Air Med Transport Limited

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Air Med Transport Limited is operated by Air Med transport Limited. The service provides a patient transport service.

We inspected this service using our focused inspection methodology. We reviewed two of the five questions, are they safe and well-led? We did not review the questions, are they caring, effective and responsive to people's needs.This inspection was to follow up concerns from our inspection of the service on 27 November 2019, when we suspended the service.

The service provided patient transport, including transporting persons detained under the Mental Health Act 1983.

We rated this service as **Inadequate** overall.

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

- The service did not always provide mandatory training in key skills to staff. Driver training was not always provided by an accredited provider. Staff had not received training in the use of hard handcuffs, patient moving and handling and other mandatory training such as infection prevention and control. Staff had completed safeguarding training, but this was not level two safeguarding training.
- Staff Disclosure and Barring Service (DBS) checks were in progress but not completed.
- Staff records did not always include pre-employment checks; such as an application form or references.
- The service did not always control infection risk well. Staff did not always keep vehicles visibly clean.
- The lack of maintenance of vehicles and equipment put people at risk of avoidable harm.
- Processes to assess and respond to patient risk were unsafe.
- Policies available to staff were not always in line with best practice guidelines or reviewed regularly.
- The service did not keep individual care records for patients. Staff did not always complete records accurately.
- The provider did not appropriately manage patient safety incidents. The provider did not investigate incidents or share lessons learned with the whole team.

We found there had been some improvements since the last inspection on 27 November 2019:

- The provider had created an action plan to address staff mandatory training. This was still in progress at the time of the inspection. Staff had completed some mandatory training provided by an external company.
- The registered manager, who was safeguarding lead, had completed safeguarding level three training.
- The vehicle storage and cleaning areas were clean and tidy.
- The provider had booked a visit from an engineer to check the service's equipment the week after the inspection.
- An ambulance was at a garage and some repairs of the vehicle had been carried out, including re-covering of seats and making sure there were no leaks in the external structure.
- The provider had developed an action plan to make the improvements needed. However, most of the actions were still not started or in the initial stages at the time of the inspection.

Following this inspection, we extended the suspension of this service until the provider could demonstrate that it had improved.

This service will continue to be in special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not

Summary of findings

improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Heidi Smoult

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	Summary of each main service
Patient transport services	Inadequate 	The service provided patient transport, including transporting persons detained under the Mental Health Act 1983. Vehicles and equipment posed a risk to patients and staff. There was a lack of risk assessment for safely transporting patients. Staff who were driving patient transport vehicles had not received appropriate training. Policies and guidance were not fit for purpose. Staff Disclosure and Barring Service (DBS) checks were still in progress and not in place. Staff records were missing application forms and references. The service was not well led as there was a lack of clinical and operational oversight.

Summary of findings

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Inadequate

Air Med Transport Limited

Services we looked at
Patient transport services

Summary of this inspection

Background to Air Med Transport Limited

Air Med Transport Limited is operated by Air Med transport Limited. The service has been registered to provide a regulated service since March 2016.

The provider is an independent ambulance service that is based in Perry Barr in Birmingham.

The service mainly provides secure transport for patients with mental health needs and transport for patients discharged home from hospital.

Patients transported by the service are physically well which means vehicles were not equipped in the same way conventional ambulances might be. The vehicles are not adapted for patients with physical conditions and therefore did not have emergency equipment or drugs on board.

The service had a registered manager in place since registration in March 2016.

The service is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the provider's base unit, which is where the service was provided from. There were no other registered locations. We inspected two of the service's vehicles.

We spoke with the registered manager, the administrator and two transport staff.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

The service was previously inspected on 27 November 2019. The service was rated as inadequate. We suspended the service on 29 November 2019, following the inspection, and the suspension end date was 24 January 2020.

The provider had 13 areas for improvement:

- The provider must ensure required training is provided through an accredited training provider.
- The provider must ensure staff using handcuffs are adequately trained.
- The provider must ensure that the safeguarding lead is trained to level 3 and have sufficient knowledge and qualifications to cascade safeguarding training to their staff.
- The provider must ensure that all staff have documented Disclosure and Barring Service (DBS) checks.
- The provider must ensure premises, vehicles and equipment are clean to protect patients, staff and others from infection.
- The provider must ensure vehicles and equipment are maintained to protect people from avoidable harm.
- The provider must ensure there are appropriate procedures were in place to assess and respond to patient risk.
- The provider must ensure there are policies for staff to follow that are in line with current guidance. These should include the use of high-level restraint.
- The provider must ensure the service identifies, records and manages risks.
- The provider must ensure the service has a systematic approach to oversight and maintenance of effective policies and procedures.
- The provider must ensure the service has a systematic approach to checks of cleanliness and infection prevention and control.
- The provider must ensure there is a systematic approach to checks of vehicle and equipment maintenance.
- The provider must ensure there is sufficient management of training to ensure staff received accredited and appropriate training for their roles.

The service employed nine staff. This consisted of a part time administrator, a part time cleaner, drivers and escorts. Two drivers were employed full time and the rest were employed on a zero-hours contract basis, whereby staff were allocated shifts to be 'on-call' throughout the week. Should a transfer be requested, on-call staff would be contacted and asked to attend work.

The service had a fleet of six vehicles including unmarked cars, an ambulance and minibuses.

Summary of this inspection

There were no enquiries of concern made to CQC since we inspected the service in May 2017.

The provider had given a provider return in June 2019. The provider was asked if they wanted to provide more up to date information for the inspection but asked us to use the existing information.

Due to the ongoing suspension, the service was not operational at the time of this inspection. The service had only completed one mental health patient transfer in November 2019 before the suspension started.

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Our inspection team

The team that inspected the service comprised three CQC inspectors and a specialist advisor who was a paramedic with experience in patient transport services. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

We inspected this service on 17 January 2020.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	N/A	N/A	N/A	Inadequate	Inadequate
Overall	Inadequate	N/A	N/A	N/A	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	
Caring	
Responsive	
Well-led	Inadequate

Are patient transport services safe?

Inadequate

We rated safe as inadequate.

Mandatory training

The service did not always provide mandatory training in key skills to staff. Driver training was not always provided by an accredited provider. Staff had not received training in the use of hard handcuffs, patient moving and handling and other mandatory training such as infection prevention and control.

Following our previous inspection on 27 November 2019, the provider had created an action plan to address staff mandatory training. This was still in progress at the time of the inspection. Start dates had been set for some training, such as basic life support and patient moving and handling. However, not all training was listed in the plan. There were only two training target dates set for patient moving and handling and safeguarding training which were January 2020.

We saw staff had completed some training through a new external training provider, which was first aid and safeguarding vulnerable adults and children.

We saw emails to confirm there were plans for the training provider to complete driver assessments, but this had not yet taken place. The provider's action plan stated training was planned for staff in patient moving and handling, but this had not yet taken place. The registered manager told us staff used hard handcuffs on patients but there was no evidence of handcuff training.

We saw an invoice that confirmed the provider had purchased an e-learning product from an external training company, however this was not yet in place. Staff could not yet access the training which would cover mandatory training subjects such as infection prevention and control.

Since the inspection, the provider has provided evidence staff completed driver assessments and training in the use of handcuffs in February 2020.

Safeguarding

Staff had training on how to recognise and report abuse but this was not aligned to the national safeguarding training structure. Disclosure and Barring Service (DBS) checks were in progress and not completed.

Following our previous inspection in November 2019, the provider had sourced a new external training provider to deliver safeguarding training for staff.

We saw confirmation staff had attended a face to face presentation in safeguarding vulnerable adults and children. We could not assess if staff understood how to protect patients from abuse as we did not speak with any staff about this during the inspection. This training not aligned to the national safeguarding training structure so we could not be assured it was the appropriate training for the staff roles. Data had been submitted as part of the pre-inspection provider return which stated staff had received level two safeguarding training. However, we did not see records to support this.

The registered manager was the safeguarding lead. Following our previous inspection in November 2019, the safeguarding lead had completed an online safeguarding level three course.

Inadequate

Patient transport services

There was a safeguarding policy for adults and children at risk. However, the policy was not clear on when to report possible safeguarding concerns and had the potential to confuse staff. The registered manager said they had procured an external company to help with reviewing and improving policies. However, we saw the company was for human resources and health and safety and did not appear to have the necessary input for the safeguarding policy. We raised this with the registered manager who said they would review what support they procure following the inspection.

At our inspection in November 2019, the registered manager told us all staff should have a Disclosure and Barring Service (DBS) check in place but could not provide the evidence to support this. At this inspection, we saw new DBS checks had been requested for all transport staff but the requests were still in progress and were not completed. This meant the provider was not assured staff were of good character and suitable to work with vulnerable people.

Following the inspection, evidence was provided which showed DBS checks for staff had been finalised.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always keep vehicles visibly clean.

Following our inspection in November 2019, the areas at the unit used for cleaning vehicles and equipment had been cleaned, including the sink area. Dirty mop heads had been disposed in line with appropriate infection control measures.

The service had a vehicle deep clean policy and vehicle cleaning schedule for staff. We saw templates of these but did not see completed forms.

We inspected two vehicles which were minibuses used for transporting patients which were not visibly clean inside. This increased the risk of infection.

The registered manager had previously told us they carried out spot checks on vehicles to make sure they were clean, but we did not see records to support this.

Following our inspection in November 2019, the provider had developed an action plan which included vehicle infection prevention control (IPC) audit and vehicle and crew spot audit. However, these actions had not yet been started.

Environment and equipment

The maintenance and use of the premises were suitable. However, the lack of maintenance of vehicles and equipment put people at risk of avoidable harm.

Premises were appropriate and well maintained. The premises were safe and secure and had out of hours' security arrangements.

The service did not have effective systems to ensure the safety and maintenance of equipment. This meant there was not always safe, ready to use, equipment for the vehicles.

Following our inspection in November 2019, we saw the provider had booked a clinical engineering company to attend the location the week after the inspection in January 2020. This was to check the equipment such as wheelchairs, scoop stretchers, stretchers, oxygen piping and vehicle ramp. This did not include the production of an equipment servicing and maintenance schedule.

Since November 2019, the provider had developed an action plan which included creating an asset register of equipment with test dates and asset labels. However, this was stated to be in progress and we did not see an asset register. This action had a start date of 10 January 2020 but there was not a target completion date.

Previously, we inspected an ambulance which contained a stretcher, wheelchair and a transit chair for transporting patients. These were not labelled to show when they had last been serviced and the registered manager was not able to provide any documentation to confirm when they had been. This posed a risk of harm to patients as it could fail whilst being used and cause physical harm to a patient, if the equipment had not been serviced regularly. During this inspection, we looked inside the same ambulance which was at the garage for repair. Equipment had not yet been serviced or labelled. We saw some repair work had been completed.

As at the inspection in November 2019, there was no log to monitor where hard handcuffs were at any time and when they were last used, cleaned or checked. This meant the registered manager did not have oversight of when staff used hard handcuffs. Patients were at risk of avoidable harm from improper use of hard handcuffs that were not cleaned or maintained.

We saw Ministry of Transport test (MOT) certificates were in date for all vehicles.

Assessing and responding to patient risk

The procedures for assessing and responding to patient risk were unsafe.

The manager and staff did not complete job specific risk assessments for patients.

The service had some generic organisation risk assessment forms for risks such as manual handling and infection control. However, the documents were not specific for each patient.

The service had a service user handling and transfer policy, but this was last reviewed in May 2018 and did not have a next review date. The policy related to the management of violent and aggressive behaviour and was not appropriate for transporting mental health patients. It was not specific for use for healthcare and did not include current guidance and best practice principles. For example, the policies advised that pain compliance could be used as a last resort, but this is specifically prohibited by all current guidance documents. This meant patients could be potentially at risk of avoidable harm as staff did not have appropriate policies to follow.

Before booking a transfer, the registered manager spoke with the booking establishment, including whether the patient was detained under the Mental Health Act, to ensure the staff and vehicles were planned and used safely.

The booking establishment provided a summary of the booking for the patient transfer. The summary included brief details of the patient's history and current physical and mental health conditions. However, staff at the service did not then complete their own risk assessment to consider risks for transfer such as suitable vehicle arrangements, restraint or staffing mix and numbers. This put staff, patients and the public at risk of avoidable harm.

The provider told us hard handcuffs were used on some patients but there was no record of an assessment of use or who they were used on and by whom. There was no log of handcuffs and their location and who had use of them. The provider had no assurance handcuffs were used safely, where they were located or how often they were used. The type of handcuffs available for staff to use were not in line with current best practice of National Institute for Health and Care Excellence (NICE) Guideline 10.

Staffing

The service had enough staff, but they did not have appropriate training and guidance to keep patients safe from avoidable harm and to provide the right care and treatment. Staff employment files did not contain all the information required to ensure suitability for employment.

The service had the appropriate number of staff for the transport services offered. Staff could be called on an ad hoc basis to support with a job requiring more staff. Staffing requirements for each journey were set by the booking organisation.

We checked all seven employment records for transport staff. The employment records were missing vital information such as application forms and training certificates. Staff Disclosure and Barring Service (DBS) checks had been applied for during the week of the inspection so were still in progress.

Records

The service did not keep individual care records for patients. Staff did not always complete records accurately.

Staff used the booking organisation's form to inform them of the patient needs for each job. Staff did not complete a separate care plan or risk assessment for each patient transport job.

We looked at job sheets for September, October and December 2019. We saw that for a patient transfer in September 2019, staff had used a control and restraint form to record the job. It appeared restraint had been used from the notes, but the provider confirmed no restraint was required and staff had logged the shift start and finish time in the wrong box on the wrong form. The provider had not picked this up as the job forms were not checked by the provider.

Medicines

We did not review medicines.

Incidents

The provider did not appropriately manage patient safety incidents. The provider did not investigate incidents or share lessons learned with the whole team.

Inadequate

Patient transport services

We did not see a system for staff to report incidents. We saw staff had provided statements where incidents had been raised by a booking organisation.

There had been two recent incidents which had been investigated by a booking organisation. The provider had not carried out its own investigation and there was no evidence of identifying root causes or lessons learnt.

We did not speak with staff about reporting incidents.

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

We did not rate or inspect this area

Evidence-based care and treatment

We did not review evidence based care and treatment.

Nutrition and hydration

We did not review nutrition and hydration.

Pain relief

We did not review pain relief.

Response times

We did not review response times.

Patient outcomes

We did not review patient outcomes.

Competent staff

We did not review competent staff.

Multidisciplinary working

We did not review multidisciplinary working.

Health promotion

We did not review health promotion.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

Are patient transport services caring?

We did not inspect or rated this area.

Compassionate care

We did not review compassionate care.

Emotional support

We did not review emotional care.

Understanding and involvement of patients and those close to them

We did not review understanding and involvement of patients and those close to them.

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

We did not inspect or rate this area.

Service delivery to meet the needs of local people

We did not review service delivery to meet the needs of local people.

Meeting people's individual needs

We did not review meeting people's individual needs.

Access and flow

We did not review access and flow.

Learning from complaints and concerns

We did not review learning from complaints and concerns.

Are patient transport services well-led?

Inadequate

We rated well-led as inadequate.

Leadership

The leadership lacked a full understanding of how to safely operate the service.

The service was led by the registered manager who was the director of the company. Since the last inspection on 27 November 2019, the registered manager had a better

understanding of the basics of running the service such as equipment logging and servicing and holding a risk register. There was a new action plan in place, but many actions were still to be carried out.

The registered manager was safeguarding lead and had completed level three in safeguarding practices since the last inspection.

The registered manager had taken over the role of operations manager in August 2019. The new action plan had an action to recruit an operations manager, but this had not been progressed. There were no other managers apart from the registered manager.

We did not speak with any staff about their views on leadership for the service.

Vision and strategy

The service did not have a clear vision for what it wanted to achieve or a strategy to turn it into action.

There was no evidence of core values being shared with new or existing staff and there was no clear business strategy.

Culture

We did not review culture.

Governance

There was a lack of effective governance processes throughout the service which meant the leadership had limited to no oversight of risk, performance or safety issues within the service.

Some training had been provided by an external company to staff since the last inspection in November 2019. However, staff had not received all required training such as advanced driver assessments for blue lights. The registered manager had previously told us drivers would sometimes use blue lights to get to their destination quicker.

There were plans to review the policies. Not all policies were reviewed within a year and were out of date, including the fundamental service user handling and transfer policy. This policy was not fit for purpose and required updating to be in line with current guidelines, including the National Institute for Health and Care Excellence (NICE) Guideline 10. The registered manager told us they had obtained a support package from an external company with the policies. However, the company supported the provider with human resources and health and safety advice and did not appear to be suitable to advise on clinical policies and guidelines. This was raised with the registered manager during the inspection.

There was still a lack of equipment logging and management of servicing schedules. Equipment in vehicles and stored for repair was not labelled with serial numbers and not labelled to show when it was last serviced. We saw an external company were due to visit the service the week after the inspection to check equipment. However, this did not include the creation of an equipment log and maintenance schedule.

There was still a lack of oversight of vehicle cleaning as the two vehicles we inspected were visibly dirty inside.

An administrator and a cleaner worked at the unit. Their duties included vehicle storage, vehicle cleaning facilities, office space, reception area, equipment storage room, cleaning equipment cupboard, medical gases storage and toilet facilities. Previously, the registered manager rarely attended the unit to oversee its running. The administrator and cleaner both worked part time. The registered manager did not provide assurance oversight of the unit had changed since the last inspection.

We did not see evidence of staff meetings or how information and learning was shared with staff.

Management of risks, issues and performance

The provider did not manage performance or risk. The provider did not appropriately manage patient safety incidents. The provider did not investigate incidents or share lessons learned with the whole team.

Since the last inspection in November 2019, there were plans to start a risk register. However, during the inspection we did not see a tool to assess and monitor risks.

The service provided some generic organisation risk assessment forms for risks such as manual handling and infection control. These were dated May 2016 and May 2018 respectively and there was no next review date. These were not specific to each job being carried out.

We did not see any management of performance of the service. The registered manager told us the booking

organisations did not set performance targets for the service. The registered manager told us the service had service level agreements with booking organisations, but could not provide these.

Two complaints about staff language and management of patients during a transport job had not been investigated and learning had not been identified or shared with staff. No disciplinary processes had been put into place to investigate concerns or address performance. This meant there was a risk staff could repeat language and behaviour which could potentially cause harm to patients.

A driver had been involved in a road traffic collision whilst working for the service in a company vehicle, but this had not been investigated. This meant potential safety and competency issues had not been identified or addressed. This put staff and patients at potential risk of future road traffic collisions.

Information management

The manager and staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

There had been some improvement since the inspection on 27 November 2019, as the manager had decided to start again with staff records. We saw systems to monitor staff Disclosure and Barring Service (DBS) checks. However, records were still not organised. Staff paper records did not include vital information such as application forms and these were not available electronically. The registered manager could not provide assurance staff had been through robust recruitment procedures.

Training records were not easy to understand. The registered manager could provide completed staff training on emails from the external training company but there was no training matrix. It was not clear for each member of staff which training they had completed and which they needed to complete.

The provider did not hold a record of equipment the service held and whether it had been serviced. This was planned to be introduced but was not yet in place. There was no handcuff log to record when and where handcuffs were used.

Job sheets were kept in paper form. In one instance a member of staff had used a restraint form to record a transport job. This was misleading and difficult to understand. The registered manager did not check job sheets and relied on the administrator to do this. Issues had not been identified such as staff using the wrong form.

Public and staff engagement

We did not review public and staff engagement.

Innovation, improvement and sustainability

We did not review innovation, improvement and sustainability.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
Action the provider MUST take to meet the regulations:

- The provider must ensure staff complete mandatory training required for their roles. (Regulation 12 (2) (c)).
- The provider must ensure staff using handcuffs are adequately trained (Regulation 12 (2) (c)).
- The provider must ensure staff are trained to safeguarding level two and the safeguarding policy is fit for purpose (Regulation 13 (1) (2) (3)).
- The provider must ensure that all staff have documented Disclosure and Barring Service (DBS) checks (Regulation 19 (1) (a) (2) (a)).
- The provider must ensure vehicles and equipment are clean to protect patients, staff and others from infection (Regulation 12 (1) (2) (h)).
- The provider must ensure vehicles and equipment are maintained to protect people from avoidable harm (Regulation 12 (1) (2) (e)).
- The provider must ensure there are appropriate procedures in place to assess and respond to patient risk (Regulation 12 (1) (2) (a) (b)).
- The provider must ensure there are up to date policies for staff to follow. These should include the use of high-level restraint such as handcuffs (Regulation 12 (1) (2)).
- The provider must ensure the service identifies, records and manages risks (Regulation 17 (2) (b)).
- The provider must ensure the service keeps individual care records for patients and staff complete records accurately (Regulation 17 (2) (c)).
- The provider must ensure the service has a systematic approach to oversight and maintenance of effective policies and procedures (Regulation 17 (2)).
- The provider must ensure the service has a systematic approach to checks of cleanliness and infection prevention and control (Regulation 17 (2) (a)).
- The provider must ensure there is a systematic approach to checks of vehicle and equipment maintenance (Regulation 17 (2) (a)).
- The provider must ensure there is sufficient management of training to ensure staff received accredited and appropriate training for their roles (Regulation 17 (2) (a)).
- The provider must appropriately manage patient safety incidents, that complaints and incidents are investigated, and lessons learned shared with the whole team (Regulation 16 (1) (2)).

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints