Transsecure NW Ltd

Quality Report

60 Audley Range
Blackburn
Lancashire
BB1 1TF
Tel: 0333 8000 999
Website: www.transsecure.co.uk

Date of inspection visit: 17 and 22 July 2020
Date of publication: 12/10/2020

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

Ratings

Overall summary

Transsecure NW Limited is operated by Transsecure NW Limited. The service was first registered in August 2019. It is an independent ambulance service based in Blackburn which serves local, regional and national acute NHS hospital trusts, local authorities and independent hospitals. The service also transports patients across the country, when required.

We carried out a short notice announced focussed inspection of the service on 17 and 22 July 2020 in response to concerns raised to us around risk. We did not rate the service.

We found the following areas that required improvement:

- It was not clear that the service understood how to protect patients from abuse. The training for safeguarding was not sufficient for the care and treatment that the service provided and it was not clear that the systems and processes in place were effective in safeguarding patients from abuse.
- It was not clear that the service was able to monitor the suitability of patients effectively because there was no procedure or guidance to support staff in making a decision as to whether the patient was suitable for transport or not.
- Risk assessment information was not documented appropriately by the service including key information such as infectious status, allergies, recent medication and medical conditions. It was therefore not apparent that the service was managing patient risk effectively.
- Incidents of restraint were not managed safely or in line with best practice guidance. It was not clear that patients were being restrained appropriately or that staff had received the appropriate training in the application of restraint techniques.
- Patient records were not always completed in full and did not consistently include reasons for decisions taken by the service. It was therefore unclear that the service was providing safe care and treatment to patients being transported.

Summary of findings

- It was not clear that the service had effective systems in place to guide staff in obtaining patient consent or assessing patients mental capacity because there were no service policies or procedures in relation to consent or mental capacity. In addition, only one staff member had completed any training in mental capacity and there was no documented training for any staff member in relation to consent.
- Governance arrangements in place within the service were neither adequate nor effective. There were no audit programmes in place to drive improvement, there was limited evidence of risk management systems and there was a lack of policies, procedures and processes for staff to follow as guidance. In addition, where policies and procedures were in place, they were not always relevant to the service being provided and there was limited oversight of the policies and procedures in place.

We found the following area of good practice:

- Patient records showed that the service ensured that patients nutritional and hydrational needs were met.

Following this inspection, we told the provider that it must take some actions to comply with the regulations. Details are at the end of the report.

Ann Ford

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		Transsecure NW Limited provides patient transport services from one ambulance base location, situated in Blackburn. The service provides patient transport services for patients with mental health needs and those detained under the Mental Health Act 1983. We did not rate this service as this was a focussed inspection.

Summary of findings

Contents

Summary of this inspection

Background to Transsecure NW Ltd

Transsecure NW Limited opened in August 2019. It is an independent ambulance service based in Blackburn. The service provides patient transport services for local, regional and national acute NHS hospital trusts, local authorities and independent hospitals, 24 hours a day, 365 days a year.

The service provides patient transport services predominantly for adults; however, the service is also able to transport children. The service transports patients with mental health needs and those detained under the Mental Health Act 1983. The majority of work undertaken by the service is inter-hospital transfers; however, the service also transported patients with mental health needs to and from home addresses when required.

Transsecure NW Ltd had not previously been inspected or rated. This focussed inspection was carried out to look at elements of safe, effective and well led in response to concerns raised to us.

Our inspection team

The team that inspected the service comprised of a Care Quality Commission inspection manager and a Care Quality Commission inspector. The inspection team was overseen by Judith Connor, Head of Hospital Inspection(North West).

Information about Transsecure NW Ltd

The service is registered to provide the following regulated activities;

- Transport services, triage and medical advice provided remotely

There were no special reviews or investigations of the service ongoing by the Care Quality Commission at any time prior to this inspection.

During the inspection we spoke with two members of the management team. We reviewed 103 patient records and inspected one ambulance. We reviewed information that was provided by the service before, during and after the inspection.

Patient transport services

Safe	
Effective	
Well-led	

Are patient transport services safe?

Safeguarding

Staff did not receive training on how to recognise and report abuse and it was not clear that the service worked well with other agencies to do so. The safeguarding policy was not fit for purpose and there was no service policy for safeguarding children.

There was a safeguarding policy and procedure in place; however, this was dated October 2018 and noted for review within 12 months. There was no named author. The policy summary stated it had been reviewed and revised; however, there was no date when the policy had actually been reviewed, name of reviewer or document version control. The summary detailed the revision being due to the inclusion of new guidance Adult Safeguarding: Roles and Competencies for Health Care Staff 2018; however, it was not clear that the new guidance had been added to the relevant sections within the policy and this guidance had not been added to the underpinning knowledge list.

There was no guidance within this policy, or any other separate policy for safeguarding children. This was important because Transsecure NW Ltd was able to transport children which meant there was a risk staff would not recognise or report potential abuse in children appropriately.

The procedure for reporting adult safeguarding concerns was not clear and did not detail the contact number for any local safeguarding authorities should the safeguarding lead be unavailable. During the inspection we were told that the procedure for reporting a safeguarding concern was for the safeguarding lead to liaise with the hospital that had commissioned the journey, who would then advise if the local authority needed to be contacted. This was not reflective of the Transsecure NW Ltd policy which stated that the local authority processes should be followed, if the policy was not being followed this meant that people were put at risk of further abuse due to a potential delay in referring to the local authority to investigate. Furthermore, the safeguarding incident log which was to be completed by staff was not referenced within the procedure as an appendix or otherwise. Therefore, it was unclear how staff would know to complete this form in the event of needing to raise a safeguarding concern. The safeguarding incident log was more reflective of an incident report and investigation than a safeguarding concern or referral form.

Details about training requirements for safeguarding were unclear within the Transsecure NW Ltd policy. For example, the policy stated that the registered manager would ensure staff were 'trained to enhance their knowledge'. However, the policy also stated that the care workers were responsible for remaining up to date with training. In addition, the policy stated that staff would be trained in recognising and responding to incidents and allegations or concerns of abuse or harm as part of the induction programme.

We reviewed 14 staff records and found that only three members of staff had records for completing some form of safeguarding adults training, one at level two and two at level three. We saw that staff who had completed training at level three had done so online which did not meet with best practice guidance which states that level three should include face to face training hours.

We reviewed 14 staff records and found that only one member of staff had a record for completing safeguarding children training, level two. This was important because Transsecure NW Ltd were able to transport children which meant there was a risk staff would not recognise or report abuse in relation to children appropriately. The intercollegiate document, 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Fourth edition: January 2019' states that all staff working with children, young people and their parents should be trained up to level two.

During inspection we were told that the registered manager was the service safeguarding lead and was trained to level five. However, training certificates were not available during the inspection to evidence this.

Patient transport services

We were told that prior to the concerns raised with the Care Quality Commission which initiated the inspection, there had been no safeguarding concerns or referrals raised. However, the concern which had initiated the inspection had not been recorded as a safeguarding concern, an initial report had not been made by Transsecure NW Ltd nor an initial investigation completed. In addition, we were told that the service did not undertake any audits. This meant we could not be assured that Transsecure NW Ltd was able to make sure staff were reporting safeguarding concerns appropriately.

In response to our concerns regarding safeguarding, we took immediate action with the provider.

Cleanliness, Infection Control and Hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and vehicles visibly clean.

There was an infection control policy and procedure in place; however, this was dated as last reviewed December 2018 and noted for review within 12 months. There was no author or document version control. There was no detail within this policy about how compliance against it would be measured. The policy did not contain any information in relation to the cleaning of the service vehicles or equipment. In addition, the policy did not cross reference to any associated documents; for example, a daily vehicle cleaning checklist or similar.

Details about training requirements for infection prevention and control within the service policy stated that the service would 'provide staff with the appropriate training and equipment'. However, we reviewed 14 staff records and found that only one member of staff had a record for completing training in infection prevention and control. This meant there was a risk of infection to patients or the transfer of infections because it was not apparent that staff had received the appropriate training.

The policy indicated that Transsecure NW Ltd would provide suitable and sufficient information on a patient's infection status whenever it arranged for that person to be moved from the care of one organisation to another so that risks may be minimised. However, the policy did not outline where this information should be recorded. We reviewed 98 records specifically in relation to infection status and found no documented information either asked or recorded; for example, whether the patient had Covid 19 symptoms or if there was a history of MRSA.

We reviewed 11 narrative patient records for journeys undertaken during the Covid 19 pandemic and saw that 11 records had documented that staff wore full personal protective equipment (PPE) due to Covid 19.

During the inspection we saw that the seating material within the middle part of the ambulance was significantly ripped exposing the foam underneath across the whole of the front part of the seat. This was an infection control risk as foam cannot be adequately cleaned or wiped. We saw that as part of the patient records staff were required to tick for 'vehicle cleaning checks documented'. However, as this was not detailed in any policy, it was unclear what this meant. In addition, we were told that the service did not undertake any audits. This meant it was unclear how Transsecure NW Ltd could highlight areas of concern effectively such as the ripped seat or make improvements going forwards.

In response to our concerns around infection prevention and control, we took immediate action with the provider.

Environment and Equipment

The design, maintenance and use of vehicles and equipment did not always keep people safe.

During the inspection, we saw that Transsecure NW Ltd had one vehicle and were told another had been purchased to be used as a spare. The vehicle we saw comprised of three parts, the cab, middle saloon section and a secure seclusion cell at the rear. There was seating for five staff members including the driver. The vehicle was equipped with a satellite navigation system and a dashboard camera. We saw that the vehicle had a valid MOT certificate and insurance. We were told that the vehicle was serviced every 3500 to 5000 miles.

We were told that the vehicle was checked for roadworthiness before each transfer and we saw that as part of the patient records staff were required to tick for 'vehicle pre and post safety checks completed'. However, as this was not detailed in any Transsecure NW Ltd policy, it was unclear what this meant. In addition, we were told that

Patient transport services

Transsecure NW Ltd did not undertake any audits. This meant it was unclear how areas of concern could be highlighted effectively or how the service could drive improvements in relation to vehicle checks.

During the inspection we saw that the vehicle carried three boxes containing various pieces of equipment; for example, an automatic external defibrillator and basic first aid kits. The vehicle had laminated inventory checklists for each box which were taped to the windows within the middle saloon section. We were told that these correlated to the part of the patient records where staff were required to tick for 'vehicle equipment identified and replenished'. Following the inspection, we were told that there was an additional sheet, separate to the patient records which recorded inventory consumption and replenishment. However, we did not observe this during the inspection. The first aid kits were not tagged or inventoried. This meant whilst staff checked the kit was present, it was unclear if the contents were correct or when the contents were checked. We saw that the kits contained replenishable items with expiration dates. Transsecure NW Ltd did not undertake any audits. This meant there was a risk that the service was carrying items which could be out of date and it was unclear how this would be monitored or highlighted.

We were told that Transsecure NW Ltd carried two sets of mechanical handcuffs and that these were checked as part of the vehicle equipment checks to make sure they were in working order and to check for metal fatigue. However, this was not documented. This meant there was a risk that should there be an incident in which the handcuffs malfunctioned or caused injury to a patient, the service could not evidence when the handcuffs were last checked.

During the inspection we were told that Transsecure NW Ltd did not carry any other form of restraint aids. However, during the vehicle inspection we saw that box three contained one set of material restraint straps. These were not listed on the laminated inventory list for box three. We were told that these restraint straps were not being used as staff had not been trained to use them. It was therefore unclear why the straps were being carried and presented a risk that the straps could be used by staff without the necessary training.

During the inspection we saw that all of the ceiling in the middle saloon section of the vehicle had ligature points. In addition, we were shown a large bottle of engine oil which was situated to the side of the seat within this section. We were told that no risk assessments, including ligature risk assessments had been carried out in relation to the vehicle. This was important because it was not clear that Transsecure NW Ltd had assessed these risks in relation to the vehicle or how the risk to patients was reduced or negated.

In response to our concerns regarding environment and equipment, we took immediate action with the provider.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Procedures were not in place or were not clear to help staff identify and act upon patients at risk of deterioration. It was not apparent that restraint incidents were managed safely or that incidents were reviewed or investigated in line with best practice guidance. Staff were not trained appropriately in the application of restraint techniques. Staff did not receive the appropriate training or support in the form of guidance to safely manage or transport patients with mental health needs.

We had concerns that Transsecure NW Ltd did not have effective systems in place to determine that only suitable patients were transported. We were told that the service did not transport patients who had received rapid tranquilisation or patients with physical health or medical needs. However, these exclusions were not documented in the form of a procedure or as an inclusion/exclusion list for staff to follow. We were told that patient suitability was assessed during the booking stage and confirmed by a follow up telephone call by a member of staff who would be undertaking the transfer. However, this was not documented and there was no written process or procedure for staff to follow. This was a risk because it was unclear if Transsecure NW Ltd had assessed whether they were able to meet the needs of the patients being transported.

We reviewed 21 narrative patient records in relation to the suitability of the patients being transferred and found concerns with five records. For example, one transfer was for a patient with a unpredictable medical condition. The person commissioning Transsecure NW Ltd had ticked to say a registered mental health nurse (RMN) was required to travel with the patient. However, there was no evidence this took place within the associated narrative patient record.

Furthermore, the narrative stated that Transsecure NW Ltd staff had advised the patient not to be concerned as they had read up on the patient's condition. This was a concern because there was no documented evidence that staff had completed any relevant training in the condition.

In response to our concerns regarding the suitability of patients being transferred by the service we took immediate action with the provider.

During the inspection we were told that risk assessments were completed for all patients during the booking process. However, there was no documented evidence of this and there was no policy or procedure around the completion of risk assessments. We saw that only basic information had been recorded by Transsecure NW Ltd in the booking diary, such as where the patient was being transferred from and to, staff undertaking the journey and the total mileage. We reviewed 30 booking diary entries and found no risk assessment information recorded. In addition, Transsecure NW Ltd asked the person commissioning the transfer to complete an ambulance (secure) service journey sheet booking form. This document contained minimal risk information and related predominantly to whether the patient was at risk of being violent and/or requiring restraint. Missing information included allergies, infectious status, medical conditions and last administered medication. Furthermore, as the document was not always completed by Transsecure NW Ltd, there was no evidence that risks in relation to the care of the patient during the journey were being assessed appropriately or effectively. We reviewed 48 ambulance (secure) service journey booking forms and found only one had been completed by Transsecure NW Ltd and this had omissions. The remaining 47 records were completed by the person commissioning Transsecure NW Ltd and had omissions on 32 occasions. For example, the reason for the transfer, whether the patient was detained under the Mental Health Act 1983 or on an informal admission and whether there was a risk of the patient needing to be restrained.

There was some evidence that Transsecure NW Ltd confirmed the patient's demeanour and presentation immediately prior to arriving at the transferring hospital. However, this was not done consistently, and the information given by ward staff was not recorded. We reviewed 21 narrative patient records specifically in relation to the ward being contacted and asked about the patient's current presentation and found eight had the information recorded. However, as the presentation was not documented it was not clear how decisions were being made to support the care the patient received from Transsecure NW Ltd. In addition, there was no evidence that patients were risk assessed before being placed into the secure cell for transportation.

During the inspection we were told that all patients detained under the Mental Health Act 1983 were placed into the secure cell for transportation and all informal patients travelled within the middle compartment. However,it was not clear that all patients required this form of transportation. For example, we saw that one record indicated that the patient was vulnerable due to a slight build, facial injuries and was visibly upset. However, this patient was placed into the secure cell. This meant that patients were not being risk assessed or considered on an individual basis to make sure they received the appropriate person-centred care and treatment.

During the inspection we saw that the number of staff who completed transfers differed. For example, one transfer involved five staff members being dispatched and others involved three staff members. We were told that the minimum amount of staff for each transfer was three; however, we saw one record in which only two staff members had been recorded as transporting a patient. There was no documented process or procedure to inform how many staff were required to safely transfer a patient. We were told that this was agreed with the person commissioning the transfer in addition to the verbal risk assessment information asked over the telephone when the booking was taken by Transsecure NW Ltd. There was no documented evidence of this.

In response to our concerns regarding risk assessments not being completed by the service, we took immediate action with the provider.

There was an emergency guidance policy and procedure in place which outlined actions for staff to take in the event of a patient becoming ill during a journey. However, the policy did not state when it had been written, did not have a review date or document version control. There was no relevant legislation listed or best practice guidance associated with the document. We had concerns that patients would not always be managed appropriately in the event of an emergency. This was because although the policy stated that there may be scenarios where staff would need to call the emergency services, it also stated that staff

should report concerns to the on-call manager in the first instance. We also saw that there was no documented procedure within the policy for staff to follow and there was no clear guidance on how a patient should be monitored or cared for should their health deteriorate. For example monitoring vital signs such as pulse or changes in breathing. This meant that should a patient deteriorate whilst on a transfer, they may not be cared for appropriately.

During the inspection, we reviewed 14 staff files and found that only one staff member had a record for completing first aid training. This meant that we were not assured that staff would be able to provide care to patients whose health deteriorated and this exposed them to risk of harm. We reviewed 17 narrative patient records and did not find any recorded occasions when a patient had become acutely unwell during a journey. However, we saw one record in which by the end of the journey the patient complained of back pain. There was no record of a conversation with the patient about the pain or reassurance around reiterating this information to staff at the receiving hospital. In addition, this information was not documented as being handed over to staff on arrival at the destination.

In response to our concerns regarding patient deterioration, we took immediate action with the provider.

All staff had received adult basic life support training including how to use an automatic external defibrillator (a portable device with simple audio and visual commands, which through electrical therapy allows the heart to re-establish an organised rhythm so that it can function properly). However, there were no records to indicate any staff had received paediatric basic life support training. This was a risk because Transsecure NW Ltd were able to transport children.

There was a Mental Health Act 1983 and Regulations 2008 policy and procedure in place; however, this was dated as last reviewed June 2019 and noted for review in 12 months. There was no author or document version control. There was no detail within this policy about how compliance against it would be measured. The relevant legislation list did not encompass all legislation detailed within the policy. The policy did not contain any information for staff in relation to paperwork for transporting patients with mental health needs and contained information which was not relevant to the service. For example, Section 132 which relates to the rights of detained patients within an inpatient setting. In addition, the policy did not cross reference to any associated documents; for example, the service restraint policy or a Mental Capacity Act 2005 policy.

We had concerns that both the documentation required to transport patients detained under the Mental Health Act 1983 and the section papers relating to the detainment were not being managed appropriately by Transsecure NW Ltd. As part of the patient records, Transsecure NW Ltd completed a 'safe transfer pack'. This comprised of three check lists detailing welfare checks, vehicle checks and handover checks. Within the handover checklist staff were required to tick that the section papers were checked before departure and at the end of the list record, section papers were signed as received at the destination. However, what the checks should comprise of was not detailed and there was no associated process or procedure to accompany the transfer pack which outlined what checks staff should make. For example, a requirement to confirm the presence of the H4 transportation form. The H4 transportation form is a statutory form which gives authority to lawfully convey a patient detained under the Mental Health Act 1983 from one hospital to another; for treatment of their condition, where the receiving hospital is managed by a different hospital trust. This meant there was a risk that Transsecure NW Ltd could not evidence that they were transporting patients lawfully.

We checked 17 narrative patient records in relation to relevant mental health documentation checks and saw that there were 15 occasions when the paperwork was documented as received (but not checked) and two occasions where there was no narrative to state that the paperwork had been received before departure. We saw that on all occasions the paperwork was documented as handed over at the destination hospital. However, there were two occasions when the paperwork was incorrect. For example, on one occasion the section papers were photocopies and this patient had been transported 173 miles. We checked 17 narrative patient records and found 16 records which did not contain any information about the H4 form. The one record which did detail checks against the H4 form, found that it had been completed by the transferring hospital incorrectly; however, Transsecure NW Ltd only identified this as the vehicle arrived at the destination hospital.

Patient transport services

We saw that mental health awareness was detailed as a subject in the Transsecure NW Ltd in-house fundamental care programme certificate. However, it was not clear what training or information was provided within this and we were not able to be shown this during the inspection. In addition, we were unable to see if all staff had completed the training required for these certificates. Transsecure NW Ltd was only able to evidence certificates for five staff which were sent prior to the inspection. This meant that we could not be assured that all staff had sufficient training and competency to enable them to safely care for the patients they were transporting, putting patients at risk.

There was a restraint policy and procedure in place; however, this was dated as last reviewed January 2019 and noted for review in 12 months. There was no named author or document version control. The policy did not contain any information about the use of mechanical restraints or any procedure to determine if and how mechanical restraint should be used or authorised, and how the risks should be managed. The policy did not cross reference to any associated policies or documents; for example, the Mental Health Act 1983 policy or a consent policy.

The policy stated that all incidents of restraint should be proportionate and have an explanation in the recording which met with best practice guidance. In addition, the policy also stated that all incidents of restraint must be subject to audit and monitoring so that there can be learning from each incident and ways in which the reduction of the use of restraint could be sought. However, we reviewed four sets of patients records in which mechanical restraint had been used and found only two had limited evidence of explanation around the decisions taken to use restraint. Furthermore, there were no associated incident reports or investigation reviews for any of the incidents, in line with national guidance or service policy.

The policy had a restraint register log which was to be completed by Transsecure NW Ltd to log all restraint incidents. However, the restraint register log was not referenced within the policy as an appendix or otherwise. Therefore, it was unclear how staff would know to complete this log in the event of an incident in which restraint was used. During the inspection, we saw that the restraint register log in use by Transsecure NW Ltd was not the same as the one which was detailed in the policy and contained limited information. We had concerns that key information was not recorded; for example, the total time the transfer had taken (from and returning to the ambulance base location) was recorded but not the time the patient was in mechanical restraints. We found one incident when using mechanical restraints had resulted in the patient being injured, this was not recorded. This did not meet with any national guidance.

We reviewed the four recorded mechanical restraint incidents and found that only two had a record of explanation to the patient about the use of mechanical restraints. This meant that it was not clear that patients were being consulted or receiving an explanation about the process. We had concerns that the use of language within both the mechanical restraint incidents and other narrative patient records was not appropriate or conducive of treating patients with dignity and respect. For example, more than one record used language issuing instructions to patients such as getting onto their knees and being told that the service staff 'expected them to comply'.

During the review of the four recorded mechanical restraint incidents, we found that two patients had had their presentation checked with hospital staff immediately before the arrival of Transsecure NW Ltd and two had not. In addition, we saw that the two patients who did not have their presentation checked immediately prior to arrival had already had the decision made to use mechanical restraints before the patient had been seen. Therefore, we were not assured that patients were being risk assessed effectively or appropriately prior to having mechanical restraints applied. We also saw that in two of the four sets of patient records the safe transfer pack tick list had been ticked as complete; however, it was not reflective of the narrative patient record. For example, the box relating to the patient being offered hygiene facilities/comfort stop was ticked, however this was not detailed within the narrative and the patient was noted to be unable to get out of the ambulance after a journey of one hour and 40 minutes. Therefore, it was not clear that this patient had been offered stops or comfort checks as ticked within the safe transfer pack.

We had concerns that patient's physical health needs were not being considered by the service. For example, two of the four patient restraint records indicated that the patients weighed in excess of 125kg. There was no risk assessment as to the appropriateness of handcuffing these patients to the rear which would present a significant risk of positional

asphyxia. In addition, there was no detail recorded about how these patients were handcuffed; for example, wrists crossed, wrists facing downward/upward. Furthermore, there was no evidence of physical checks during any of the journeys for patient comfort, including checks for reddening or irritation. We saw that one of these patients sat on the floor of the secure cell throughout the journey and had the medical condition epilepsy.

We had concerns that patients subjected to mechanical restraint where not being monitored appropriately by the service in line with best practice guidance, National institute for Health and Care Excellence NG10 and Department of Health: Positive and Proactive Care (2014). There was no evidence in the four mechanical restraint records of vital signs being monitored either before, during the journey or after the restraint had been applied. For example, patients' respiratory levels or manual heart rate checks. Best practice guidance also states that staff should be trained and competent to interpret these vital signs. We found no recorded evidence in the 14 staff files checked that staff involved in these four transfers were fully trained or had their competences assessed in interpreting vital signs.

We found that information provided prior to the inspection showed that only one member of staff involved in each of the transfers in which mechanical restraint had been used had received mechanical restraint training. This meant there was a risk that patients may be harmed or injured due to staff not having the appropriate training.

We had concerns that not all staff who were involved in the use of restraint had received the appropriate restraint technique application training. During the inspection we reviewed 14 staff files and found there were only five records of staff completing level 1 prevention and management of violence and aggression (PMVA) training. On reviewing the four mechanical restraint records we found that on two of the transfers there was a staff member who had not received this PMVA training and another staff member on one transfer who received the training after the transfer had taken place. In addition to these concerns, details of manual restraint techniques or mechanical restraint techniques were not listed on the course outline for level 1 PMVA training. This meant it was not clear that any staff members had received the appropriate training to restrain patients safely, putting both patients and staff at risk of harm. Prior to the inspection we were provided with an invoice which showed that the service had booked a two-day course with an external provider for PMVA and handcuff training for six delegates for the 23 and 24 July 2020. Following the inspection, we were told that there were 12 members of staff who had completed the PMVA training course.

Due to the number of concerns we had in relation to the management of restraint within the service we reviewed an additional 72 narrative patient records specifically in relation to restraint and found one transfer in which the patient had been physically restrained by Transsecure NW Ltd which had not been recorded on the restraint register as an incident of restraint.

In response to our concerns regarding restraint, we took immediate action with the provider.

Records

Staff kept did not always keep detailed records of patients' care and treatment. Records were not always clear, up-to-date, kept securely or easily available to all staff providing care.

Transsecure NW Ltd did not have a document or record management policy in place to provide guidance to staff in relation to document completion.

The service had four types of documentation which made up the patient records; the booking diary information, the ambulance (secure) service journey booking form, the narrative patient record and the safe transfer pack.

During the inspection we reviewed 30 diary booking entries and found omissions and anomalies with all of the entries, information taken was basic and was not consistent.

We reviewed 46 ambulance (secure) service journey booking forms and found omissions with 37 booking forms and those completed in full had not been completed by Transsecure NW Ltd but had been completed by those commissioning the service.

We reviewed 21 narrative patient records and found concerns with 16 records. It was not clear that these 16 narratives were contemporaneous and we were told that handwritten notes were made during the journey or key timed information was put into a smart phone; however, we were not fully assured that these notes were directly linked to a secure system as we had differing accounts of how these notes were managed. In addition, we saw only

one record which contained the (scanned) original contemporaneous handwritten notes made during the journey and were told that original handwritten notes were not kept at the registered address.

We found that the same information was not always recorded within the narratives; for example, one narrative dated the beginning of June contained a titled 'evaluation and improvement' section, yet another typed in the middle of June did not.

We reviewed 13 safe transfer packs and found only five had been completed in full and of these two were not reflective of the narrative patient record written for each journey.

During the inspection, we saw that the narrative patient records were reviewed and signed by the registered manager; however, this was not completed consistently and there was no oversight documentation of this. In addition, as there was no policy or procedure in place in relation to patient records, it was unclear what was being checked when the narratives were being reviewed. We were told that Transsecure NW Ltd did not undertake any audits. This meant that there was a risk that patient documentation was not being completed correctly and it was not clear how improvements could be made effectively.

In response to our concerns around records, we took immediate action against the provider.

Medicines

The service did not always use systems and processes to safely manage medicines. The service medication policy was not fit for purpose or relevant to the service being provided. It was not clear that patients who had been medicated prior to transfer were being transported safely.

There was an overarching medication policy and procedure in place; however, this was dated as last reviewed February 2019 and noted for review within 12 months. There was no author or document version control. There was no detail within this policy about how compliance against it would be measured. The policy did not cross reference to any associated documents; for example, a consent policy. The policy was not clear, was not easy to understand and was not always appropriate to the service being provided. For example, the policy detailed that there were three levels of support for medication administration. Level one stated that Transsecure NW Ltd could provide general support or some assistance with medication administration; however, levels two and three did not mention Transsecure NW Ltd but were not removed or detailed as not being applicable to the service staff. In addition, level three stated that a healthcare professional (at the transferring hospital), with the agreement of the registered manager and having personally provided training, could delegate administering medication by specialist technique (such as rectal administration) to care workers (Transsecure NW Ltd staff).

The procedure within the medication policy stated that Transsecure NW Ltd were responsible for agreeing on the level of support required and ensuring that the appropriate record keeping was met. However, the medication assessment form which was attached at the end of the document to be completed by staff was not referenced within the procedure as an appendix or otherwise. Therefore, it was unclear how staff would know to complete this form in the event of needing to assist a patient with their medication. The medication assessment form was more reflective of an assessment tool used in an inpatient setting and did not appear relevant to a transport service.

The policy did not detail any procedure or process for patients who had received sedation medication or other medication prior to transfer or how to determine the risk. During the inspection, we were told that Transsecure NW Ltd asked during the booking stage if the patient had received medication within the last four or 12 hours. It was not clear what these time periods related to. In addition, we were told the service did not transfer patients who had received rapid tranquilisation or medication intramuscularly. However, there was no documented inclusion/exclusion criteria and as this was not documented within the booking information, this could not be evidenced.

We reviewed 46 ambulance (secure) service journey booking forms and found concerns with 13 records. We found that 12 records had information documented in the 'present medication' box; however, only one record documented the dosage of the medication and the time it was given, this had been written by the person commissioning the service. We found that six records had the 'present medication' documented and the box for 'escort required' was ticked on five occasions and 'RMN' required was ticked on one occasion. However, there was

no evidence within any of the associated narrative patient records that an escort or nurse from the transferring hospital was sent. This meant it was unclear what the 'escort required' request box meant or that the person commissioning the transfer and completing the form was clear on what was being requested or confirmed. Furthermore, as there was no associated document or record management policy or procedure it was unclear how staff working for Transsecure NW Ltd or those commissioning the transfer could seek guidance or assistance. Following the inspection, the provider advised that the booking form would be amended to ask specifically whether the commissioning service wished to provide an escort for the patient being transferred. However, this had not been evidenced at the time of the publication of the report.

We reviewed 87 narrative patient records specifically in relation to medication concerns. We found issues with six records. We had concerns that staff were unable to care for and monitor patients safely during transfers and within their competency. In addition, we had concerns that medication was not being recorded by either Transsecure NW Ltd or the person commissioning the transfer completely or accurately. For example, in one record continual references were made to a patient being drowsy, incoherent and struggling to mobilise. This patient was detailed as being given oral medication prior to transfer. It was not clear if this medication had caused the presenting condition or that Transsecure NW Ltd staff were able to safely care for this patient.

The policy did not detail any information around how Transsecure NW Ltd would transport the patient's own medication, including potential controlled or restricted medication. However, we reviewed 17 narrative patient records and saw that each time a patient's medication was handed over to Transsecure NW Ltd, it was annotated as being locked away securely in the vehicle and a note was made when the medication was handed over at the receiving hospital.

We saw that the policy stated that Transsecure NW Ltd would 'ensure that all staff involved in medication management are trained, assessed and competent to perform the activities required of them within their role'. However, we reviewed 14 staff records and found that only two members of staff had records for completing training in the safe handling of medication. In addition, only one of these members of staff had a record for completing training in the administration of medication. This meant there was a risk that staff could give assistance with medication without the appropriate knowledge and training which would put patients at risk of harm.

We were told that Transsecure NW Ltd did not undertake any audits. This meant that there was a risk that incidents or concerns around medication would not be recognised and it was not clear how improvements could be made effectively.

In response to our concerns around medication, we took immediate action with the provider.

Incidents

The service did not always manage patient safety incidents well. Staff did not recognise incidents and near misses and did not report them appropriately. Managers did not investigate incidents nor share lessons learned with the whole team, the wider service and partner organisations.

There was an accident and incident reporting policy and procedure in place which was in date and had been reviewed in April 2020. There was no author or document version control. There was no detail within this policy for grading incidents to enable differing levels of investigation; in line with best practice guidance. There no information on how compliance against the policy would be measured. The policy did not cross reference to all associated documents; for example, the service serious incident notification policy and procedure. The policy was always not clear and was not always easy to understand; for example, the policy stated that an appropriate accident book could be obtained from good bookshops and where available the service may have an online accident reporting system which could be used. In addition, at the end of the policy staff were advised to complete the accident and incident log. This meant it was not clear what action staff should take in the event of either an accident or incident needing to be reported.

During the inspection we were told that incidents were recorded on incident report forms which were located in the ambulance; however, the vehicle only held an accident log book only and did not contain any incident or accident report forms.

Patient transport services

We were told that there had been no incidents since the service began; however, we saw there had been the four incidents of restraint, an accident whilst transporting a patient on a journey and five incidents which had been recorded in the narrative patient records, examples included missing paperwork and the staff being asked to leave the premises after handing over a patient at a destination hospital. We saw that only one of these five incidents was detailed as an incident/near miss on the narrative patient record. There was no associated report or investigation.

The incident of an accident whilst transporting a patient on a journey had been logged in the accident book but there was no evidence of an investigation or any learning to mitigate the risk of this happening again.

On reviewing management meeting meetings there was no evidence that any incidents or learning from incidents were discussed or shared wider than the service.

Therefore, we were not assured that incidents were being recognised or reported appropriately. In addition, we were told that the service did not undertake any audits. This meant that it was unclear how the service could effectively make improvements.

In response to our concerns around incidents, we took immediate action with the provider.

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

Nutrition and Hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey.

During the inspection, we saw that nutrition and hydration was considered for patients and this was evident within the narrative patient records. In addition, we saw that journeys included stops when necessary for patients to ensure needs where met on journeys of any great length.

Competent Staff

The service did not always make sure staff were competent for their roles and there were no appropriate policies or processes in place in relation to staff competency.

There was no recruitment policy or process in place within the service. This meant that Transsecure NW Ltd was unable to evidence that the required checks as outlined in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been carried out. In addition, the lack of policy and/or process meant that it was unclear what action should be taken if a staff member had a positive Disclosure Barring Service (DBS) check. Therefore, we had concerns that Transsecure NW Ltd was unable to make sure that only fit and proper staff were employed to provide care and treatment to patients.

During the inspection, we checked all 14 staff files and found that there were omissions in all 14 records in line with schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found no written references, contracts of employment, or interview processes available for any members of staff. In addition, we saw that one staff member had a positive DBS check. No independent risk assessments had been completed in relation to this to ensure patients were protected from any risks that this may have posed to them.

We reviewed all 14 staff files and found that 13 did not contain any record or evidence that showed that driver history was checked as part of the recruitment processes and drivers that had poor driving history or did not conform to safe driving standards would be assessed for driving vehicles for Transsecure NW Ltd. We were told that only photocard driving licenses were checked for each member of staff. This meant there was a risk that driving convictions would not be seen. In addition, we found that for one member of staff there was evidence of poor driving history but there was no evidence that this member of staff had been assessed for driving vehicles for Transsecure NW Ltd. There was no evidence in any of the 14 staff files reviewed that they had undergone any recent training or assessment on their suitability to drive ambulance vehicles. This meant there was a risk that we were not assured that staff were suitable to drive vehicles and therefore, patients may be at risk of harm.

There was no induction policy or process in place within Transsecure NW Ltd. We were told that staff induction was divided into two parts, the first related to staff reading and signing as understanding the service policies and procedures and the second was a practical demonstration of the vehicle. However, we were unable to verify that all staff had signed as having read and understood

Patient transport services

Transsecure NW Ltd policies and procedures as the file which held this information was not available at the time of the inspection. In addition, it was not clear that the policies and procedures in place were up to date, relevant or appropriate to the service being provided by Transsecure NW Ltd.

In response to our concerns around competent staff, we took immediate action with the provider.

Consent, Mental Capacity and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not follow national guidance to gain patients' consent. It was not clear that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

We had concerns that Transsecure NW Ltd did not have any policies or procedures covering mental capacity, consent or best interest decisions. This was important as it meant that there was no clear process for staff to follow when documenting a best interest decision or to ensure that appropriate consent was obtained when required.

We reviewed 30 booking diary entries and found no information relating to patient's capacity.

We reviewed 46 ambulance (secure) service booking forms and saw there was no requirement to complete any information in relation to a patient's capacity or cognitive understanding.

We reviewed 17 narrative patient records and found that there were two recorded incidents which detailed that patients had been 'told' that they would be 'given a search'. There was no detail annotated that the patients had been asked or had given consent to this process. In addition, there was no process or procedure in place for undertaking searches of patients in the event that there were concerns around concealed weapons; for example, if the patient had a history of self-harm.

We reviewed 14 staff records and found that only one member of staff had a record for completing any form of mental capacity assessment training. There was no evidence of any training being completed by staff around consent or best interest decisions.

Are patient transport services well-led?

Governance

Leaders did not always operate effective governance processes, throughout the service or with partner organisations. Staff at all levels did not always have regular opportunities to meet, discuss and learn from the performance of the service.

We had concerns that there was limited oversight of the policies and procedures in place. We were provided with an email which detailed instruction for a policy file to be set up containing a set list of policies. However, we saw that the paper file located in the office, did not contain the policies on the list. For example, there was no 'employee training guide' or 'safe staffing' policies within the folder. In addition, policies named within the list did not mirror the policies within the folder available. For example, the email detailed a 'DoLS and restraint policy' but the policy within the file was entitled 'restraint policy and procedure'. Furthermore, there were a lack of policies and procedures for staff to reference for guidance; for example, there was no consent policy or safeguarding children policy, either within the folder or on the email list.

During the inspection we were told that the policies had been downloaded from an external company for which the licence had expired. Policies were generic and prior to the expiration of the licence, had been amended to include the Transsecure NW Ltd name. However, there was limited evidence that the policies had been tailored to the actual service being provided and therefore were not reflective. Transsecure NW Ltd had no plans on how they were going to update any policies or procedures going forward.

Policies and procedures were not always clear, were not always easy to understand and did not always contain compliance measures to make sure that the policies and procedures were effective or that change could be made when required. For example:

The challenging behaviour, violence and aggression had no author, no date, no review date and no compliance measures. The document made one reference to mechanical restraints and did not include any procedure or detail of what mechanical restraints were used by Transsecure NW Ltd. The policy did not reference relevant guidance (NICE Guidance: NG10).

The restraint policy and procedure did not detail the use of any form of mechanical restraints and the policy referenced documents which were not in use by Transsecure NW Ltd; for example, care plans.

The mental health policy had no process or procedure within it which helped staff to look after patients with mental health needs in the context of the service. There was no detail around a procedure or process for staff to check the documents and papers for the legal authority to convey patients. The policy appeared more appropriate to an acute mental health setting (inpatient).

The overarching medication policy and procedure outlined when a service user's care plan would require an urgent review. Also, it stated the local policy would dictate the codes used on the medication administration record charts and staff administering should be aware of the codes. However, none of this information was relevant or applicable to the service being provided.

The infection prevention and control policy and procedure referenced exposure prone procedures and aseptic techniques both of which were for clinical procedures such as cannulation, neither of which Transsecure NW Ltd was carrying out.

We had concerns because it is important that policies and procedures are specific to the service provided to support staff in delivering safe care and treatment based best on best practice guidance.

In response to our concerns around policies and procedures, we took immediate action with the provider.

We were told that Transsecure NW Ltd undertook regular team meetings; however, only one meeting had the minutes recorded for it and this had been attended by only three staff members. There was no standard agenda or action log. The notes of the meeting did not include any discussion around performance or risks to the service. In addition, we were told that there was a weekly meeting between the operations manager and the registered manager; however, these were informal and not recorded. This was important because there was no record of what had been discussed, what actions needed to be taken or who would be responsible for the actions. This meant that it was unclear that there was an effective system in place to highlight areas of concern or make improvements in a timely manner.

There was no evidence that Transsecure NW Ltd had facilitated meetings with any external partners such as the local acute NHS mental health trusts which work was commissioned on behalf of. This was important because the service had no contracts or service level agreements in place with any external organisations. It was therefore unclear how performance could be evaluated or learning shared.

Management of risks, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify or escalate relevant risks and issues nor identify actions to reduce their impact.

There was no evidence of an effective risk management system in place within Transsecure NW Ltd. It was not clear that there was an understanding of the risks the service faced or how the risks would be managed or mitigated.

It was not clear that incidents were being managed effectively and therefore, we were not assured that Transsecure NW Ltd was able to highlight areas of concern, seek improvements or prevent the risk of similar incidents from reoccurring. Narrative patient records had an incidents/near miss section; however, it was not clear that incidents were being recognised when they happened. We saw that when incidents occurred during the transfers, the incidents/near misses section was completed as 'none' despite incidents being recorded within the narrative. In addition, some records had an evaluation and improvement section; however, this was not consistently included as a section within the record for completion. Furthermore, we were not assured that there was a clear understanding of what constituted as a risk or concern which could be improved; for staff, patients or the service. For example, one evaluation and improvement section detailed that the only improvement which could be thought of was free standing cushions for the patient's comfort. However, this patient was annotated as being 'heavily medicated, extra vulnerable with learning difficulties' and at one point during the transfer 'could not stand up'.

It was not clear that there were systems in place to monitor compliance or give adequate oversight of the service being provided. There were no records to indicate any quality monitoring or audits had been carried out in relation to key processes such as infection control, staff records or patient

records. We were told that no audits or quality monitoring had taken place. We saw that there was no evidence that quality monitoring was discussed at the team meeting from 13 May 2020 which was minuted.

We saw evidence that those commissioning Transsecure NW Ltd fed back positively, on occasions, about the service being provided to patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that the care and treatment of service users is appropriate, meets their needs and reflects their preferences. This was a breach of Regulation 9(1).
- The service must ensure that it carries out an assessment of the needs for care and treatment and it designs care and treatment that meets those needs. This was a breach of Regulation 9 (3)(a).
- The service must ensure that staff treat service users in a caring and compassionate way and that services users are treated with dignity and respect at all times. This was a breach of Regulation 10(1).
- The service must ensure that care and treatment is provided in a safe way for service users and that the risks to the health and safety of service users is assessed and that all is done to mitigate any such risks. This was a breach of Regulation 12(2)(a)(b).
- The service must ensure that persons providing care and treatment to service users have the qualifications, competence, skills and experience to do so safely. This was a breach of Regulation 12(2)(c).
- The service must ensure that the vehicle is safe for use for the intended purpose and is used in a safe way. This was a breach of Regulation 12(2)(d).
- The service must ensure that the equipment used by the service in providing care and treatment to a service user is safe for such use and used in a safe way. This was a breach of Regulation 12(2)(e).
- The service must ensure that the assessment of the risk of infections including detection, prevention and control is effective. This was a breach of Regulation 12(2)(h).
- The service must ensure that medicines are managed in a safe way. This was a breach of Regulation 12(2)(g).
- The service must ensure that there are robust procedures and processes in place, which are operated effectively to make sure that people are protected and to prevent the abuse of service users. This was a breach of Regulation 13(1).
- The service must ensure that staff receive safeguarding training that is relevant, and at a suitable level for their roles. This was a breach of Regulation 13(2).
- The service must ensure that systems and processes are established and operated effectively to investigate, immediately upon becoming aware of any allegation, or evidence of abuse. This was a breach of Regulation 13(3).
- The service must ensure that care and treatment is not provided in a way that controls or restrains a service user that is not necessary to prevent, or is not a proportionate response to, the risk of harm posed to the service user or another individual if the service user was not subject to control or restraint. This was a breach of Regulation 13(4)(b).
- The service must ensure that care and treatment is not provided in a way that is degrading to the service user. This was a breach of Regulation 13(4)(c).
- The service must ensure that care and treatment is not provided in a way that significantly disregards the needs of the service user for care and treatment. This was a breach of Regulation 13(4)(d).
- The registered person must, in relation to premises and equipment, maintain hygiene appropriate for the purposes for which they are being used. This was a breach of Regulation 15(2).
- The service must ensure that there are appropriate systems and processes in place to assess, monitor and improve the quality and safety of the services provided and that these are operated effectively. This was a breach of Regulation 17(2)(a).

Outstanding practice and areas for improvement

- The service must that ensure that there is an effective system in place to make sure that only suitable patients are transported by the service. This was a breach of Regulation 17(2)(a).
- The service must ensure that there is an effective system in place to make sure that patients are safely cared for and monitored should there be a deterioration in condition whilst on a transfer. This was a breach of Regulation 17(2)(a).
- The service must ensure that there are appropriate and effective policies and procedures in place to provide support and guidance to staff. This was a breach of Regulation 17(2)(a).
- The service must ensure that there are appropriate systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk from the carrying on of a regulated activity. This was a breach of Regulation 17(2)(b).
- The service must ensure that there is an effective system in place to manage incidents so that they are managed in a way that would reduce the risk of a similar incident occurring again. This was a breach of Regulation 17(2)(b).
- The service must ensure that records are securely maintained, are accurate, complete and contemporaneous for each service user. In addition, care and treatment provided to the service user and decisions taken in relation to the care and treatment provided must be documented. This was a breach of Regulation 17(2)(c).
- The service must ensure that records relating to persons employed in the carrying on of the regulated activity are available and maintained securely. This was a breach of Regulation 17(d)(i).
- The service must ensure that persons employed by the service provider in the provision of a regulated activity receive the appropriate training and support to enable them to carry out their duties. This was a breach of Regulation 18(2)(a).
- The service must ensure that persons employed by the service for the purposes of carrying on a regulated activity are of good character and have the qualifications, competence, skills and experience necessary for the work being performed by them. This was a breach of Regulation 19(1)(a)(b).
- The service must ensure that full recruitment processes and procedures are established and operated effectively for all staff. This was a breach of Regulation 19(2).
- The service must ensure that the information as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is available and that appropriate risk assessments are completed to ensure that patients are protected from any risks posed to them if a staff member does not meet the checks as specified in Schedule 3. This was a breach of Regulation 19(3)(a)(b).

Action the provider SHOULD take to improve

- The service should consider ways to implement effective processes to monitor the outcomes of staff team meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed