Trak Bak Racing Limited

Santa Pod Raceway

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We have placed this service in special measures due to their need to make significant improvements. We have also suspended the provider from providing regulated activity for a six month period. This means the service cannot continue to operate until it makes significant improvements. On 6 July 2021 we received an application from the provider to deregister from providing regulated activity. We are currently processing this application.

We inspected the service on 28 April and 4 May 2021, we were so concerned about its quality and safety that we suspended their registration for six weeks, preventing it from operating. We also issued a warning notice in relation to breaches of the regulations that we found.

On 7 June 2021 we carried out a focused inspection to see if the service complied with the regulations it was not meeting at our previous inspection. We gave 48 hours' notice of the inspection due to the service's opening times being variable and operating on different days and times of the week.

We found;

Our rating of this location stayed the same. We rated it as inadequate because:

- There were still no reliable systems to ensure all staff were appropriately trained, qualified and competent to provide safe care. The safeguarding procedure was not available to review so there was no evidence it had been updated. There was minimal evidence the service was now assured fit and proper persons were employed to protect patients from abuse. The provider did not have robust processes to ensure infection risk was controlled well.
- The provider could still not be assured care and treatment was in line with national guidance. There was still no evidence of audits being planned in line with the identified requirement in the service's policies. Reviewed policies and procedures were not always correct. Staff were still not supported to develop their skills.
- The provider still did not take into account peoples individual needs.
- Leaders did not demonstrate they had the capability to ensure the care and treatment provided was safe and of high quality. There was no registered manager in place and no individual with capacity to oversee the improvement process was identified. Leaders did not demonstrate they had the understanding of the safety and business priorities and how to manage them. There were still no reliable and consistent systems to provide oversight of safety and quality of care delivered. There was still no consistent, embedded system for reviewing risks. Leaders were still not clear about their legal responsibilities of providing care under the regulated activities.

However:

- The provider had made some practical improvements in the environment and equipment availability. Some cleaning and equipment checking processes had been improved.
- The provider had introduced a process to make staff aware of any updates to legislation, standards and evidence-based guidelines.
- A fleet manager was identified to ensure ambulances were appropriately serviced and had annual safety checks.
- Remote access to Joint Royal Colleges Ambulance Liaison Committee (JRCALC) was put in place to allow staff access to guidelines at all times.
- All staff we spoke with displayed a commitment to improve the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Inadequate 	We rated this service as inadequate at this inspection. We found that : Leaders still did not ensure staff were appropriately trained, registered and competent to provide safe care. Leaders still did not ensure that staff, patients and the public were protected from abuse. The provider did not have comprehensive systems in place to ensure the environment and all equipment were safe. Leaders still did not have full understanding of the requirements to deliver regulated activity. Governance systems put in place were not in line with the providers policy. Leaders still did not have a system in place to ensure they had effective governance systems in place or oversight of issues or risks that may affect the service. The provider had made some practical improvements within the service.

Summary of findings

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Summary of this inspection

Background to Santa Pod Raceway

Santapod Raceway is an independent ambulance service to transport patients of all ages from Santapod Raceway in Wellingborough to hospital or other care providers.

Santa Pod Raceway is operated by Trak Back Racing Limited. The service mainly provides care and treatment within the confines of public event site cover, which is not a regulated activity. However, the provider will transport patients off site to other local healthcare providers in the event of an emergency. This regulated activity is reported under emergency and urgent care services.

The service registered with the Care Quality Commission (CQC) in July 2020 for regulated activity: -

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

The inspection on 7 June 2021 was a follow up inspection, during which we reviewed areas that had been highlighted as breaches of regulation during our previous inspection carried out on 28 April and 4 May 2021.

There is currently no registered manager at the service.

Santa Pod Raceway medical staff are all self-employed. The provider told us there was a pool of 20 staff who worked for them on an as required basis.

The service had 48 hours' notice of our visit to ensure staff would be available due to the service opening times being variable and operating on different days and times of the week. Before the inspection we reviewed information, we had received from the provider since our fist inspection.

What people who use the service say

Since the service registered with us in July 2020 no regulated activity had been undertaken. Therefore, feedback was not available from people who used the service.

How we carried out this inspection

During our inspection we spoke with five members of staff on a face to face basis and reviewed 16 updated policies, procedures and standard operating policies.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of this inspection

Action the service MUST take to improve:

- The provider must ensure policies are in place for the proper and safe management of all medicines including medical gasses. Regulation 12: Safe Care and Treatment 12 (1)
- The provider must ensure the induction process for new medical staff is fit for purpose to prepare staff for their role. Regulation 18: Staffing 18 (2)

Action the service SHOULD take to improve:

- The provider should review the process followed regarding ongoing policy reviews to ensure the process is robust.
- The provider should look at how equipment is managed in kit bags to ensure equipment specifically to treat different age groups is easily accessible.
- The provider should ensure the controlled drug book is stored in line with legislation.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Inadequate	Not inspected	Inspected but not rated	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not inspected	Insufficient evidence to rate	Inadequate	Inadequate

Inadequate

Emergency and urgent care

Safe	Inadequate
Effective	Inadequate
Responsive	Inspected but not rated
Well-led	Inadequate

Are Emergency and urgent care safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

The provider still did not provide mandatory training in key skills. They still did not make sure everyone had completed it.

The provider still did not have an effective process to ensure staff were appropriately trained to provide safe care. There were no personnel files for us to review. The provider told us they had requested training evidence from all staff and were waiting to receive the information. We saw email evidence that one member of staff had submitted training certificates.

The provider still did not monitor staff mandatory training. A spreadsheet was in place to monitor mandatory training, but it was still empty. Managers were not able to identify staff who were required to complete training updates.

Safeguarding

Safeguarding policies still did not reflect up-to-date legislation and were not comprehensive. There was still no consistent evidence that staff had received training on how to recognise and report abuse.

The provider could not give assurance their safeguarding procedures included comprehensive information required to keep service users safe, referenced up to date legislation or was consistently appropriate to the service. The safeguarding procedure was not available during our inspection, we were told by staff we spoke with the policy was currently being reviewed.

The provider still did not have a process to assure themselves of the appropriateness of staff training in safeguarding. There was no identified safeguarding lead who was trained to level 3 or above.

Inadequate

Emergency and urgent care

The provider was still not assured all staff, deployed for the purposes of the regulated activity, were of good character and service users were protected from abuse. The provider had issued a new contract to all staff on 4 June 2021. We were told the new contract included staff requirement to register with the disclosure and baring update service (DBS). However, on review of the contract, the requirement to register with the DBS update service was not included. We were told this was an error and the provider would look at adding as an addendum to the contract.

We saw evidence of one staff member's, out of the 20 people employed, updated DBS check and subscription to the DBS update service. We still saw no evidence managers had checked the DBS database to confirm a clear DBS for other staff.

Cleanliness, infection control and hygiene

The service still did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.

The provider still had no evidence of any policy or practices relating to the COVID-19 pandemic. The updated infection prevention and control (IPC) policy included information on highly infectious diseases but did not include specific information relating to COVID-19.

The provider was still not meeting Health and Safety Executives legislation in their duty to protect the health, safety and welfare of employees. The provider had not implemented staff testing (FIT) to ensure appropriate face masks were available to protect staff from the risk of infection from airborne virus including COVID-19. Equipment had been purchased to carry out FIT testing. However, the provider had been unable to source training to allow the testing of staff to be undertaken.

Staff we spoke with told us that only staff who had been FIT tested by other employers and had appropriate face masks had worked for the provider during the coronavirus pandemic. However, staff working on the day of our inspection had not been FIT tested and did not have access to equipment to keep them safe. Therefore, the provider could not be assured a robust process was in place to ensure the safety of staff in the workplace. This led to increased risk to staff.

The provider now had cleaning schedules and procedures to identify cleaning requirements for ambulances and the equipment stored therein. Staff signed and dated the schedules when they had completed the cleaning. However, these did not state what cleaning solutions should be used for which equipment or in what circumstances.

The provider could not be assured that effective cleaning had been undertaken in the medical centre. During our inspection we saw equipment that was dirty in the medical centre. General cleaning of the medical centre was included on the provider's medical centre checklist, used by the duty manager at each event. However, this does not identify specific information on how cleaning was carried out.

The provider could not be assured cleaning of the ambulances was carried in line with IPC guidance. Visible rust was still evident within the vehicles. Therefore, this increased infection risk to patients.

The provider had implemented a process to manage cleaning equipment. Appropriate disposable coloured mop heads were now in use with changes recorded on a designated sheet in line with their IPC policy. Information displayed in the

medical centre to advise which colour mop was to be used was now correct. Staff cleaned the buckets and stored them appropriately during our inspection. The IPC policy, which was reviewed in June 2021, did not include cleaning or storage instructions for mop buckets. We also saw dirty mop buckets which were not stored correctly as they were upside down. Therefore, the provider could not be assured staff had the information required to manage appropriately.

The provider could not be assured that effective cleaning procedures were undertaken. New flooring had been installed to allow effective cleaning in the sluice area. However, this was already stained with rust.

The provider now had a service level agreement with an external company for monthly deep clean of vehicles and the medical centre. We saw evidence of this during our inspection

Spill kits to safely manage a spillage of body fluids in line with the services IPC policy were now available on ambulances.

Environment and equipment

The maintenance of equipment still did not always keep people safe, medical devices were not checked constantly before an event and could not be relied on to work when needed. We still had inconsistent evidence staff were trained to use them. However, the design, maintenance and use of facilities, premises and vehicles kept people safe. Staff now managed clinical waste well.

The provider still could not evidence effective and consistent systems were in place to ensure equipment would work and was safe to use. Staff we spoke with described how checks on equipment kit bags were carried out before an event using a check sheet and seal to indicate the check had been completed and appropriate equipment was in place. However, staff told us that the provider's policies did not identify the requirements for checking equipment worked and was in date. This added a risk to delivery of effective and safe patient care.

The provider had no audit trail if issues arose with the equipment available within a kit bag. The check sheet used did not include any staff identification to confirm who had carried out the required checks. Therefore, the provider could not identify who was responsible for the last check or address any issues with the individual concerned.

The provider did not have a system to ensure equipment, specifically to treat different age groups, was easily accessible to provide care. Staff we spoke with told us equipment to care for children and adults were kept together in kit bags. They told us this could lead to delays in finding the appropriate equipment. This posed a risk that care delivery could be delayed.

The provider still could not provide any evidence of a system to provide oversight of equipment in use, its appropriateness and maintenance requirements. The pulse oximeter identified as not being serviced at the previous inspection was in use and had still not been serviced. The pulse oximeter was replaced with an appropriately serviced one during our inspection.

The service still could not provide evidence decisions made for a patient's treatment relating to blood sugar levels were safe. Blood sugar levels are measured using a blood glucose monitor to assess if sugar levels in blood are within normal limits if a patient becomes unwell. The blood glucose monitor identified at our previous inspection which could not be tested was still in use. This posed a safety risk to patients.

Inadequate

Emergency and urgent care

The provider still could not provide evidence staff were trained and competent to use all equipment within the service due to a lack of training records and competency checks for staff. This added increased risk to patients, staff and the provider.

A vehicle event check sheet (VECS) was available which recorded staff identity, vehicle checks and kit availability checks prior to each event and at each shift change. We reviewed three VECS for events that had been undertaken since our last inspection. All three VECS were completed comprehensively regarding vehicle and equipment checks. However, staff were identified but signatures were not present.

The provider had implemented a process to identify, segregate and manage faulty equipment. Staff we spoke with told us how they would follow the process to reduce the risk of faulty equipment being taken for use in error. The process included the use of a book to record details of faulty equipment and actions taken. However, during our inspection we saw the record was not always completed comprehensively. Staff we spoke with told us the process was under review.

The provider could now evidence that the ambulances were road worthy. During our inspection we saw documents confirming appropriate annual safety checks, servicing of the vehicles and fitted electric ramps had been undertaken. The provider had also commenced a monthly servicing of the ambulances by the in-house mechanic. We saw evidence one had been carried out in June 2021. A fleet manager had been identified to manage the process to keep the ambulances fit for purpose.

Management of sharps was in line with Health and Safety Executive (HSE) legislation. A sharps management standard operating policy (SOP) had been put in place from May 2021. During our inspection we saw evidence that the sharps management met the providers SOP and HSE legislation.

The provider had ensured ambulances now had appropriate equipment to transport children safely and to safely manage the spillage of body fluids in line with the IPC policy.

The provider was meeting British Standard BSE 5306-3:2009 for Fire Extinguishing installations and equipment on premises and commissioning and maintenance of portable fire extinguishers code of practice. We saw evidence servicing of all fire equipment had been undertaken in May 2021. We saw evidence the racetrack manager had a reminder in his diary to ensure this is carried out annually.

The provider had introduced a stock management system. We saw evidence the provider was using a stock sign in and out sheet, with a spreadsheet which included batch numbers, quantities and expiry dates. A system to alert when stocks were reaching a level that required action to reorder ran behind the spreadsheet. The spreadsheet was checked by the same designated member of staff.

Clinical waste was now managed well, with the correct clinical waste bags now in use for the type of waste each bin was designated for. The external waste container outside the medical centre was clean and secure with the key kept in the medical centre.

Staffing

There was still no evidence demonstrating all staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service still had minimal evidence of staff professional registration, training or competence. There were no formal personnel files for us to review. The provider told us they had requested training and registration evidence from all staff and were waiting to receive the information. We saw email evidence that one member of staff had submitted training certificates, evidence of professional registration and qualifications.

Records

Records were stored securely and easily available to all staff providing care.

Staff we spoke with told us clinical records were easily available to all staff providing care. Clinical records were archived and stored securely in the medical centre and could be easily retrieved once archived if required.

Medicines

The service has systems and processes to manage, record, prescribe, administer and store medicines. However, the systems to safely store drugs and processes to manage medicines were not always robust.

The provider still did not have a valid Home Office Controlled Drug Licence to allow the service to hold certain medications at our inspection on 7 June 2021. We saw evidence confirming an application had been sent and was in process with the Home Office.

The provider could not be assured the process undertaken to review medicines management policies was robust. The medicine management policy been reviewed in June 2021 but was not appropriate for the service. The policy included information that the medical centre did not hold any prescription only medication. However, the medical centre did hold prescription only medication, including controlled drugs (CDs).

The medicines, adverse reactions, errors management protocol, including 'near miss' events, was reviewed in May 2021 but it did not have the correct information regarding reports required to be sent to the Medicines and Healthcare Regulations Agency (MHRA).

The recording of CDs was now in an appropriate CD record book. We saw evidence that stock checks had been carried out for medicines on all days the medical centre had been open since our previous inspection. However, the CD record book was stored in the general medicine's cupboard, not in the controlled drug cupboard in line with legislation.

The provider did not have oversight of drugs used within the service. The provider's clinical governance policy stated monthly medication audits should be carried out. We saw evidence one was completed for May 2021, before that the last one was September 2019. This left the system open to abuse.

All medicines we saw were now stored correctly. The medicines cupboard, which contained the CD safe was now secured to an internal wall in line with regulations for the safe storage of CDs

There were no medicines stored in the medicine's fridge. The fridge temperature checks had been completed consistently on event days since our last inspection. A fridge temperature monitoring device was now in place to monitor the temperatures when the medical centre was closed. However, the monitor did not have an external alert mechanism if triggered. There was no record the alarm had been checked to see if it had been triggered when fridge temperature checks were carried out. Therefore, the provider could not be assured the fridge had remained at the correct temperature to ensure safe storage of medicines.

Inadequate

Emergency and urgent care

The provider could not be assured that all staff would take appropriate actions to ensure the safety of medicines, if the fridge temperature was not in the correct range. There were no written instructions for staff to follow in the event of a fridge failure. This could lead to use of medicines that were unsafe.

The provider still could not evidence that the Patient Group Direction (PGDs) met the legal requirements relating to their use. We were still unable to access the PGDs. Staff we spoke with told us the PGDs were still under review with the medical director.

Medical gas management was now in line with legislation. However, staff we spoke with told us they were not aware of a medical gasses management policy. On review of the revised medicine management policy medical gasses were not included.

The provider had introduced a process to manage the disposal of out of date medicines. A record book was now in place to identify the name, date and quantity of medicines awaiting disposal. During our inspection there were no medicines awaiting disposal.

Are Emergency and urgent care effective?

Inadequate

Our rating of effective stayed the same. We rated it as inadequate.

Evidence based care and treatment.

The service still could not evidence care, and treatment was always based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. However, steps had been taken to improve staff access to updated information on national guidance and evidence based-practice.

The provider still could not be assured that care and treatment was in line with all national guidance. A policy review group had been set up to review out of date policies, protocols and standard operating procedures. During our inspection we saw 16 updated documents, three contained incorrect information. Therefore, the provider could not be assured the process undertaken was robust.

The provider still could not evidence systems to review and manage quality of care delivered, staff compliance with guidelines, or identify any training needs for staff. There was no evidence audits into care delivery had been carried out, in line with the provider's policies or had any plans to carry out audits in the future.

The provider still could not evidence they had pathways specific to the treatment of children and young people. Staff we spoke with told us the provider's protocols for adults suffering from specific conditions had not been updated to deliver care in line with national guidance. Therefore, the provider could not be assured staff had access to the correct information to provide safe care.

The provider could not evidence staff had access to guidelines and protocols when working remotely. However, during our inspection the racetrack manager downloaded the guidance from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) to their work provided smart phones to allow staff access at all times.

Inadequate

Emergency and urgent care

The provider had introduced a process to make staff aware of any updates to legislation, standards and evidence-based guidelines. Managers told us all staff were sent an email alerting them that they needed to read the updates folder before they next worked. We reviewed the update folder and saw evidence that staff had signed to confirm they had read the updates.

Pain Relief.

The provider now had a pain scoring system for patients with some specific needs.

A nonverbal pain scoring tool was now in place on ambulances. The tool consisted of a series of faces ranging from a happy to a crying face to asses pain levels for children, nonverbal patients and patients with specific learning needs.

Competent staff

The provider did not ensure staff were qualified, skilled and competent for their roles. Managers had not appraised staff's work performance, and none were planned. Managers had not provided staff with support or development.

The service still had minimal evidence of staff qualifications, skills, competence or continued professional development. There were no personal files for us to review. We saw email evidence that one member of staff had submitted training certificates and proof of professional registration. Competency assessments had not been undertaken and the provider could not provide evidence these were planned in the future.

The provider still could not provide evidence they had oversight of staff performance, issues, development or training needs. The provider had not implemented an appraisal system and still could not provide evidence they had copies of, or assurance staff had undertaken appraisals at their primary place of work. One to one meetings with staff or general staff meetings had not taken place and the provider could not provide evidence these were planned in the future.

The provider could not be assured new staff understood the clinical requirements, equipment used or were aware of the policies and procedures for the service. Managers we spoke with told us the induction process for new staff did not include any aspects of clinical or medical requirements. Therefore, this added risk to service users, staff and the provider.

Are Emergency and urgent care responsive?

Inspected but not rated

Our rating of responsive stayed the same.

Meeting people's individual needs

The provider was not inclusive and did not always take into account all patients' individual needs. The provider made reasonable adjustments to help patients access services.

Inadequate

Emergency and urgent care

The provider still had no evidence they identified and recorded individual patient specific needs or any evidence of prompts in place to ensure staff considered them. The provider's patient report forms standard operating procedure introduced in May 2021 did not include individual patient specific needs. They were still not able to provide evidence that they had information specifically for patients with individual communication needs.

The provider still could not evidence staff had access to a translation or interpreter service. Therefore, the provider could not be assured they always considered patients individual needs. However, a nonverbal pain scoring tool was now in place on ambulances.

Are Emergency and urgent care well-led?

Inadequate

Leadership

Managers did not demonstrate the right skills and abilities to run a service providing high-quality sustainable care. They did not demonstrate they understood and managed the priorities and issues the service faced. They did not support staff to develop their skills.

The leadership still did not demonstrate full understanding of the priorities, risks and issues the service faced. A policy review group was introduced following our previous inspection. However, there was still not established suitable and effective policies and procedures to fulfil the requirements of the Health and Social Care Act 2000 (Regulated Activities) Regulations 2014.

The provider still did not offer support to staff to develop their skills and knowledge or have oversight of any staff training or development needs.

The provider did not have a registered manager. A registered manager is an identified individual who manages the regulated activity the provider has registered with the Care Quality Commission to undertake. The process to recruit into the registered manager position had not been started. However, since our inspection we have been told the recruitment process has started.

Vision and Strategy

The provider had a vision for what it wanted to achieve. However, there was no strategy to turn it into action. Staff were not able to show they understood the vision.

The provider still had no evidence of a strategy to support the values, vision and mission statements included in the medical services quality management manual. The provider still could not provide evidence of how the values, vision and mission statements had been shared with staff.

Governance

Inadequate

Emergency and urgent care

The provider still did not operate effective governance processes throughout the whole service. Staff at all levels were unclear about their roles and accountabilities and did not have opportunities to meet, discuss and learn from their performance.

The providers quality management manual (QMM) identified the requirement to hold at least two clinical governance meetings a year which were to be used to oversee all clinical activity. This included, auditing of risk, equipment and medicine management, training, competence assessments, case reviews, complaints, incident, polices and clinical quality and effectiveness.

The provider could not demonstrate full understanding of or evidence robust governance processes. We reviewed minutes from the medical service clinical governance meeting in May 2021. However, they did not reflect aspects of clinical governance required in the providers QMM. Managers could not provide evidence a clinical governance meeting, which reflected the QMM expectations, had been undertaken or plans to hold one. However, the QMM now identified the leadership structure up to the managing director.

Managers we spoke with told us a medical section was to be added to the debrief document used for each event. We were told the chief executive officer (CEO) was involved in all debriefs so would be aware of any issues or concerns. However, managers did not provide evidence to support this.

A monthly medical meeting between the racetrack manager and the commercial director was in place. The CEO reviewed and signed the minutes. We saw minutes of the meeting which took place in May 2021 and a future meeting was identified.

The provider now had evidence of oversight of some aspects of the service issues. We saw evidence that a system was in place to manage vehicle maintenance and annual safety checks. A fleet manager was identified to oversee the process. The system implemented to identify, segregate and manage faulty equipment was not always followed by staff. Staff we spoke with told us the process was under review. However, the provider still did not have oversight of equipment in use, its age, appropriateness and safety.

The provider still did not have oversight of most staff member's character, training and qualifications. A process was ongoing to obtain the required data but minimal evidence was available at the time of our inspection.

The provider still could not evidence systems to review and manage quality of care delivered, staff compliance with guidelines, or identify any training needs for staff. We did not see any evidence audits had been carried out in line with the provider's policies or any plans to carry out in the future.

The provider could not be assured updated policies had been subject to a robust process of review. A policy review group had been set up since our last inspection. This process was ongoing. During our inspection we saw 16 updated policies with document control in place. However, three reviewed policies contained incorrect information.

The provider could not evidence staff were aware of changes to internal policies, procedures and standard operating procedures. The provider had introduced an IT system to share documents with staff. However, at the time of our inspection no documents had been uploaded for staff to access.

Records relating to staff were not still managed well. The provider still had no evidence of a process to ensure consistency of information within staff files. During our inspection we saw information relating to staff stored in a box in an open office. This was not in line with data protection legislation or the provider's own policy.

Inadequate

Emergency and urgent care

The vehicle event check sheet (VECS) which recorded staff identity, vehicle checks and kit, availability prior to each event and at shift change, were completed more comprehensively than at our previous inspection.

Managing risks, issues and performance

The provider still did not have systems and processes to manage all overarching risks.

The provider still had no evidence that systems were in place to identify, monitor, review and mitigate risks to the service and service user's, future performance or audit processes.

The provider had implemented a resource escalation action plan in May 2021. The document included escalation levels and actions required to any rising risk including the unexpected lack of provision to provide regulated activity. However, the provider had no evidence of how this was shared with staff or embedded within the service.

Information Management

Arrangements were not in place to ensure identifiable records were in line with data security standards.

The providers information and records management policy, operational from May 2021, included conflicting advice regarding the length of time clinical records should be kept. Staff we spoke with told us clinical records were archived and stored securely in the medical centre. Therefore, the provider could not be assured the process undertaken when writing the policy was robust.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider must ensure policies are in place for the proper and safe management of all medicines including medical gasses.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider must ensure the induction process for new medical staff is fit for purpose to prepare staff for their role.**