Alexandra Private Ambulance Service

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Alexandra Private Ambulance Service is an independent ambulance service provider based in Cheadle, Cheshire. Alexandra Private Ambulance Service is registered to provide patient transport services. Alexandra Private Ambulance Service offers ambulance transport on an 'as required' basis and provides pre-planned transport. The service provides patient transport services to and from a private hospital as well as a repatriation service for people from the Isle of Man who require further inland medical treatment. Alexandra Private Ambulance Service collects these patients from a local airport.

We inspected this service using our comprehensive inspection methodology. We carried out a scheduled comprehensive inspection on 16 January 2018. The service had one registered base which we inspected.

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.

The main service provided by this service was patient transport.

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:

- Staff were knowledgeable about how to report an incident and had access to incident reporting forms including while on the ambulances.
- The service ensured a minimum of two staff were allocated to each patient transfer depending on risk and need. The staffing levels and skill mix of the staff met the patients' needs.
- The ambulance at the station and the ambulance station itself were visibly clean and systems were in place to ensure ambulances were well maintained.
- All equipment necessary to meet the various needs of patients was available.
- Services were planned and delivered in a way that met the needs of the local population. The service considered the needs of different people, such as bariatric patients or people whose first language was not English, and journeys were planned based upon their requirements.
- We observed good hand hygiene, and infection control processes.
- The service had a system for handling, managing and monitoring complaints and concerns.

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

- Although staff were aware of how and when to report incidents, a policy on incident reporting was not in place. Staff followed the incident policy for the local hospital where the service was based, but this process was not formalised.
- Records did not show that staff were up to date with training, to ensure they were able to carry out the duties they were employed to perform. The registered manager told us that staff attended some of the training provided by the local hospital where the service was based, however this was not formally recorded.
- The provider did not have robust safeguarding procedures and processes that made sure patients were protected. Not all staff were up to date with safeguarding training.
- The provider did not have systems and processes in place to implement the statutory obligations of Duty of Candour and ensure all staff are trained and understand it.

Summary of findings

- The provider did not have records management or consent policies.
- Not all staff received an annual appraisal.

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services		We found the following areas of good practice: • Staff were knowledgeable about reporting incidents and had access to incident reporting forms while on the ambulance. • The ambulance on site and the station were visibly clean and staff followed infection control procedures. Staff used hand gel in clinical areas to maintain good hand hygiene and used personal protective equipment. • Systems were in place to ensure ambulances were well maintained with equipment to meet the needs of patients. • Systems were in place to identify, assess and manage patients whose condition deteriorated. • Staff carried or had access to a pocket guide with clinical information which was developed from the latest guidance. • The service had systems and processes to monitor how the service was performing. • Systems were in place for the planning of patient journeys and the care patients required. • The service took account of the needs of patients and ensured flexibility, choice and continuity of care. • The service had a system for handling, managing and monitoring complaints and concerns. • Staff knew how to advise a patient if they wished to make a complaint. • The service had plans to develop the service. However • Although staff were aware of how and when to report incidents, the service did not have a policy on incident reporting. Staff had access to the policy belonging to the hospital host site, but the protocol for using this was not defined. • Systems and processes were not in place to implement the duty of candour requirements. • Records indicated staff were not up to date with mandatory training, however not all training was formally recorded.

Summary of findings

- The service did not have a records management policy.
- The service did not have documented safeguarding systems, to protect adults, children and young people from avoidable harm.
- Recruitment systems did not ensure that staff were properly vetted prior to undertaking employment.
- Appraisals had not been carried out for the three members of staff for 2015 to 2016.
- The service did not have a formal process for managing risks or performance.

Summary of findings

Contents

Summary of this inspection

Background to Alexandra Private Ambulance Service

Alexandra Private Ambulance Service is operated by Alexandra Private Ambulance Service. The service opened in 1997. It is an independent ambulance service in Cheadle, Cheshire. The service primarily serves the communities of Cheshire. However, patients are transported across the UK as required. The service predominantly provides patient transport services to adults only and provides bariatric transport with the appropriate bariatric equipment in use.

The service provides medical patient transport services to a private hospital and an air ambulance trust.

The service is registered to provide the following regulated activities:

Transport services, triage and medical advice provided remotely

We last inspected Alexandra Private Ambulance Service in February 2013. Suitable arrangements were in place to ensure people using the service were provided with effective, safe and appropriate personalised care.

The service has had the same registered manager in post since 2011. This person is also the managing director.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection (North West).

Information about Alexandra Private Ambulance Service

Alexandra Private Ambulance Service was initially established in 1997 by the current managing director. The company provides patient transport to meet the needs of patients from a private hospital and an air ambulance service based outside of the United Kingdom. The company employs three patient transport services staff and the registered manager completes all office and administration activities, operating a fleet of two ambulances.

During the inspection, we visited the service's only ambulance station in Cheshire. The service was managed from this location. Ambulances were securely kept at this location.

We spoke with the director of the service who is also the registered manager as well as a member of patient transport services staff. We inspected one ambulance and inspected cleanliness, infection control practices and stock levels for equipment and supplies.

During our inspection we looked at five patient records. We reviewed other documentation including policies, staff records, training records and call log sheets.

The CQC has not completed any special reviews or investigations of this service. The service has been inspected once before, in February 2013, when the service was found to be meeting all the required standards of quality and safety.

Activity (September 2016 to September 2017)

We requested information in relation to the number of patient transport journeys undertaken from the period of September 2016 to September 2017. The provider informed us that they did not formally monitor the number of journeys but on average completed between 30 to 40 patient transport journeys per month.

Track record on safety

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

Summary of this inspection

- There were no serious clinical incidents or serious injuries reported by the service.

There were no complaints.

Patient transport services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are patient transport services safe?

Incidents

- The provider told us they would deal with any incidents immediately. There was a company incident reporting form which informed staff to report incidents immediately. When necessary, staff referred to the incident policy developed by the hospital where they were based.
- Staff were required to report and record incidents via a paper record and called the office to log the incident. Each ambulance had a folder containing accident and incident reporting forms. From June 2016 to December 2017, the service reported that no incidents or accidents had taken place. No near misses were recorded.
- The provider told us they would deal with an incident immediately to safeguard the safety of people using the service. They said a full investigation would take place and a report would be completed and the provider would also meet with the staff to share learning.
- Staff we spoke with could describe the procedures for reporting incidents. They said they were confident to report any accidents, incidents or near misses. Staff who worked remotely could speak with the on call manager.
- The service reported that there were no never events in the last 12 months. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- Vehicle accidents and equipment defects were recorded on a separate defect report. From January to March 2017, 5 defects had been recorded. We saw examples of minor accidents, which managers had discussed with staff.
- The service did not have a duty of candour policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff did not receive training in duty of candour. Despite their lack of training, the registered manager told us they would be open and honest with people if things went wrong and would immediately seek support if a patient experienced avoidable harm.

Cleanliness, infection control and hygiene

- The ambulance we looked at was uncluttered and visibly clean. The ambulance station was tidy and well organised. There was no excess equipment so the areas were not cluttered, making them easy to clean.
- The service did not had an infection prevention and control policy, infection prevention and control guidance and vehicle equipment and premises cleaning guidance which covered a range of areas such as personal protective equipment, vehicle cleaning and waste storage. Staff followed infection control principles, including washing their hands and using hand gel after patient contact.
- Crews were required to ensure their ambulance was fit for purpose, before, during and after transporting a patient. Decontamination cleaning wipes were available on the ambulance we saw and we were informed that staff cleaned surfaces, seats and equipment after each patient.
- The crew assigned to the ambulance each day completed the day-to-day cleaning of ambulances. We found the daily cleaning sheet record on the ambulance had been completed consistently.

Patient transport services

- Cleaning materials and chemicals were available for staff use. Different coloured mops and buckets were available for different areas; advice as to which mop should be used in which area was prominently displayed to prevent cross-infection.
- The ambulances had a deep clean through a contract with an external company every six weeks. This included all fixtures and fittings internally including seats, interior lighting, grab rails, flooring and foot wells.
- Hand washing facilities were available at the ambulance station.
- We saw no evidence of infection, prevention and control audits or checks within the service. This meant the service could not be assured staff were compliant with infection control procedures.
- There were arrangements with the local hospital for disposing of used linen and restocking with clean linen. Staff told us that if a patient was known to be carrying an infection, they were not transported with another patient. The vehicle would be cleaned afterwards in accordance with infection control practices.
- Staff had access to personal protective equipment such as gloves and aprons to reduce the risk of the spread of infection. Crews carried a spill kit on their ambulances to manage any small spillages and reduce the infection and hygiene risk to other patients.
- Clinical waste bags were carried on each ambulance and full bags were disposed of at the hospital or at the ambulance station. The ambulance station had facilities for depositing and disposing of clinical waste through an external contractor.
- Staff were provided with sufficient uniform, which ensured they could change during a shift if necessary. Staff were responsible for cleaning their own uniform, unless it had been heavily contaminated and was disposed of as clinical waste.

Environment and equipment

- The premises were clean and tidy with adequate space to safely store the ambulances. In addition, the unit provided a suitable environment for taking bookings and there was office space, facilities for staff, cleaning and separate storage areas.
- The keys for the ambulances were stored securely. There was secure access to the station building and within that to the offices. Staff attended the office to collect the designated ambulance keys. All ambulances were locked when unattended.
- All drivers had their driving licence and eligibility to drive ambulances checked prior to employment. We saw evidence of these checks on our inspection.
- The service had two ambulances for the transport of patients. Systems were in place to ensure that both ambulances were maintained, serviced, cleaned, insured and taxed appropriately.
- Vehicles were covered by a current MOT safety test certificates as required and a central log was kept at the station.Managers ensured newer ambulances were covered by a first MOT safety test certificate after one year as required in law. Records showed that drivers had the correct licence category, Category B for the weight of the vehicles driven.
- Where ambulances were off road awaiting repair, this was clearly displayed on the ambulance to prevent staff from using it. We were told the provider maintained membership of a vehicle breakdown organisation together with a call out arrangement with a local 24 hour garage. Staff informed us they reported any defects directly to the manager. A garage performed vehicle inspections every six months so staff were aware of any faults and action needed.
- There was a system for reporting equipment defects and staff had received appropriate training to use equipment safely. Equipment had been safety tested; stickers showed when the equipment was next due for testing and records were available to support their suitability for use. The seatbelts and trolley straps were in working order in the ambulance we checked.
- The ambulance we inspected was fully equipped, with disposable single use equipment stored appropriately and within the manufacturers' expiry dates.

Medicines

- Emergency medicines were not carried on the patient transport service ambulances or stored at the base and patient transport services staff did not administer medicines. Patients or their accompanying carers were responsible for their own medicines administration

while in transit. Patient transport services staff would ensure medicines provided by the hospital for patients to take home would be stored securely in a bag on the ambulance.

- Oxygen cylinders were appropriately stored on the ambulance we saw. An appropriate health care professional had to prescribe the oxygen so staff could administer it or the patient had to have a home oxygen order form in place. We saw completed documentation when staff had administered oxygen to patients. The service obtained medical gases through an arrangement with the hospital which provided storage and maintenance facilities.

Records

- Patient transport service drivers received work sheets at the start of a shift, which were completed by the on call duty manager and included the basic details of the journey to be completed. These included collection times and addresses. Patient specific information such as relevant medical conditions, mobility, whether an escort was travelling with the patient and patient's health and circumstances were assessed by the private hospital staff and the air ambulance staff. This information was given to the patient transport service drivers during the handover process. A records management policy was not in place.
- Patient information was stored in the driver's cab out of sight, respecting patient confidentiality.
- Records were held securely in the station office. Storage was in locked filing cabinets. The provider retained patient report forms for a period but disposed of them after around three months due to lack of space.
- Staff personnel files were stored in a locked cupboard on the service premises. We were told only the registered manager had access to this key to ensure the confidentiality of staff members was respected.

Safeguarding

- The provider did not have a safeguarding policy. However, we found that front line staff were aware of their responsibilities in managing a safeguarding concern. For example, we spoke with a member of staff who was aware of when they were required to notify external agencies.
- None of the four staff files we checked showed up-to-date safeguarding training.
- The registered manager informed us that if they had a safeguarding concern they would contact the hospital where the patient was transported from and seek advice, and if required would contact the police. They informed us they relied on hospital staff from where the patient was collected to make the safeguarding referral. The registered manager was not aware of their responsibility in making a safeguarding alert to the responsible local authority safeguarding team and or of the legal requirement to notify the CQC.

Mandatory training

- The service had a mandatory training programme. Mandatory training included patient handling, data protection, equality and diversity, infection control and personal safety. Mandatory training was delivered through a mixture of e-learning and face-to face training. All staff were required to complete and record their mandatory training.
- < >e found that not all staff were up to date with their mandatory training. For example, we found that not all staff had completed the training in mental capacity. None of the four staff files we checked showed up-to-date safeguarding training, basic life support training or infection prevention and control training. However, following the inspection the provider gave us evidence that all staff were booked to attend basic life support training. Staff were attending some ad hoc training delivered by the hospital where they were based, but this was not recorded.
- Patient transport services staff who drove the vehicles completed an in-house driving assessment on commencement of employment and would undertake a further assessment once they felt confident to transport patients.

Assessing and responding to patient risk

- Staff requested detailed information on risks posed when transporting patients at the time of the booking. Basic risk assessment screening questions were asked at this time.
- When transporting patients, the ambulance crew would use their first aid knowledge to assess if a patient's condition was deteriorating.

Patient transport services

- Crew had access to advice from an on call member of staff or they would divert to a hospital if necessary. There was an escalation process in place for the management of deteriorating patients. Staff informed us they would stop the vehicle as soon as it was safe to do so, call the on call manager for advice and inform the organisation where the patient was collected from. They would then support the patient as best they could until help arrived.

Staffing

- The service employed four patient transport services staff, three of whom were qualified ambulance technicians. The registered manager completed all office and administration duties.
- Recruitment systems did not ensure that staff were properly vetted prior to undertaking employment. We were informed that the file for one member of staff could not be located as they had left the service then returned a few weeks later. When they had left, the file was either destroyed or stored away. Documentation for the file was in the process of being sought.
- For the remaining three files we looked at, proof of identification, references and qualifications were not documented. All staff were known to each other and had worked together in the public sector for many years prior to working together in this service but processes needed formalising.
- All ambulance staff had valid enhanced Disclosure and Barring Service (DBS) checks. We saw evidence that a check with the DBS had been carried out prior to staff commencing duties, which involved accessing patients and their personal and confidential information. This protected patients from receiving care and treatment from unsuitable staff.
- A written diarised rostering system was used to plan shifts. Shortfalls in cover were shown on this system and staff could request to work additional shifts. The diarised rostering tracked sickness and holidays. If a short notice booking was received, the service would not accept it if they could not supply two staff. We were informed that staff were allocated time for rest and meal breaks.
- For emergencies out of hours staff had a direct number to the duty manager on call. Staff we spoke with knew how to escalate concerns when working out of hours.

Are patient transport services effective? (for example, treatment is effective)

Evidence-based care and treatment

- The service had some policies and procedures in place that were used to guide staff in their daily work. The provider acknowledged that there were gaps in the provision of policies and procedures which they planned to address.
- The policies and procedures referred to best practice guidance including the department of health and the Joint Royal Colleges Ambulance Liaison Committee.
- The NHS ambulance trust set or assessed patients' eligibility to travel on patient transport in line with the guidelines in the Department of Health 'Eligibility criteria for patient transport services' document. The eligibility criteria were set nationally and it was the responsibility of the providers booking the patient transport to make sure it was used for patients who met the criteria.

Assessment and planning of care

- The service provided non-emergency transport for patients who required transferring between hospitals, transfers home or to another place of care. During the booking process, basic journey information was gained regarding the collection address and discharge destination.
- Staff did not transport a patient if they felt they were not equipped to do so, or the patient needed more specialist care. Patient transport service staff were not clinically trained, but did seek advice from clinical staff at the hospital as necessary or the manager on call for the service. If a patient was observed or assessed as not well enough to travel or be discharged from hospital, the ambulance care assistants made the decision not to take them.
- Where necessary, health professionals accompanied patients on the journey to or between hospitals to ensure they were transported safely and according to their individual needs.

Patient transport services

- If distance or rural journeys were scheduled, the journey would be pre-planned with comfort breaks and refreshments. Ambulances held bottled water to provide for patients as required during a journey.

Response times and patient outcomes

- The provider informed us that on average they completed between 30 to 40 patient journeys per month. The level of activity was the same each month and the registered manager reviewed data in relation to themes and trends.

  The provider collected data and monitored the performance of staff for the jobs that were assigned through the crew worksheets. Staff also called the on call duty manager to report any difficulties, so the manager on call was always aware of what issues were causing a delay.

- Booking staff did not accept a job when they recognised that they did not have the staff capacity or vehicles at the correct locations. The provider told us this rarely happened.

Competent staff

- New patient transport services staff were required to complete an induction which tested their knowledge on safeguarding, manual handling, infection control and health and safety. Three patient transport services staff had qualified as ambulance technicians.
- Records showed that some crew had additional qualifications and had developed their skills.
- Driver and Vehicle Licensing Agency checks were completed prior to commencement of employment.
- All staff were required to complete a driving assessment on commencement of employment which was carried out by the service. This included an observation of their driving skills and completion of a test on road signs. However, the service had no arrangements in place for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor. The provider told us, that if they had a concern about the standard of a crew member's driving they would address any poor practice. Any additional staff training or refresher training may then be identified.
- Appraisals had not been carried out for the three members of staff for 2015 to 2016. This was discussed with the registered manager and they informed they would introduce an appraisals process for all for staff.

Coordination with other providers and multidisciplinary working

- Staff at the local hospital where the service was based reported good working relationships with ambulance care assistants and the registered manager of the service. We observed effective cooperation between different providers to coordinate patients' transport around their care, treatment and discharge.

Access to information

- Information was obtained from hospital staff and entered onto the patient journey forms. These included collection times and addresses.
- Feedback from the hospital was that handovers between the ambulance and hospital staff were detailed, professional and appropriate. The management team reported they had a good working relationship with the hospital staff as generally they visited the same wards and departments on a regular basis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

A policy was not in place covering the Mental Capacity Act. However, upon speaking with staff we were assured that staff knew when to complete a mental capacity assessment. Verbal consent to treatment was recorded on patient record forms.

Are patient transport services caring?

We did not inspect or rate caring as during the inspection we did not observe any patient care.

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

Service planning and delivery to meet the needs of local people

Patient transport services

- The main service was a patient transport service 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 and being discharged from hospital wards. The service also transferred patients from Liverpool Airport from the Isle of Man to access mainland medical facilities.
- The service had two core elements, pre-planned patient transport services, and unplanned services to meet the needs of patients. Workloads were planned around this.
- Patient transport services were provided to a private hospital trust and an NHS Trust. Service level agreements were in place for non-emergency and non-clinical patient transport. Journeys were also provided on an ad hoc basis. The service supported hospital discharges across the Liverpool and Manchester region.
- The manager coordinated all bookings from 8am to 5pm. Patient transport service crews worked from 8am to 5pm, seven days a week and if required would work after 5pm.All jobs were allocated a week in advance to staff.
- On the day, unplanned bookings were responded to quickly via telephone. We observed effective communication between drivers and the manager as part of service planning.

Meeting people's individual needs

- The ambulance care assistants ensured patients were not left at home without being safe and supported. Some patients were discharged from hospital and had a package of care to be arranged at home. If the support person or team had not arrived when the patient came home, the ambulance care assistants called the hospital to find out where they were.
- Staff told us that at the time of booking the question was asked if the patient required a relative or carer to support them. Staff told us this was put in place to meet the patients' individual needs and level of risk. This ensured that an appropriate ambulance was allocated with suitable seating arrangements. The provider's ambulances contained bariatric equipment to transfer patients who exceeded a certain weight. Staff confirmed they were competent to use this equipment, which was generally planned.
- The private hospital provided ambulance crews with patient details such as 'do not attempt cardio pulmonary resuscitation' (DNACPR) information and any special notes or instructions, which stayed with the patient. The booking process meant people's individual needs were identified and considered the level of support required, the person's family circumstances and communication needs.
- For patients with communication difficulties or who did not speak English as a first language, staff had access to a telephone-based interpreting service provided by the private hospital.

Access and flow

- Patients could access their care and treatment in a timely way. The provider ensured it could provide ambulances where and when they were needed. From taking a booking to providing the ambulance service, the provider aimed to be there within the hour. This was monitored by the on call duty manager. Patients were advised if there was a delay.
- Patient transport requests were received on an intermittent rather than a contractual basis and the service responded at short notice. Long journeys or night transfers were required to be pre-planned.
- If a journey was running late, the driver would 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.

Learning from complaints and concerns

- Staff knew how to advise a patient if they wished to complain and written information of how to make a complaint was present on the ambulance we inspected.
- The service had a system for handling, managing and monitoring complaints and concerns and outlined the process for dealing with complaints, initially by local resolution and informally. Where this did not lead to a resolution, complainants were given a letter of acknowledgement followed up by a further letter within 25 working days, once an investigation had been made into the complaint.
- The service had not received any complaints from patients within the last 12 months.

Patient transport services

Are patient transport services well-led?

Vision and strategy for this this core service

- The service did not have a written statement of vision, strategy and guiding values. However, the registered manager informed us their strategy was to continue to evolve as a company seeking to always be better, striving to be "excellent" at what they did.
- The registered manager we spoke with had a good understanding of the commercial aspect of the patient transport service, ensuring they remained competitive.

Governance, risk management and quality measurement

- The service did not have a formal process for managing risks, such as a risk register. The team was small and had regular informal discussions about any issues that arose, but these were not documented.
- The service was not carrying out any internal audits looking at practices, system and process. Therefore, areas for improvement were not identified and areas of best practice were not shared or monitored.
- The provider informed us that operational meetings did take place to discuss practice issues but these were not minuted.

Leadership / culture of service

- The leadership team consisted of the managing director who was the CQC registered manager. The manager looked after the welfare of the staff and was responsible for the planning of the day to day work.
- The managing director went out on transfer cases as required. This allowed them to maintain their practice.
- The provider and staff informed us that regular team meetings were held but were not recorded.
- The managing director told us learning was cascaded to staff. All staff members had a work email account. Noticeboards in the ambulance station displayed staff briefings, education updates, alerts regarding equipment and information on staff wellbeing.

Public and staff engagement

- The service's publicly accessible website contained information for the public in relation to what the service could offer.
- The provider informed us they had not completed any patient surveys and were introducing these. The provider's website had opportunities for the public to give feedback about the service.
- Staff could access information such as policies and procedures electronically and duty rotas.

Innovation, improvement and sustainability

- There was genuine positivity about the future of the service with a hope and plans to help the service expand.
- Senior managers considered the sustainability of the service during contract negotiations.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should formalise the incident reporting protocol.
- The provider should consider putting in place a records management policy.
- The provider should consider putting in place a policy for consent and capacity.
- The provider should review its appraisal process.
- The provider should ensure staff are up to date with their mandatory training and that this is recorded.
- The provider should ensure they have documented protocols in place for safeguarding procedures and processes. If the local hospital policies are used, this should be clearly set out in a standard operating procedure or other document.
- The provider should ensure that checks for new staff are formalised and recorded prior to them commencing employment.
- The provider should consider how it can implement robust systems to assess, monitor and improve the quality and safety of the services provided.
- The provider should ensure there are systems and processes in place to implement the statutory obligations of Duty of Candour and ensure all staff are trained and understand it.