient wrote 'I have found every driver to be of an excellent standard'.
- We were able to observe two staff, patient interactions during our inspection. We saw staff members treated the patients with respect and dignity. This was in line with NICE QS15, statement 1, which states to ensure 'patients are treated with dignity, kindness, compassion, courtesy, respect, understanding, and honesty'.
- The service trained all staff in the safe moving and handling of patients, and this helped to maintain patient's dignity during transport. We heard ambulance staff speaking with patients in a kind and supportive manner, when helping patients on and off vehicles.
- In line with NICE QS 15, statement 3, we saw staff introduced themselves by name, and consistently showed patience and sensitivity to the needs of patients. Additionally, we saw responses on the patient feedback form to 'did the crew identify and introduce themselves to you?' was 'yes'.

Understanding and involvement of patients and those close to them

- Patients were booked for transport against a set of eligibility criteria, which was determined by the contracting NHS trusts.
- The service contacted patients the day before their journey to ensure they had all the correct information, such as access to the patient's property, mobility, illness,

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such as asthma, and if an escort was accompanying the patient. This meant patients could be fully involved in their transfer plan. Booking staff told us, they kept patients fully informed of any delays.

- We saw staff explained to patients what was going to happen and asked patients for permission before carrying anything out. All responses on the patient feedback form to the question 'do you feel the crew attended to your needs throughout your journey?' was 'yes'. We saw on the patient feedback forms, that staff go the 'extra mile', are 'courteous and polite' and 'very respectful and diligent'.

Emotional support

- Ambulance crews routinely transported patients who were end of life. Staff were aware of the need to support family or other patients should a patient become unwell during a journey.

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

Service planning and delivery to meet the needs of local people

- The main service was a patient transport service (PTS) which provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or requiring treatment such as renal dialysis.
- The service provided patient transport work to two NHS trusts. Bookings were undertaken through direct contact with the trusts. Additionally the service provided an 'ad hoc' high dependency transfer service, for both trusts as and when required.
- The control desk at the head office had permanent members of staff, which meant bookings could be responded to quickly. Each booking would come via an online booking form, which was sent to the service via an email, from the NHS trusts.
- Booking staff at the head office worked Monday to Friday from 7am to 9pm. Out of hours the night control

operator would manage bookings. Booking staff allocated jobs to the crews, who would confirm they are able to do it. After 9pm, crews are able to log onto the system and check their jobs for the following day.

- All of the vehicles were equipped with a tracking device. The service had the ability to monitor the location of its vehicles and identify where they were.

Meeting people's individual needs

- The booking process meant people's individual needs were identified. For example, the process took into account the level of support required, the person's family circumstances, and communication needs.
- The patient booking form included sections to highlight additional or complex needs, which a patient may have. This enabled the service to take into account a patient's individual needs.
- Control room staff received information about patients requiring transport, which may be living with dementia, or have other disabilities at the point of booking. This enabled the service to ensure that an escort would be with the patient for the duration of transport. As bookings were made in advance, the service could contact the patient before the journey, and confirm requirements.
- Staff were made aware if patient had a mental health problem at the point of booking. The service did not undertake secure transport for mental health patients. Staff did not transport a patient if they felt they were not equipped to do so, or the patient needed more specialist care.
- Booking staff, we spoke with said that at the time of booking a journey, information would be supplied by the NHS trust. Additionally, the day before the journey staff would contact the patient and asked relevant questions to obtain information on the patient's mobility, the type of vehicle required, what equipment was needed, additional needs such as hearing or sight impairment and if the patient needed an escort.
- The service did not have access to translation services. For patients with communication difficulties or who did not speak English, the service was informed at the booking stage, and ensured the patient travelled with

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an escort. The NHS trust assessment teams, would assess the patients and if a translator was required they would book this, and ensure the service was aware of an additional person for the journey.

- The service did not have any communication aids, to support patients who were unable to speak due to their medical condition or who had complex needs. There was a potential risk of patients not being able to explain what was wrong or understand.
- The service had eight vehicles equipped with specialist equipment to support bariatric patients. Bariatric patients are those with excessive body weight, which can affect patients' health. Staff were alerted to the need to provide this service by the booking system.
- Patients with any additional needs were identified prior to the transfer. A regular carer or relative for any planned journeys accompanied patients who had impairments such as, those living with dementia, learning disability, or visual impairment.
- Staff said that at the time of booking it was identified whether the patient required a relative or carer to support them. This ensured an appropriate vehicle was allocated to ensure seating arrangements were suitable.
- Ambulances had different points of entry, including sliding doors, steps, and tailgates. However, during our inspection we saw all patients were helped into the ambulance via the rear ramp. We saw one patient did not like using the ramp, so staff offered them the use of a wheelchair to access the ambulance. However, we saw the risk of using the steps, was on the risk register.
- We saw there was bottled water available on board the vehicles for patients, travelling on hot days or those on longer journeys.
- Staff gave us examples of how they met individual needs. For example, some staff took the same patients on the same journey multiple times a week. For example, drivers who transport patients attending dialysis units for treatment would make that journey three times a week, all year. This allowed staff to meet the patient's individual needs, for example if a patient liked to travel along, sit in the front of the car, or liked to listen to a specific music station.
- Savoy Ventures provided a service in line with contracts awarded from two NHS trusts. Patients were booked for transport against a set of eligibility criteria, which was determined by the contracting NHS trust.
- Bookings were emailed to the service, the job details were recorded electronically and were used to inform the resource required in order to fulfil the booking.
- Portable hand held devices carried by staff provided them with accurate journey information including name, pick up point, destination, mobility requirements, and any specific notes based on individual needs.
- We saw between May and September 2017, that 10% of bookings were cancelled. Staff told us, the majority of bookings were cancelled by the NHS trust. If the booking was cancelled by the service, a member of staff would contact the patient and alternative arrangements would be made.
- Ambulance crews had travelling time built into their shift, if they were due to pick a patient up some distance from their base location. This ensured an efficient response could be provided to patients.
- There was an up-to-date website, which gave full details of work undertaken by the service and included positive testimonials from members of the public.
- If a journey was running late, the driver would contact control who will ring ahead to the destination with an estimated time of arrival and keep the patient and the hospital informed. Any potential delay was communicated with patients, carers, and hospital staff by telephone. In addition to this, we saw staff in the booking office sent traffic reports every two hours, between 7am and 7pm, to both trusts they provided services for.
- The service monitored on scene turnaround times, to improve the quality of the care the service provided to patients.

Learning from complaints and concerns

- The 'Complaints Procedure' issue 3 (dated October 2017) outlined the process for dealing with complaints, which included but was not limited to; how to make a complaint, how the process worked, how long the

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process took and what to do if not satisfied with the response. We also saw the complaints procedure was included in the quality and governance section of the service's website.

- The Quality Assurance manager had overall responsibility for responding to all complaints. All complaints were acknowledged with either an email or telephone call within 24 hours, in line with the services policy. The aim was to have the complaint reviewed and completed within 21 days.
- Savoy Ventures received complaints either directly or via the trusts' patient advice and liaison service (PALS). Between October 2016 and September 2017 the service received 273 complaints, 65 (24%), were received directly to the service the remaining 208 were received via a trust's PALS service.
- We saw the service kept a complaints log, which included the date the complaint was received, whether it was direct or via a trust, the subject of the complaint, the outcome, and the root cause. We saw the service had resolved all of the 273 complaints received, in line with policy, within the reporting period. Additionally, we saw complaints were discussed at the weekly 'complaints/investigation' meetings.
- We saw no information about making complaints and sharing patient experiences displayed within the ambulances we viewed. However, patients, carers, and members of the public could provide feedback via the website. We saw this could be email, letter, telephone, or in person at a hospital where there was a Savoy Transport Desk. Since our inspection, the service has told us, they now have notices in all vehicles, informing the public how to make a complaint directly to the service
- An additional five managers who were part of the management team managed individual departments within the service. The additional five managers reported directly to the operation lead. These managers were IT, quality assurance, HR, fleet, HDU, and area managers. However, they were not responsible for the day to day work, this was undertaken by a designated planner.
- The service had a Care Quality Commission registered manager in post, who was responsible for the daily running of the service, for example, provision of staff, and equipment. The manager was fully aware of the Care Quality Commission registration requirements for the service.
- A named medical director worked alongside the operations manager to assist with clinical leadership, advice, medical supervision, and support.
- We observed a positive staff culture across the service. Staff spoke positively about the leadership of the service. Staff said they were proud to work for the service. They wanted to make a difference to patients and were passionate about performing their role to a high standard.
- The staff we spoke with said they felt valued by management, who kept them well informed. Staff were courteous and supportive of one another.
- There was a positive regard for the welfare of staff. For example, we saw the service held many events to promote a positive culture and good team working. In addition, the service held other events to engage staff and improve morale, such as team building events and days out, Christmas parties, and an annual summer fun day and barbeque.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The chief executive led the management team, supported by the operations manager, health, safety and environment manager, accounts manager and director.

Vision and strategy for this this core service

- Savoy Ventures Limited had a clear vision and focus to 'provide a safe and caring service to their patients and clients responding to the needs of each individual while maintaining a professional and efficient service'. There was a set of goals, which underpinned the vision, these included but were not limited to; 'to provide a safe and caring service', 'to support our staff', 'to promote openness and honesty' and 'to learn from our mistakes'.

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- Staff we spoke with were not able to tell us the service's vision and values, but staff we spoke with demonstrated their passion and drive to provide a high quality and safe service.

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

- The service had a new governance structure in place. The service held meetings where governance issues were addressed. The meetings included, but were not limited to; health and safety, management team, and renal department meetings.
- We saw Clinical Governance Committee (CGC) meetings minutes, dating back to 2013. We saw items discussed included, but were not limited to; incident review, infection control, medicines, audits, training, and equipment. We saw actions were taken, within a set timeframe. We saw the minutes of the September 2017 meeting during our inspection.
- The management team met monthly, and items discussed included; health and safety, quality assurance, staff training, fleet, high dependency operations and staff forum. We saw there were actions identified within clear timeframes. During our inspection, we saw the minutes of the manager team meeting for September and October 2017.
- The site managers held a monthly meeting. We saw the meeting had regular agenda items, which included but were not limited to; driver checks, uniform, identification, and equipment. During our inspection, we saw the minutes of the site managers meeting for July, August, and September 2017.
- The renal department met weekly, and fed into the management meeting. We saw the minutes of 11 October 2017, 18 October 2017, and 24 October 2017. Items discussed included, but were not limited to; incidents, complaints, staffing and patient dignity. Actions were identified, and completed within stated timeframes.
- The service had a new designated health and safety meeting, which would meet weekly. At the time of inspection, they had only had one meeting; we looked at the minutes for 26 September 2017. We saw there were regular standing agenda items, which included,

but were not limited to; review of incidents, accidents and near misses, identifying trends and review of lifting equipment. Actions were identified and timeframes set for completion.

- There were systems in place to disseminate learning from incidents, complaints, and concerns. There was a central email system, which sent out information to staff, in order to check staff had read this, all emails had a read receipt.
- A risk register for the service was still in its infancy. We reviewed the risk register and saw, at the time of inspection there were only 16 risks identified, seven had actions required associated with them and a risk owner assigned. The remaining nine risks, were still under review. However, not all risks to the service had been identified, for example, loss of vehicles or service interruption, such as inclement weather or reduction in patient transport staff. We did see the risks that had been completed were 'risk scored' to indicate the level of risk posed. We spoke with the chief executive about the process for identifying and assessing risk prior to the introduction of the risk register. They told us the previous system was an individual paper-based risk assessment, but there was not a provider overview to manage the risks. This may have meant that key risks had not been identified or assessed which could pose a risk to the patient.
- We saw from CGC minutes we reviewed that risks identified or the risk register was not discussed. This meant the service could not be assured that appropriate arrangements were in place for the identifying, recording, and managing of risks.

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

- We saw patients were asked to complete satisfaction surveys based on the quality of the service provided. During our inspection we looked at 35 patient feedback forms; we saw 100% of patients responded 'yes' to 'were you satisfied with your transport?'.
- In addition, the service had set up a twitter account, which allowed staff and members of the public to engage more easily. They had a website with information for the public about the services they provided, and their contact details.

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- Systems were in place to gather staff feedback to enable more effective working and improved patient experiences. We saw the service undertook regular staff forums. Staff forums were held at both the NHS trusts the service provided services to, and the control centre. This meant the service held forums in places that were accessible to all staff. Members of staff could book an appointment to have a 1:1 meeting with the chief executive. We looked at the attendances for meetings held 4 October, 5 October, and 20 October 2017. We saw that five members of staff had attended.
- There were rewards for staff that had been exceptional, for example; the monthly newsletter included a section called 'star of the month'. The winner of the award was selected following a review of all compliments received

that month, and was given a cash award. The newsletter also included anonymised patient feedback and complaints, and allowed staff to be recognised. During inspection, we looked at the newsletter for October 2017.

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

- The service and its staff demonstrated a willingness to develop and improve the service provided. For example, they had introduced the swab test, to ensure deep cleans were effective and random drug and alcohol checks for staff, to ensure they provided a safe and professional service.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should have effective systems in place to ensure compliance with the correct disposal of clinical and sharp waste, in line with HTM 07-01
- The provider should ensure all staff are trained to the appropriate level of safeguarding training for children.
- The provider should ensure automated external defibrillators are tested daily in line with manufacturer's guidance.
- The provider should ensure the risk register in place covers all the risk to the service, including actions needed to lessen the risk.
- The provider should ensure they have a formal system to monitor staff infection prevention and control compliance.
- The provider should ensure there are communication aids available for staff to use to support patients who were unable to speak due to their medical condition or who had complex needs.
- The provider should ensure there is an effective system in place to audit and monitor quality and safety information to ensure the delivery of safe and effective care and treatment on an ongoing basis.