British Red Cross

British Red Cross Mitcham

Quality Report

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

Ratings

Overall rating for this ambulance location	Requires improvement
Emergency and urgent care services	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

British Red Cross Mitcham is operated by British Red Cross Society. British Red Cross Mitcham provides emergency and urgent care.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 05 September 2019 and staff interviews on 11 October 2019, this was the first date following our initial inspection visit that managers were available.

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 was emergency and urgent care.

We rated it as **Requires improvement** overall.

We found the following issues that the service provider needs to improve:

- The safeguarding adult procedure referred to the previous adult safeguarding policy which had been replaced.
- We were not assured the contract for the removal of clinical waste met the needs of the service. Collections were not always pre-planned and were missed when staff were not onsite. Clinical bins removed by the contractor were not always replaced with empty bins ready for use.
- The deep cleaning record had not been completed in one of the eight ambulances we looked. We were not assured this deep clean had been done.
- There was a supraglottic airway device bag, however, there was no access to end-tidal carbon dioxide (ETCO2) monitoring if the equipment was used to provide an objective measure of airway patency and ventilation. Following our inspection, we were informed that the provider's guidelines stated waveform capnography should be used for tracheal intubation but not for SGA insertion.
- There was an asset management system in place, but this did not include stock management and all equipment was logged in and out manually which was time consuming and not always effective.
- Keys to vehicles were not always securely stored and were left outside the key safe when the make ready centre was unattended.
- Only non-prescription medication was stored at this location. The medicines were stored in an unlocked cupboard, in an unlocked office. There were two bins full of out of date medicines. When we raised this with staff they told us there had been a problem contacting the contractor responsible for collecting the bins and they had been full for several months.
- Volunteer paramedics could store British Red Cross controlled drugs (CDs) at their home. The service could not provide details of which paramedics held stock at home and evidence that home audits of CDs had been carried out.
- The managers were not assured that treatment provided by staff was in line with best practice and followed national guidelines and the service did not monitor patient outcomes or produce patient outcome data. Following the inspection, the registered manager provided us with a copy of the clinical audit data spreadsheet. This was a record of the treatment provided on site and included an evaluation of patient report forms (PRF) following an internal review. However not all entries on the spreadsheet had a review logged and it did not list actions taken in response to the review where improvements could be made.
- Volunteers did not receive an appraisal or participate in supervision of their work.

Summary of findings

- The service did not routinely collect data on the number of patients conveyed to hospital in an easily accessible format. To provide us with the data, staff had to check all patient record forms to identify who had been conveyed.Following the inspection we were advised the number of patients conveyed was included on the clinical audit data spreadsheet. However, we reviewed this and found the data included on the spreadsheet did not match the information given to us during the course of the inspection and it was not clear which figure was correct.
- The complaints, compliments and comments procedure was due for review in July 2017 and was now two years out of date.
- Staff told us national senior management were not visible and did not listen to the views of staff. The event first aid Mitcham pulse audit reported staff concerns in relation to the availability and presence of senior management.
- The provider's corporate strategy 2015 to 2019 covered areas of the organisation nationally and internationally. But did not reference specific services provided by the location, such as event first aid including conveyance from events to hospital.
- There was no evidence the event first aid risk register, and the risk register for Mitcham were live documents and periodically reviewed. The event first aid risk register was not dated and most risks did not have a named individual as a risk owner. The risk register for the Mitcham had nine risks, all of which were added in December 2018 and seven risks did not have an assigned risk owner.
- Volunteer staff we spoke with were not aware of the results of the volunteer staff survey completed in October 2017. The results had been collated nationally but were not broken down to local level to identify specific local issues.

However, we found the following areas of good practice:

- The provider used an electronic incident reporting system. All staff were encouraged to report incidents and all staff had access to this. Staff could complete paper forms when they were unable to access the electronic form at an event site. However, staff were not always clear on what they should report as an incident and were not able to provide an example of learning following an incident.
- All staff were required to complete mandatory training in key skills. Staff who were not up to date with their mandatory training could not work until they were compliant.
- Volunteers responsible for emergency driving were required to undertake blue light driving training and an assessment with an external provider.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe. All event first aiders were volunteers that could be accessed nationally when required.
- The service controlled infection risk well. The ambulances we saw were visibly clean and tidy with access to personal protective equipment.
- All essential emergency equipment was stored correctly and was ready to use. Consumables were in date and in undamaged packaging. The seats and stretchers in all ambulances we saw had harnesses and seatbelts to ensure patients could be safely conveyed.
- The service had access to a 4x4 vehicle which had been used to assist the NHS during heavy snow fall.
- The service had access to communication aids to assist staff communicate with patients. Each ambulance had a communication booklet of pictograms to use with people unable to verbalise their needs. Staff could access language line if required and each ambulance had a multi lingual phrase book in the document folder.
- Volunteers, staff, local and senior managers were passionate about working for the organisation and upholding its values.
- The service had a clear management reporting structure and the leadership team were able to give a clear account of how it worked.
- The service engaged well with volunteers. Weekly or fortnightly meetings were held locally, and volunteer coordinators attended to provide updates and discuss training.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected emergency and urgent care services. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Requires improvement 	British Red Cross Mitcham is managed by British Red Cross Society. The Mitcham location provided medical cover for events which included a regulated activity when patients were conveyed from event sites to hospital for further care and treatment. The service had eight ambulances and provided ambulance crews at events across the south of England. The service used volunteers to staff events and ambulances. We found that systems and processes did not always ensure that staff and volunteers were supported in delivering quality care to patients.

Requires improvement

British Red Cross Mitcham

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

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Background to British Red Cross Mitcham

British Red Cross Mitcham is operated by British Red Cross Society. The service relocated to Mitcham in April 2017, from a local office in Wimbledon, where it was based since 2013. British Red Cross Mitcham is an independent ambulance service in London providing event medical cover across London and the South East of England.

The service has had a registered manager in post since 11 April 2017.

The service provides the following regulated activities:

1. Transport services, triage and medical advice provided remotely

2. Treatment of disease, disorder or injury

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one CQC inspector manager, and a specialist advisor with expertise as a paramedic. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Facts and data about British Red Cross Mitcham

The service is registered to provide the following regulated activities:

1. Transport services, triage and medical advice provided remotely

2. Treatment of disease, disorder or injury

During the inspection, we visited British Red Cross Mitcham. We spoke with 10 staff including; volunteers, ambulance crews, local and senior management. We did not meet and were not able to speak to any patients or relatives. During our inspection, we did not review patient records as none were stored at this location.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, and the most recent inspection took place in September and October 2019.

Detailed findings

The location did not employ any event first aid staff directly. All staff and volunteers were employed centrally through the provider, British Red Cross Society. The location could access staff from across the country to assist at events where needed.

Activity (September 2018 to August 2019)

- In the reporting period September 2018 to August 2019 there were 59 emergency and urgent care patient journeys undertaken.

Track record on safety

Location level data for incidents involving vehicles

- 1 road traffic accident (RTA), 4 vehicle defects.

The service was unable to provide location level data

- 0 Never events reported.
- Clinical incidents 0 no harm, 0 low harm, 0 moderate harm, 0 severe harm, 0 death reported.
- 0 serious injuries reported.
- 0 complaints reported.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Not rated	Not rated	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Not rated	Not rated	Requires improvement	Requires improvement	Requires improvement

Emergency and urgent care services

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The main service provided by British Red Cross Mitcham was medical cover for events, while we do not regulate events, we regulate and inspect the transfer of patients from events to hospital for further care and treatment.

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Summary of findings

We found the following issues that the service provider needs to improve:

- The safeguarding adult procedure referenced the adult safeguarding policy which was no longer in use and had been replaced.
- We were not assured the contract for the removal of clinical waste met the needs of the service. Collections were not always pre-planned and were missed when staff were not onsite. Clinical bins removed by the contractor were not always replaced with empty bins ready for use.
- The deep cleaning record had not been completed for one of eight ambulances we looked at. We were not assured this deep cleaning had been done.
- There was a supraglottic airway device bag, however, there was no access to end-tidal carbon dioxide (ETCO2) monitoring if the equipment was used to provide an objective measure of airway patency and ventilation. Following our inspection, we were informed that the provider's guidelines stated waveform capnography should be used for tracheal intubation but not for SGA insertion.
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Emergency and urgent care services

- Only non-prescription medication was stored at this location. The medicines were stored in an unlocked cupboard, in an unlocked office. There were two bins full of out of date medicines. When we raised this with staff told us there had been a problem contacting the contractor responsible for collecting the bins and they had been full for several months.
- Volunteer paramedics could store British Red Cross controlled drugs (CDs) at their home. The service could not provide details of which paramedics held stock at home and evidence that home audits of CDs had been carried out.
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- The complaints, compliments and comments procedure was due for review in July 2017 and was now two years out of date.
- Staff told us national senior management were not visible and did not listen to the views of staff. The event first aid Mitcham pulse audit reported staff concerns in relation to the availability and presence of senior management.
- The provider's corporate strategy 2015 to 2019 covered areas of the organisation nationally and internationally. However, it did not reference specific services provided by the location, such as event first aid including conveyance from events to hospital.
- There was no evidence the event first aid risk register and the risk register for Mitcham were live documents and periodically reviewed. The event first aid risk register was not dated and most risks did not have a named individual as a risk owner. The risk register for the Mitcham had nine risks, all of which were added in December 2018 and seven risks did not have an assigned risk owner.
- Volunteer staff we spoke with were not aware of the results of the volunteer staff survey October 2017. The results were collated nationally and not broken down to local level.

However, we found the following areas of good practice:

- The provider used an electronic incident reporting system. All staff were encouraged to report incidents and all staff had access to this. Staff could complete paper forms when they were unable to access the electronic form at an event site. However, staff were not always clear on what they should report as an incident and were not able to provide an example of learning following an incident.
- All staff were required to complete mandatory training in key skills. Staff who were not up to date with their mandatory training could not work until they were compliant. We were told the shift booking system would only allow compliant staff to book a shift, but we were not provided with evidence of this.
- Volunteers responsible for emergency driving were required to undertake blue light driving training and an assessment with an external provider.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe. All event first aiders were volunteers that could be accessed nationally when required.

Emergency and urgent care services

- The service controlled infection risk well. The ambulances we saw were visibly clean and tidy with access to personal protective equipment.
- All essential emergency equipment was stored correctly and was ready to use. Consumables were in date and in undamaged packaging. The seats and stretchers on the ambulances we saw had harnesses and seatbelts to ensure patients could be safely conveyed.
- The service had access to a 4x4 vehicle which had been used to assist the NHS during heavy snow fall.
- The service had access to communication aids to assist staff communicate with patients. Each ambulance had a communication booklet of pictograms to use with people unable to verbalise their needs. Staff could access language line if required and each ambulance had a multi lingual phrase book in the document folder.
- Volunteers, staff, local and senior managers were passionate about working for the organisation and upholding its values.
- The service had a clear management reporting structure and the leadership team were able to give a clear account of how it worked.
- The service engaged well with volunteers. Weekly or fortnightly meetings were held locally, and volunteer coordinators attended to provide updates and discuss training.

Are emergency and urgent care services safe?

Requires improvement

This was the first time we rated this service. We rated it as **requires improvement**.

Incidents

The service did not manage patient safety incidents well. Staff were unsure what to report as an incident. Managers told us they investigated incidents, but lessons were not always shared with the whole team and the wider service.

- The registered manager told us they were not aware of any incidents specifically attributed to the Mitcham location. However, they advised us there were five driving incidents at the Mitcham location, one was a minor road traffic accident (RTA) and four reported defects with vehicles. There was not a consistent approach to recording incidents at location level, therefore we were not assured all incidents were reported and investigated.
- The provider's incident reporting policy and investigation procedure were both in date. The incident reporting policy included the legal requirements and defined what an incident, accident, serious incident and critical incident were. It detailed who the reporting lead was for different areas of the organisation, for example, Head of Quality was the report lead for UK safeguarding, clinical and practice incidents.
- The policy was written for British Red Cross at organisational level and detailed their obligations to other regulators including the Charity Commission. It was not specific to event first aid, conveying patients to hospital and the regulations under the Health and Social Care Act 2008. Therefore, it was not clear to staff how this related to event first aid and each location.
- The incident reporting procedure detailed how to report incidents and the process to review incidents. Service managers were assigned as the incident owner and were accountable for outcomes of any investigation. They decided the level of investigation required by using a risk matrix to determine the impact the incident had and the likelihood of it happening again. They

appointed an incident reviewer who decided on actions to take and the timeframe. This approach meant that individuals decided on actions to be taken and timescales for completion without any independent scrutiny.

- The provider's incident policy and procedure stated the head of the reporting line was responsible for all serious incidents (SIs) under their management and together with the incident owner determined whether an incident was an SI. The head was responsible for requesting an SI review meeting within two days of the SI being declared. The SI review meeting panel agreed terms of reference for the investigation, type of investigation and the timescale.
- We were told but not provided with evidence that quarterly reports of incidents, accidents, near misses, safeguarding concerns and actions from investigations were prepared and reported to the relevant sub-committees, such as the service quality assurance committee (SQAC), of the board at national level.
- We were told staff, both salaried staff and volunteers, were encouraged to report incidents using the electronic incident reporting system. Volunteers could complete paper forms when they were unable to access the electronic form, for example when at an event site. These completed forms were given to the event duty officer who logged them onto the electronic system. We saw paper copies in the vehicle document folder on the ambulance we inspected, ensuring they were easily accessible.
- The provider had guidance for managers on writing an apology to a complainant. However, this guidance was out of date, dated August 2018. It did not clearly identify what duty of candour was and the guidance included issues of liability which might be confusing for staff.
- The duty of candour learning card we reviewed, outlined what duty of candour was. However, it stated incidents of moderate harm or above should be reported via the electronic incident reporting system which might lead staff to think incidents of low harm did not need to be reported.
- Staff we spoke with told us they were not always clear on what they should report as an incident. They were aware equipment failure and poor practice should be reported and were able to describe the reporting process.
- Staff were not able to provide any examples of learning from an incident. They told us they did not always receive feedback and feedback was only usually provided for serious incidents reported. Managers told us staff could request feedback by ticking a box on the incident form. but those staff we spoke with were not aware that they needed to tick this box to receive feedback
- Action was taken on concerns raised about peer's practice. A volunteer we spoke with gave an example of when they had reported via email, the poor practice of another volunteer, to the line manager who had taken action to address this concern.
- The registered manager and staff at location level had not received root cause analysis (RCA) training. Following our inspection, the provider told us that RCA is performed by trained investigators as outlined in the incident (including serious incident) reporting and investigation procedure.

Mandatory training

The service provided mandatory training in key skills relevant to their role to all staff and volunteers and made sure everyone completed it.

- All staff were required to complete mandatory training yearly which included six competency-based training modules such as basic life support and safeguarding. The training compliance target was 100%, however data was not available at location level to demonstrate compliance as volunteers were employed nationally and could work from multiple locations. The leadership team told us they encouraged volunteers to keep their mandatory training up to date and training nearing the expiry date was clearly identified on the employee portal.
- The level of training staff received depended on the role they undertook. An event first aider did not receive training to the same level as ambulance crew and training was tailored to the role.
- All staff were required to undertake a minimum of 12 hours continuation training every 12 months and three yearly revalidations for the role they undertook.
- Staff told us they had access to mandatory training and were up to date. If a module was not completed they would enter "skills gap" and could not book a shift at an event until it had been done. The leadership team confirmed the shift booking system would not allow volunteers with a skills gap to book a shift.

- Volunteers we spoke with told us they had to undertake a driving assessment to drive a British Red Cross vehicle. However, this assessment was reported to be an observation of the individual driving and not a structured assessment. Therefore, there was no evidence that all drivers had the necessary skills and competencies to drive a BRC vehicle.
- The leadership team told us that all volunteers who were responsible for driving on blue lights undertook a driving assessment. Staff received weekend blue light training with an external provider to gain a qualification to drive emergency response vehicles. We reviewed the British Red Cross procedure which stated that staff driving emergency response vehicles needed to be qualified to do so. We were told that volunteers would not be assigned to drive if they had not completed the course, but we were not provided with evidence that all those driving on blue lights were qualified to do so.
- Staff had access to de-escalation training, CALMER, to manage violence and aggression. A volunteer we spoke with had completed this training and told us it had helped them deal with difficult situations.

Safeguarding

Staff understood how to protect patients from abuse. Staff had completed training on how to recognise and report abuse, and they knew how to apply it.

- Safeguarding training was included in the mandatory training modules. The registered manger confirmed that all volunteers were trained to level two in adults and children's safeguarding.
- The service did not submit the most up to date safeguarding policy as part of their provider information request (PIR). They submitted the children's safeguarding policy 2016 and did not provide one for adults. During our inspection the managers stated the policy had been updated in November 2018 and that it was a joint children and adult safeguarding policy, but a copy of this was not provided therefore we could not be assured it reflected the most up to date national guidance.
- There were separate British Red Cross safeguarding procedures for adults and children, however, the content of the adult procedure was out of date.
- The safeguarding children procedure was clear and detailed, it included a flow chart of escalation for staff to follow if they had concerns. A table detailed different forms of abuse and signs for staff to look for that might indicate abuse or harm. This could assist staff identify concerns. The policy referenced current legislation including Section 11 of the Children Act 2004 and used national legislative frameworks to guide the policy.
- The safeguarding adult procedure, due for review in February 2020, referenced the adult safeguarding policy 2016 which was no longer in use and had been replaced. A table detailed different types of abuse and indicators for staff to look for that might indicate abuse or harm.
- Staff we spoke with were able to articulate what they would do if they had a safeguarding concern and understood their responsibilities. They told us a manager was contactable 24 hours a day, seven days a week, who they could escalate concerns to.
- The provider advised in the PIR there were plans to introduce a dedicated safeguarding team on call 24 hours a day. At the time of the inspection this was not yet in place.

Cleanliness, infection control and hygiene

The service controlled infection risk well most of the time. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, premises and vehicles visibly clean.

- The ambulances we saw were visibly clean and tidy. All had personal protective equipment (PPE), decontamination wipes, clinical waste bins and alcohol gel to reduce the risk of cross infection. Sharps bins on the ambulances were dated and not over full.
- We were told there was a contract for the removal of clinical waste, but this was not always effective. Due to the nature of the service the logistics team may not be present when the contractor arrived to remove the waste. This removal was not always pre-planned and often while they would remove more than one clinical waste bin they only left one clinical waste bin. It was unclear if the current contract met the provider's needs.
- The vehicle document folder contained information about infection prevention control (IPC) including information on hand hygiene, how to dispose of PPE and an ambulance deep clean record. However, the deep clean record had not been completed in one of the ambulances we saw, and we could not be assured this had been done.

- The equipment cleaning and infection control presentation used for training included an activity for staff to correctly identify what cleaning product should be used. This made staff aware of the different cleaning products available and which should be used and when.
- The infection control learning card, a 2-sided card, included useful information about infection control and the importance of washing or gelling hands before and after patient contact. This reference tool assisted to promote effective infection control measures.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them.

- The location had eight ambulances and at the time of our inspection one was ready for use. Logistic staff told us that each ambulance was made ready 48 hours before they were needed. This meant stock was not left on ambulances for long periods of time reducing waste and the risk of it being out of date.
- All essential emergency equipment such as suction and the defibrillator were available and ready to use. Consumables we checked were in date and in undamaged packaging. The seats and stretcher had harnesses and seatbelts which ensured patients could be safely conveyed. Equipment was stored correctly, and cupboards were labelled identifying their contents which aided staff to locate equipment.
- Staff told us that the vehicles differed and there was no familiarisation sheet in the vehicle to assist the driver. Staff had suggested these sheets should be available, but it had not been adopted resulting in drivers not always being aware of all the functions of the vehicle they were driving.
- The supraglottic airway device bag on the ambulance, equipment used to open a patient's airway and provide unobstructed ventilation included consumables which were all in date. However, there was no access to end-tidal carbon dioxide (ETCO2) monitoring when the equipment was used. This was not in line with the Royal College of Anaesthetists (RCA) guidelines which states if any advanced airway device is used this monitoring should be available. We were told in the last 18 months these airways had been used twice. By not having access to this monitoring if the airway was misplaced it may not be identified in a timely manner and could lead to potential patient harm.
- We were told that the safety vehicle checklist was not always completed by the staff taking the ambulance, and that this was not a mandatory check. This is not in line with best practice. While logistics staff checked the ambulance and reported it ready for use, this was frequently not checked by the crew using it to confirm no equipment had been removed. There was no evidence that these safety checks, such as tyre pressure, were audited.
- The location used a bag system for all consumables and medicines and there was paperwork to identify what was in each bag including asset numbers where appropriate. These bags were tagged with green tags to demonstrate that they were ready for use. The bags were stored on the ambulances, many in cupboards to prevent them from falling and injuring the patient or staff. However, we noted that one heavy bag was stored on a surface or seat but not secured, this was a potential hazard. We were told as all ambulances had different layouts it was not possible to have a consistent layout of the interior of the ambulance, but all had the same equipment in the same bags.
- There was an asset management system in place, but this did not include stock management and it was reported to be ineffective. Despite feedback and alternative suggestions from staff, these suggestions had not been listened to and changes had not been made. All equipment was bar coded and we saw that this was manually signed in and out, which was time consuming, introduced the risk of error and an ineffective use of a team that was stretched, as they were covering several other locations due to sickness and vacancies.
- An external company was responsible for testing and maintaining equipment. This was undertaken on a six-monthly basis and ensured equipment was not all removed at the same time. All equipment we saw had been portable appliance tested (PAT), and the PAT label demonstrated this was in date. We were told that if PAT testing was out of date the equipment would be labelled as not to be used and quarantined in a specific area in the make ready centre.
- Keys to vehicles must be stored in a locked key safe to prevent unauthorised access. However, we noted they

were stored in a basket outside the safe. Staff told us the keys were left out only when staff were present and returned to the key safe when the location was left unattended. During the inspection keys were not secured in the safe despite the logistics area being left unattended. When we raised this with staff they reported that the keys had been left in the basket so that CQC could have easy access to the ambulances and that this was not their usual practice.

- The building had a lift to access all floors, we were told this lift was not fully operational and despite it being reported as faulty this had not been fixed for a long period of time. For example, the lift could be called from the ground floor and accessed but not from the other floor. Therefore, if required the individual had to call down to the ground floor to request the lift. This meant the building was not accessible to those with mobility problems.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient or update the assessments. Staff did not always identify and quickly act upon patients at risk of deterioration.

- We reviewed the clinical audit data from January 2019 to June 2019 which looked at all patient report forms (PRFs) from each event and rated patient contact as clinically safe, not best practice, not clinically safe with no concern and not clinically safe with concern. Of 122 patients treated, 50 were rated as clinically safe, 37 safe but not in line with best practice, 2 not safe with no concern and 35 rated as not safe with concern. Problems identified included no observations, no pain relief offered and not undertaking a full examination of a patient after a fall from a bike. However, we were not able to identify if any of these patients had been conveyed to hospital and therefore part of regulated activity.
- Patients were not always assessed correctly. Staff told us they would take two sets of patient observations but as the patient record forms were not intuitive, two sets might not be recorded. We were told observations were recorded and the national early warning score (NEWS) was used. Patients that scored three or higher were referred on to volunteers with enhanced skills. However, the clinical audit data identified that of the 122 patients seen, 99 had a first set of observations recorded on PRFs and of those 99 patients, 43 had a second set of observations recorded. We were not provided with any evidence that action had been taken on these audit findings to improve practice.
- Staff we spoke with were able to describe what action they would take if a patient needed care beyond their training. They confirmed patients would be referred to an NHS crew if one was at the event or call 999 to escalate a patient for more urgent care. They had received training on how to provide a good handover to NHS staff.
- The service did not have ambulances fitted to convey bariatric patients or wheelchair users and staff would call 999 for assistance.

Staffing

The service had access to enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Planning coordinators would request volunteers with the right level of training for the specific event once it had been booked. We were not provided with numbers of staff employed directly at the location and management roles were national. Volunteers worked nationally and not from a specific location.
- Staff providing event first aid and conveying to hospital were volunteers with different levels of training and experience. Volunteers conveying patients to hospital had received additional training to event first aiders and could treat patients with a higher level of acuity.
- Staff were aware of the roles they could and could not undertake, these were documented in the event first aid minimum training standards and scope of practice for clinical roles. Each role, first aider, advanced first aider, ambulance crew, ambulance technician and paramedic had defined roles and skill sets.
- When an event could not be fully staffed with volunteers the leadership team told us they would sub-contract services from another provider. But we were not provided with evidence of when this subcontracting had occurred.
- At the time of our inspection the logistic staff at the Mitcham location were providing cover for the Enfield location, due to staff sickness and vacancies. It was

reported that when staff employed by the provider left they were not replaced in a timely manner resulting in staff covering more than one site which placed additional pressure on staff.
- Staffing was on the event first aid risk register as a potential risk. The leadership team told us that communication with volunteers was key to keeping them engaged with the service and volunteers who undertook more advance training were asked to commit to a minimum number of events. This ensured they retained their advance skills.
- The leadership team told us there was a constant recruitment programme in place to ensure they had enough staff to meet demand. A volunteer workforce meant staffing numbers could fluctuate and they had different motivations to paid staff.

Records

Staff told us they kept detailed records of patients' care and treatment however we were not able to review them during the inspection.

- We were not able to review patient record forms (PRFs) during the inspection. At the time of the inspection only logistic staff were onsite who advised us PRFs were held centrally and there were none onsite.
- PRFs were given to the event coordinator who was responsible for keeping these secure and transferring them back to the location.
- Staff told us they completed PRFs and that records should be clear and treatment delivered documented. However, we reviewed the clinical audit data which highlighted several concerns with PRFs. For example, they were untidy, were not signed by those treating the patient and parent or guardians' details not documented for paediatric patients.
- At our previous inspection we found that PRFs were being sent back to the provider by Royal Mail post and were not tracked. This was identified as a risk as patient identifiable information might be lost. During this inspection staff told us all patient record forms were given to the duty event officer who was responsible for returning these to base which were then sent securely for central storage. However, the ambulance document folder continued to have prepaid envelopes and meant we were not assured PRFs were always sent securely.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

- At the time of our previous inspection the location did not have a Home Office licence to hold controlled drugs (CDs). On this inspection we found that CDs were not stored locally and were now stored at the Newcastle location with the appropriate Home Office license. When required CDs were sent and tracked via a courier to the Mitcham location ready for volunteer paramedics to collect before an event.
- Only non-prescription medicines were stored at the location which could be administered by event first aiders. They were stored in a cupboard that had the ability to be locked and a sign stating the cupboard must always be locked, however at the time of the inspection the cupboard door and office door was left open. This meant the medicines could be accessed by unauthorised persons.
- The room in which medicines were stored had a thermometer but the temperature was not recorded. There were no minimum or maximum temperatures stated and no assurance the medicines were stored at the correct temperature.
- Medicines were not disposed of safely. There were two full bins of out of date medicines in the unlocked office. The bins were not locked and were not labelled. We were told there had been problems contacting the contractor responsible for disposing of the medicines correctly and the bins had been full for several months.
- All medicines stored at the location were tracked using a paper system, which was labour intensive, at risk of error and there was no back up if paper copies were lost. This meant there was a risk not all medicines were tracked from entry into the service to administration.
- We were told some paramedics had stocks of CDs in their home. While paramedics legally can hold and store CDs, the service could not provide details of which paramedics held British Red Cross stock. There was no evidence that home audits to ensure these CDs were stored in line with legislation had been carried out. The leadership team told us there was no restriction on how long these CDs could be stored at a paramedics' home before the individual was required to return them to the Newcastle location. There was no assurance these CDs were stored in line with legislation.

Emergency and urgent care services

- Medicines on the ambulance were in their original packaging, stored in a green tagged bag in a lockable cupboard and all medical gases seen were in date and stored in cupboards. We were told no spare medical gas cylinders were held at the location and when additional supplies were required these would be obtained from the company. There was a lockable medical gas cupboard in a ventilated area that had shelves labelled full and empty.

Are emergency and urgent care services effective?

Not sufficient evidence to rate

We did not rate the Effective key question as we were not able to review enough information gathered on patient outcomes.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, managers did not check to make sure staff followed guidance.

- The service used the Joint Royal College of Ambulance Chief's (JRCALC) as guidance on patient pathways and staff told us they accessed guidelines on the provider's online portal known as the 'Redroom'.
- Senior managers told us that they used the Health and Safety Executive (HSE) safety guides in line with best practice when planning events. The service referred to the purple guide for events and the green guide for sporting events in planning the required number of staff.
- Treatment provided was not audited and managers did not know whether treatment given followed guidance or best practice. There was no evidence that the provider was assured staff followed national guidance and best practice and took action when staff failed to do so.
- Staff told us they would call 999 if they required advanced clinical advice and support.

Pain relief

We were not provided with evidence to demonstrate staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief advice in a timely way.

- Staff told us they assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools. We did not see and were unable to speak with any patients during the inspection and could not confirm whether they had been offered pain relief or if it was given in a timely way.
- The British Red Cross event first aid minimum training standards and scope of practice for clinical roles outlined what pain relief could be given and by who. Event first aiders could provide over the counter pain relief, advanced first aiders, ambulance crew, and ambulance technicians had received additional training and could give pain relief gas. Paramedics could prescribe pain relief such as morphine in line with the association of ambulance chief executives (AACE) guidance.
- We reviewed the British Red Cross communication booklet which included information on pain. Patients could communicate information about their pain using the pictures and symbols. This communication tool was used for patients who had difficulty communicating or those that didn't speak English.

Response times

The service did not monitor response times and did not have data to make improvements to patient care.

- At the last inspection we noted data was not collected on ambulance transfer numbers and there was limited analysis for future planning needs. At this inspection we requested and were given the number of patient transfers and the event from which they were transferred. However, this information was not routinely collected, and the provider had to review all the patient report forms over the last 12 months to provide this data.

Patient outcomes

The service did not monitor effectiveness of care and treatment and did not have outcome data to make improvements to patient care.

- At our previous inspection we found and reported that patient care and treatment outcomes were not routinely monitored. At this inspection we found this was still the case and action had not been taken to address this finding.
- Volunteers told us, and service leaders confirmed, they do not get feedback on treatment given at events.

Competent staff

The service made sure staff were competent for their roles. Managers did not appraise staff's work performance and held supervision meetings with them to provide support and development.

- Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and monitor the effectiveness of the service.
- Service leaders told us volunteers did not receive an appraisal or participate in supervision of their work.
- The British Red Cross event first aid minimum training standards and scope of practice for clinical roles described individual roles and the training volunteers needed to complete in order to carry out their role. It outlined minimum requirements, responsibilities, referral rights and medication they could administer. However, this guidance had a review date of December 2017 and was out of date therefore we were not assured it reflected best practice.
- Insufficient competent volunteers was listed as a risk on the event first aid risk register. Actions listed included ongoing recruitment and developing systems to recognise qualifications volunteers already held. To mitigate this risk, the event capacity model was used to make sure the event could be staffed with the correct numbers.

Multi-disciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

- Staff told us they worked well with other agencies at big events. They would liaise closely with the event coordinators to make sure all organisations worked collaboratively. This included charities, private companies and the NHS.
- The service used a wide range of volunteers with different skill sets and professional backgrounds and meant events were staffed by people with a wide range of experience and knowledge.
- Staff told us they communicated effectively with local emergency departments. The service provided a carbon copy of the patient report form to hospital staff.

Health promotion

We were told staff gave patients practical support and advice to lead healthier lives. But we were not provided with evidence that this occurred in practice.

- Staff told us that they might treat patients under the influence of alcohol or drugs. However, they did not have leaflets or information that could be given to patients to highlight the dangers and were individuals could access support or guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.

- Staff told us they gained consent from patients, discussed treatment so patients were informed and were aware of the Mental Capacity Act. The ambulance document folder included a consent guide with information about managing patients who lacked capacity and involving children. However, the clinical audit data showed that of 122 patients, nine did not have consent recorded on their patient report form including two paediatric patients.
- We reviewed the British Red Cross appropriate use of restraint – a quick guide, this contained a tick list for staff to use as a tool to inform decision making. We were not provided with any evidence that these forms had been completed and that restraint had been used in the patient's best interest.
- The summary section of the British Red Cross guidance for the appropriate use of restraint within event first aid and ambulance support, stated this guide provided service specific guidance on restraint, what legislation covers, the use of restraint and how restraint or other

restrictive practices must be managed. However, the main content of the document was information on equipment maintenance and not how to use restraints or how practices must be managed.
- The appropriate use of restraint – a quick guide which was submitted as part of the provider information request, provided staff with a checklist to use when assessing if restraint should be used.
- The British Red Cross appropriate use of restraint procedure defined what restraint was, when it could be applied and that all incidents where restraint was used must be reported using the accident, incident, near miss procedure (AINM). The procedure stated the British Red Cross would not be involved in a DoLS application. We were not provided with any evidence of when restraint had been used and if the procedure had been followed.

Are emergency and urgent care services caring?

Not sufficient evidence to rate

We did not rate the Caring key question as we were unable to speak to any patients or relatives and were unable to review any feedback provided by patients.

Compassionate care

- Staff told us they treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- We did not observe patients being cared for by staff during the inspection. However, staff we spoke with were able to describe the care they would provide and their motivation to work as a volunteer was to care for people.

Emotional support

- Staff told us they provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- We did not observe patient care however, staff told us they understood the importance of respecting peoples personal, cultural and religious needs and this was the ethos of working for the British Red Cross.

Understanding and involvement of patients and those close to them

- Staff told us they supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- We did not observe patient care and did not speak to any patients or relatives about the care they had received. We requested contact information for people who had been treated by the location, but the provider was not able to provide this**.**

Are emergency and urgent care services responsive to people's needs?

Requires improvement

This is the first time we have rated responsiveness. We rated it as **requires improvement.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of the people attending the events they served. It also worked with others in the wider system and with local organisations to plan care.

- The provider was contracted to supply services for pre-booked events and liaised with event organisers to plan the level of service required.
- The leadership team told us they worked in partnership with other organisations at big events for example the Great North Run. They coordinated with the event control centre and worked alongside voluntary services, private ambulance providers and NHS ambulance services.
- Managers told us volunteers were provided with an event briefing detailing the service being provided and the escalation procedures in place. Staff told us they always received an event briefing including the location of local emergency departments.
- The Mitcham location could utilise speciality staff nationally and access equipment from across England. At the time of our inspection, volunteers and equipment from the Mitcham location travelled to Newcastle to provide support for the Great North Run.

Emergency and urgent care services

- Staff told us they had access to a 4x4 vehicle. This had been used to assist the NHS during heavy snow fall to transport clinical staff to hospitals.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

- Staff we spoke with told us they would respect patient needs and beliefs in line with the British Red Cross values.
- We reviewed the communication booklet and found this to include a number of pictograms including, symptoms, pain and medication and was used as a tool to communicate with people. We saw a copy of this in the vehicle document folder of the ambulance we inspected.
- The interpretation and translation procedure explained how staff could access resources to support patients. A multilingual phrase book was in the vehicle document folder of the ambulance we inspected.
- The do not attempt cardiopulmonary resuscitation (DNACPR) procedure gave guidance for staff to follow, although we did not speak to staff who had experienced treating a patient with a DNACPR in place.

Access and flow

People could access the service when they needed it. However, the service was not assured patients received the right care in a timely way and data was not collected or monitored to improve the service.

- The leadership team told us if they were contracted to provide emergency cover that included conveying patients to hospital there would be multiple ambulances at the site to ensure there was always cover in the event of a patient being conveyed to hospital. If there was only one ambulance at the event and a patient needed to be conveyed to hospital, a 999 call would be made to the local ambulance service and an NHS ambulance requested.
- The service was not equipped to accommodate bariatric patients or wheelchair users. In this instance the ambulance crew would call 999 for assistance with conveying a patient to hospital for further treatment which could lead to a delay for the patient.
- The leadership team told us they did not obtain feedback from hospitals regarding the treatment volunteers had provided. The service had no assurance that the correct treatment had been given.
- The leadership team told us they did not monitor ambulance hand over times and did not have data to review to improve the service.

Learning from complaints and concerns

There was no data or information to demonstrate that it was easy for people to give feedback and raise concerns about care received. Complaints data was not provided on a location level and therefore we could not be assured lessons were learnt.

- The leadership team told us complaints were received nationally and shared with local leaders. The registered manager advised us they were not aware of any complaints made against the Mitcham location.
- The British Red Cross volunteer complaint, issues and concerns policy and procedure were both in date. They outlined who would investigate and the action that would be taken.
- The British Red Cross complaints, compliments and comments procedure, was two years out of date as it was due for review in July 2017. The procedure outlined the process for staff and the timescales for responding. We were not provided with any examples of complaints and the responses that had been provided by the service.
- The ambulance document folder had a "Your experience" questionnaire to be given to members of the public to obtain their feedback. This information was collected nationally and not at location level. We were not provided with any examples of patient feedback.

Are emergency and urgent care services well-led?

Requires improvement

This is the first time we have rated responsiveness. We rated it as **requires improvement.**

Leadership of service

Emergency and urgent care services

Leaders understood the issues the service faced. Local leaders were visible and approachable in the service for staff.

- Event first aid had a national senior leadership team with regional service delivery managers. The registered manager for Mitcham was also the registered manager for the Enfield location and had oversight of the south region.
- The local and national managers we spoke with were passionate about working for the organisation and had a good understanding of the challenges they faced.
- Staff we spoke with told us that local managers were accessible, helpful and supportive. However national senior managers were not visible and did not listen to the views of staff or acknowledge when things went wrong. While they stated senior managers were open to suggestions, when these were made they were not acted on and no rationale was given why not. For example, there was a lack of cages to store stock at the Mitcham location but at Hillingdon there were 50 cages not being used. It had been suggested that these unused cages could be transferred, however, this was not taken forward and no rationale given. This resulted in staff feeling they were ignored.
- We reviewed the event first aid Mitcham pulse audit, it was reported that there were staff concerns over the availability and presence of senior management.
- The fit and proper person (FPP) procedure submitted as part of the provider information request (PIR) was out of date. As a provider of regulated activity, they must evidence compliance with the fit and proper person requirement that came into force in 2015. As a regulated charity they must also comply with the FPP test for Her Majesty's Revenue and Customs (HMRC). We were not assured the provider was compliant with the FFP regulation which is a breach of their condition of registration.

Vision and strategy for this service

The provider had a vision for what it wanted to achieve and a strategy to turn it into action as a national and international organisation. The vision and strategy were focused on sustainability of services and helping people in crisis. However, this did not specifically include the regulated activity they undertook or the services they provided at a local level.

- The provider had a mission statement for event first aid which described the vision for the service nationally. One aim was to "place our service users at the heart of what we do" and staff we spoke with at the Mitcham location supported this.
- The provider had a corporate strategy 2015 to 2019 which covered areas of the organisation nationally and internationally. It was not clear how this linked to the service as it did not mention event first aid or the location.

Culture within the service

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

- All staff we spoke with were open, honest and proud of the work they did for the British Red Cross. The leadership team told us they were proud of the first aid care volunteers had delivered at events during a busy summer period.
- The Mitcham location employed salaried logistical staff. We observed good team work and staff were respectful and supportive of each other.
- Volunteers we spoke with were passionate about their roles and told us they believed in the ethos of the organisation which is why they volunteered. Discriminatory behaviour was not tolerated, and equality was promoted in line with the values.
- The leadership team told us the service could not run without volunteers giving their spare time to the organisation and spoke highly of them.
- Volunteers were encouraged to attend local meetings to meet with colleagues and build good working relationships.
- We were told by a volunteer that following a traumatic event a debrief would be held to provide support to staff and staff wellbeing was taken seriously by the provider.

Governance

We were not assured that leaders operated effective governance processes throughout the service that fed down to location level. Senior staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss the performance of the service.

- The service had a management reporting structure from local level to the senior management team. However, we were not assured that information was fed back at location level. Local staff and volunteers told us they did not always receive feedback when concerns had been raised and staff could not give examples of learning shared from other locations.
- The governance committee structure fed up from advisory groups locally to national level. The board of trustees had overarching control and clinical governance was overseen by the service quality and assurance committee. Reporting lines were clearly outlined in structure charts and the leadership team we spoke with were able to give a clear account of how it worked. However, staff at location level and volunteers did not appear to be aware of the reporting lines and how to escalate local concerns. For example, the problems experienced with the removal of clinical waste was not on the local risk register and had not been escalated.
- We reviewed the minutes from the event first aid and ambulance support national equipment and standards advisory group (NESAG) from October and December 2018. We found these minutes to be detailed and included a review of the previous minutes and actions, actions were assigned to a named individual, a review of the NESAG risk register and updates from other advisory groups. However, the meeting focused on national issues and locations were not discussed individually. Therefore, leaders might not be aware of problems affecting each location and location level concerns were not addressed.
- At a local level each advisory group had operational staff and volunteer representation to gather input from all staff groups. Advisory groups fed into the safety and risk governance group.
- All volunteers were subject to a disclosure barring service (DBS) check and this was carried out at a national level. The processing of DBS checks was on the local risk register as there were delays in the process which meant volunteers were unable to work in the interim.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. While risks and issues were identified and escalated it was unclear if actions to reduce their impact had been taken or what progress had been made to resolve these.

- The event first aid risk register had oversight of the risks nationally, it was not dated and did not list the progress of actions. Each risk was rated, and a job title was assigned as the risk owner. However, most risks did not have a named individual and listed a job title instead. This meant we were not assured the risks were being managed and there was no indication of how long they had been on the risk register.
- The risk register for the Mitcham location had nine risks listed. All of these were placed on the risk register in December 2018. Seven of these did not have an assigned risk owner and there was no evidence it was a live document or reviewed periodically. The information provided in each column did not always correspond with the details required. For instance, the column "progress to date" had a list of actions to take rather than an update. This meant we were not assured those responsible for completing the risk register understood what information was required.
- The risk register for event first aid identified manual handling of equipment was a concern. An action to mitigate this risk was for staff to complete a compulsory update on manual handling. However, the risk register was not dated, and it was not clear how long this had been a risk or whether it had been completed.
- Treatment was not monitored, and staff did not received feedback on the care they had given. This meant staff did not know if they had made an error and managers did not know if staff required further training.
- The removal of clinical waste and out of date medicine was not listed as a risk on the risk register. Staff told us the collection of clinical waste was missed when the location was unmanned however this had not been escalated or recognised as a risk.
- All drivers providing emergency blue light response were required to complete training provided by a third party. This ensured drivers were compliant with Section 19 of the Road Traffic Regulations Act 2006. However, we were not provided with a list of all drivers and evidence they had completed this training.

- There was a lone worker policy and the building was accessible via coded access reducing the risk of unauthorised access to the building.

Information Management

The service did not always collect reliable data and analyse it. Staff could not find the data they needed to understand performance and make improvement to the quality of care. However, the information systems in place were integrated and secure. Staff had access to the information they needed to undertake their roles.

- Staff told us they could access online portals to view information remotely. There were platforms such as the 'redroom', which was the organisations intranet, where staff could review the latest information or log onto the learning portal.
- Staff we spoke with were aware of how to dispose of confidential waste and stated they had easy access to shredders at the location.
- Staff who were not compliant with mandatory training or had incomplete training records could not book a shift for the role they did not have the necessary skills to undertake. The electronic staff record system and electronic booking system worked together and made sure only those with the correct level of training were booked.
- It was stated patient report forms (PFR) were used to record treatment provided. Staff told us they completed these, but they found the frequent changes to the paperwork difficult to keep up with at times.
- The service did not collect outcome data. Patients were not contacted following their treatment and information was not sought from hospitals where patients were transferred. The leadership team told us that due to the geographical area covered and the complexities in obtaining patient information from the NHS, they were not able to collect outcome data.
- The service used a satellite navigation system to track vehicles. This was used to audit the use of blue lights and the provider could check for discrepancies. The leadership team told us sanctions would be imposed on a driver if they were found to have abused the system. We were not provided with evidence of when the system had identified issues with drivers using blue lights inappropriately or what action had been taken. Therefore, we could not be assured the use of blue lights was monitored.

Public and staff engagement

Leaders, staff and volunteers actively and openly engaged with each other. However, there was limited engagement with the public or other providers to help shape services.

- The Mitcham location engaged well with volunteers. They were sent emailed updates every Monday and weekly or fortnightly meetings were held locally. Volunteer coordinators attended local meetings to provide updates, discuss training and meet with volunteer staff. The leadership team told us they often attended events to meet the volunteers.
- Staff we spoke with reported that there was an annual staff conference that all staff and volunteers were invited to. However, this was seen as national senior managers presenting a glossy picture and not acknowledging the challenges the service faced and how these would be addressed. Staff felt disengaged and stated they would not attend this event.
- The results of the volunteer staff survey October 2017, highlighted the top ten positive and negative responses. None of the staff we spoke with were aware of the survey or the results and it was not broken down to local level. It was unclear how this information was used to improve the service.
- There was limited engagement with service users. Staff at events were asked to hand out feedback forms to people treated. This information was collated nationally with a report sent down the service lines. We were not provided with any reports that collated patient feedback.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that medicines are stored securely and out of date medicine are disposed of correctly and in a timely way. 12(2)(g)
- The provider must ensure that clinical waste is disposed of in a timely way. 12(2)(h)
- The provider must ensure that staff have access to end-tidal carbon dioxide (ETCO2) monitoring when using a supraglottic airway device is used. 12(2)(e)
- The provider must establish effective formalised processes to ensure the accountability and audit of individual paramedics' usage, storage and return of Controlled Drugs (CDs). 12(2)(g)
- The provider must ensure that policies and procedures are in date. 17(2)(a)(d)
- The provider must routinely collect data of patients conveyed as part of regulated activity in an easily accessible format. 17(2)(a)

Action the hospital SHOULD take to improve

- The provider should review how it monitors patient outcomes to have the ability to demonstrate effective care has been delivered.
- The provider should provide staff with appropriate professional development, supervision and appraisal to enable them to carry out their duties they are employed to perform.
- The provider should ensure that patient consent is always recorded accurately on patient report forms.
- The provider should make sure keys to vehicles are always securely stored.
- The provider should update the location and event risk register adding dates and actions.
- The provider should relate the organisational strategy to the service provided at the location.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The registered person must ensure the proper and safe disposal of out of date medication. The registered person must ensure that staff have access to end-tidal carbon dioxide (ETCO2) monitoring when using a supraglottic airway device is used. The registered manager must establish effective formalised processes to ensure the accountability and audit of individual paramedics' usage, storage and return of Controlled Drugs (CDs). The registered person must ensure that clinical waste is disposed of in a timely manner and arrangements with the contractor are in place to attend the location when it is manned. Regulation 12 (1)(2)(e)(g)(h)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance

Systems and processes must enable the registered person to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The registered person must ensure that all staff and volunteers completing patient report forms do so fully, and document all information relating to the care and

treatment of the service user.

The registered manager must ensure that policies and procedures are in date and reviewed regularly.

The registered manager must ensure that the number patients conveyed is part of routine data collection.

17(2)(a)(d)