QAS Ambulance 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

Overall summary

QAS Ambulance Limited is operated by QAS Ambulance Limited. The service was first registered in April 2013. It is an independent ambulance service based in Manchester which serves several local and regional acute NHS hospital trusts and local authorities. The service provides patient transport services from one ambulance base location situated in Manchester. The service also provides event cover (unregulated activity) and is able to provide patient transportation services from event sites (regulated activity), as required.

We carried out an unannounced focussed inspection of the service on 4 March 2020 to follow up on enforcement action issued from the previous comprehensive inspection on 23 and 24 April 2019. We did not rate the service as this was a focussed inspection.

We found the following areas that required improvement:

- There was no procedure or guidance to support staff in making a decision as to whether the patient was suitable for transport or not, either for transportation from event sites or routine patient transport journeys. It was therefore unclear that the service was able to monitor the suitability of the patients effectively.
- Patient booking forms and patient journey records (including patient risk assessment information) were not always completed in full. Similar information remained incomplete at the previous inspection. It was therefore unclear that the service was effectively able to drive improvements in record keeping.
- Systems put into place to monitor the service provided were not always comprehensive or embedded appropriately. It was therefore unclear that the service provided was being monitored effectively or that improvements could be made easily.

We found the following areas of good practice:

- The service had made significant improvements to make sure that medicines were managed safely.
- The service had made significant improvements in relation to commencing a programme to review and update all policies and procedures and to implement a formal risk system.
- The service had implemented a formal five-year vision and strategy with milestone target dates and workable plans to achieve these.

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. Details are at the end of the report.

Ann Ford

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

Summary of findings

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Summary of this inspection

Background to QAS Ambulance Limited

QAS Ambulance Limited opened in April 2013. It is an independent ambulance service based in Manchester. The service primarily serves local and regional acute NHS hospital trusts and local authorities.

The service provides patient transport services predominantly for adults; however, the service is also able to transport children. The majority of work undertaken by the service is patient discharges and inter-hospital transfers.

In addition, the service provides medical cover at events and repatriation work; however, these activities are not regulated. Transportation of patients from event sites is classed as regulated activity and as such, we did look if any journeys had taken place since the last inspection, which they had not.

QAS Ambulance Limited was last inspected in April 2019, the service was rated as inadequate. During the inspection in April 2019 we told the provider that it must take some actions to comply with the regulations. This focussed inspection was to follow up what actions had been put into place to make improvements in relation to the issues found previously.

Our inspection team

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

Information about QAS Ambulance Limited

QAS Ambulance service was established in 2013. The provider offers patient transport services 24 hours a day, seven days a week from an ambulance base location in Manchester.

The service has had a registered manager in post since August 2019.

The service is registered to provide the following regulated activities;

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

There were no special reviews or investigations of the service ongoing by the Care Quality Commission at any time during the 12 months prior to this inspection.

During the inspection we spoke with three members of the management team. We reviewed 35 patient booking forms and 50 patient journey records. We reviewed information that was provided by the service both during and after the inspection.

Patient transport services

Safe	
Well-led	

Are patient transport services safe?

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Procedures were not in place or were not clear to help staff identify and act upon patients at risk of deterioration.

At the previous inspection we found that the service did not have an effective system in place to make sure that only suitable patients were transported; for example, there was no inclusion/exclusion criteria. Furthermore, out of the 18 records reviewed during the last inspection, there was limited evidence of the service determining the suitability of patients to be transported. In addition, whilst members of the management team had informed inspector's that risk assessments were undertaken before each booking and patient journey, there was no documented evidence of this. This was a risk because it was unclear if the service had assessed whether they were able to meet the needs of the patients being transported.

During the inspection of 4 March 2020, we found that some improvements had been made in relation to patient risk assessment, risk assessment documentation and training. However, we had concerns that other areas had not been addressed. There remained no inclusion/exclusion criteria for patients, either for event transportation or routine patient transport journeys. There was no patient deterioration procedure for when patients were transported from event sites and the procedure in place for routine patient transport journeys was located within another procedure and was not clear.

The service had elected to train staff in a higher level of first aid training; previously, staff were trained in basic first aid at work. The new training was an external course, accredited to level three and was in first response emergency care. This meant that staff were able to undertake skills such as monitoring patient's observations during a journey. We saw that all staff had completed this level of training. This showed that the service had improved the level of staff training and knowledge, in order to increase staff competency and make sure patients could be transported safely. Furthermore, the service had introduced training for all staff in risk assessment completion which was facilitated online. We saw that all staff had completed this training and there was evidence that staff feedback had been sought in relation to the training and was positive.

The service did not have a documented inclusion/exclusion criteria for either routine patient transport journeys or patients transferred from event sites. During the inspection we saw that a flowchart was in use for taking bookings for routine patient transport journeys which detailed some inclusions/exclusions; for example, it asked if the patient would require advanced life support resuscitation (which the service could not provide). However, the exclusions were limited and did not include all relevant exclusions; for example, the service did not transfer patients detained under the Mental Health Act 1983. This was a risk because there was no guidance to support staff in making a decision as to whether the patient was suitable for transport and it was unclear that the service was able to monitor the suitability of the patients effectively.

The service had implemented a patient booking form and this included key risk assessment information such as moving and handling risk assessments, details of pressure sores and whether the patient was infectious. We reviewed 35 patient booking forms and saw that (when relevant) risk information had been completed in 26 of the patient booking forms. However, we saw that patient booking forms were not audited. This was a risk because the service was not able to demonstrate that staff taking bookings were capturing risk assessment information accurately and the service was unable to highlight areas of concern, promote best practice or make improvements easily.

The service had strengthened the risk assessment information on the patient journey forms which were used in routine patient transport journeys; for example, information such as whether there were any safeguarding concerns was now included. We reviewed 50 patient journey records and saw that dynamic operational risk assessments had been completed by staff on 38 occasions.

However, other risk assessment information (when relevant) was only completed in 22 records such as safeguarding concerns and current patient condition. We saw that there had been one audit of patient journeys record forms in February which was completed by a member of the management team. This audit included checking that risk assessment information had been completed. We saw that on three occasions the audit recorded that risk assessment information had not been completed; however, there was no associated commentary or detail of what action had been taken. Furthermore, there was no associated process or procedure to accompany the audit, this meant that it was unclear what action should be taken or how staff would be supported to improve, going forwards.

The service had created a form for completion when transporting patients from event sites to hospital. We saw that patients who were transported by the service required a full patient report form to be completed. The patient report form included key risk information; for example, National Early Warning score calculations (NEWS) and joint decision-making information discussed with a registered health care professional or manager. However, as there was no associated procedure or process for transporting patients from event sites to accompany completing the patient report form, such as an inclusion/exclusion criteria, it was unclear what type of patients the service was able to transport from event sites or if this could be done safely. For example, patients with a high National Early Warning score indicative of acute or severe illness or injury. We were unable to check the suitability of patients transported from event sites as the service had not completed any of these journeys since the previous inspection.

We had concerns that the procedure for dealing with deteriorating patients was not easy to locate for staff and was not always clear. The procedure was made up of two paragraphs within the standard operating procedure for blue light driving and was entitled "routine patient transport". The information within the paragraphs did not clearly set out a process for staff to follow; for example, it stated "should the patient deteriorate to the point where a PTS crew consider the need to accelerate the crew should stop, render emergency first aid and dial 999". However, there was no clear definition of what the condition would be which would cause consideration for acceleration; for example, loss of consciousness or NEWS in excess of a certain score. Furthermore, there was no specific event site transportation deterioration procedure, it was therefore unclear what staff should do if a patient who had been thought suitable for transport by a manager or registered health care professional at an event site deteriorated on route. These were both risks because it was not always clear that patients could be safely transported by the service. However, there was no evidence within the 50 patient journey records reviewed during the inspection that there had been any patients who had deteriorated during routine patient transport journeys.

Records

Staff did not always keep detailed records of patients' care and treatment. However, records were clear and stored securely.

At the previous inspection we found that the service had not completed a contemporaneous record for every patient journey that had been undertaken. Eight out of 18 records had not been fully completed. Furthermore, patients had been transported from event sites to hospital, yet no patient records had been completed for any of these journeys.

During the inspection of 4 March 2020, we found that some improvements had been made in relation to patient record completion and patient record documentation. However, we had concerns that some areas had not been addressed effectively; for example, the same information remained incomplete on patient journey records and only one record audit had been completed, it was therefore unclear how the service could effectively improve or how staff were being supported to improve, going forwards.

The service had introduced an event ambulance transfer record form for completion when transporting patients from event sites to hospital. This form detailed basic information such as journey times, destination hospital, staff and vehicle numbers. We saw that the form requested that patients who were transported by the service to hospital from event sites should have a full patient report form completed. This was good practice because the service's patient report form was highly detailed, contained key risk information and decision making and would provide a detailed record of the patient's care and treatment during their journey. Furthermore, the service had enlisted the help of a registered paramedic to provide informal training to staff on patient report form completion in order to support staff. However, as the service had not

transported any patients from event sites to hospital since the last inspection, we were unable to review any completed event ambulance transfer records or patient report forms.

We reviewed 50 patient journey records and 35 patient booking forms. Standard information had been completed in full on 27 patient journey records and eight patient booking forms. Information commonly omitted included GP details and home addresses (patient journey forms) and patient's date of birth and transport reasons (patient booking forms). There had been one patient journey record audit completed in February 2020. The audit highlighted that there were two occasions where standard information had not been completed by staff; however, only one occasion had associated commentary which detailed what action had been taken (staff were spoken with). It was unclear due to a lack of notes in the commentary field why the second occasion had not resulted in any form of action or support. Furthermore, as there was no associated procedure or process to accompany the audit, it was unclear what action managers completing the audit should follow, in the event of omissions or anomalies within the records.

Patient booking forms had not been audited and we were told there were no plans at present to audit these records. This was a risk because it meant that it was unclear how the service could effectively monitor the completion of patient booking forms to make improvements or highlight areas of concern. However, we saw that there had been three versions of the booking form created and implemented since the last inspection which showed that the service was reviewing the information captured and adjusting the forms accordingly despite this not being officially documented.

Medicines

The service used systems and processes to safely administer, record and store medicines.

At the previous inspection we found that the service did not have a medicines management policy in place and did not have an effective system in place to support staff in the administration of medical gases, including relevant training. This was a risk as it meant that it was not clear that medicines were being managed safely by the service.

During the inspection of 4 March 2020, we found that significant improvements had been made in relation to staff training, medicine management policies and ensuring effective systems were in place to safely manage medicines. There were minor anomalies within the medicines management policy and the medical gases policy; however, we saw evidence that the service had sought to rectify these anomalies promptly following this inspection.

We saw that all staff had received training in oxygen therapy as part of the accredited level three first aid training course and that completion was 100%. The service had provided an additional accredited level three course in emergency medical gases which included the use of nitrous oxide for staff which all staff had completed in January 2020. This was good practice.

The service had implemented a medicines management policy which was in date, version controlled and available to staff electronically. The policy had been reviewed and signed off by a registered health care professional with a working knowledge of current legislation and best practice guidance. This showed good practice as the service was actively seeking to make sure that the policy detailed the latest information. However, we saw that some information which was relevant to the service was not included within the policy; for example, guidance for staff on transportation of syringe drivers and intravenous fluids.

The service had implemented a medical gases policy which was in date, version controlled and available to staff electronically. The policy included information for staff in relation to when it would be appropriate to administer nitrous oxide including an exclusion list and indications for administration. This showed good practice as the instructions were clear and gave structured guidance for staff. However, other information had not been updated following the additional training; for example, there was no guidance to support staff in differentiating between administering oxygen when prescribed by a health care professional or in administering oxygen in an emergency situation.

Both omissions of information were highlighted to the management team during the inspection and we saw that following the inspection, a temporary memorandum had been completed for all staff issuing guidance on the anomalies. We were told that the additional information would be added into both policies at the end of month policy reviews.

Patient transport services

During the inspection we saw that effective systems had been put into in place to safely manage medicines. The patient journey form had been updated to include an information box specifically relating to the administration of oxygen and the patient booking form requested information on the oxygen prescription which could be passed onto the ambulance patient transport staff attending the patient. Of the 50 patient journey records reviewed we saw that one patient had been transported with prescribed oxygen. The oxygen information had been completed in full and staff had taken two sets of vital sign observations during the journey including oxygen saturation levels. This showed good practice as the medical gases policy did not stipulate that vital sign observations were to be recorded when oxygen was prescribed.

In addition, we saw that the service had implemented an electronic training system for staff which enabled clear oversight of when training was due for renewal, including medical gases. We also saw that the service had implemented a comprehensive electronic health and safety suite which allowed operational risk assessments to be completed, held and updated as appropriate. We saw that both medical gases including administration of and storage/handling of had been recorded within this system.

Are patient transport services well-led?

Leadership capabilities had improved to help run the services. The team understood and managed the priorities and issues that the service faced.

At the previous inspection we found that members of the management team did not have any formal management qualifications. This was important as they were responsible for undertaking all aspects of managing the service, including risk management and developing policies and procedures for use within the service.

During the inspection of 4 March 2020, we found that the service had made significant improvements to strengthen the leadership team by increasing the managerial expertise, experience and knowledge within it.

The service had employed an additional manager with experience of quality improvement and compliance methodology, to support with the completion of all the actions detailed at the April 2019 Care Quality Commission inspection as well as additional compliance and quality improvement issues and concerns, going forwards. This was good practice and we saw that this had strengthened the leadership team and allowed governance tasks to be delegated based specifically on individual leader's areas of strength. For example, one manager had developed a vision and associated strategy for the service, this detailed a five year forward plan which was both comprehensive in nature and set out targeted, realistic expectations and detailed plans as to how the service would achieve them.

Governance

Leaders did not always operate effective governance processes throughout the service. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At the previous inspection we found that the policies which had been implemented did not always reflect the service that was being provided and there was no requirement to monitor compliance against policies or procedures on a regular basis. Furthermore, monthly team meetings held by the service had no documented actions, meaning that it was unclear who was responsible for actions which required taking forwards or that these would be completed in a timely manner.

During the inspection of 4 March 2020, we found that some improvements had been made in relation to reviewing and updating policies and the documentation of actions from team meetings. We had concerns that in some areas anomalies remained in relation to policies and procedures; however, it was apparent that this was a large task and an ongoing process.

We saw that the service had begun a comprehensive review of all policies and that policies which had been streamlined, simplified and standardised were of a high quality and were pertinent to service being provided. Furthermore, we saw that work was ongoing to create an electronic index-based version of the policies so that staff could easily find the information they required by clicking on a link which took them to the relevant part of the policy. This was good practice as it showed the service was keen to make sure staff had access to the information they needed to carry out their day to day tasks. However, we saw that updated policies did not always include direct references nor the date the reference was from. For example, the

resuscitation policy did not state the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines date from which information within the policy referred to. This was important because it would not be clear when policies were reviewed, which best practice guidance or legislation had been used when the original document was written. We highlighted this to the leadership team during the inspection and we were told that this would be rectified.

In addition, we saw that updated policies which could be monitored for compliance had detailed compliance and frequency measures documented; for example, the infection prevention and control policy detailed what audits would be carried out, what training would be provided for staff and who's responsibility it would be to compile the subsequent reports in order to measure compliance against the policy.

We saw evidence that the service was completing regular team meetings which had been documented and we saw that a range of topics had been discussed, including the reviewing and updating of all service policies and procedures. The most recent meeting in February, had an attendance log and an associated action log with designated owners of tasks. There was no standard agenda; however, we saw that it was noted that this would be implemented from the March meeting, going forwards. We saw that actions which had been completed were signed off and those which were not were carried forward for the next meeting. This meant that there was an effective system in place to make sure that actions were assigned to an owner and that that they would be made in a timely manner.

Management of risks, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify or escalate all relevant risks and issues or identify actions to reduce their impact. However, they had plans to cope with unexpected events and staff contributed to decision-making.

At the previous inspection we found that the service did not have effective systems in place to monitor the service provided so that improvements could be made in a timely manner, when needed.

During the inspection of 4 March 2020, we found that some improvements had been made in relation to implementing systems to monitor the service provided. However, we had concerns that in some areas the systems were not comprehensive or embedded, it was therefore not always apparent that the systems were effective. Furthermore, there were other areas which had not been addressed.

We saw that the service had implemented additional audits to those reviewed at the previous inspection in order to drive service improvements; for example, a staff training audit had been introduced. This allowed the service to spot check staff competency and we were given a verbal example of this in relation to hand washing techniques. As a result of a low pass rate the service had arranged refresher training for staff following the audit. This showed good practice.

The management team had implemented a system to audit patient records; however, not all records were being audited. Patient booking forms had been in use since September 2019 but were not being audited. We reviewed 35 patient booking forms and saw that repeated information was being omitted; however, as the forms were not audited it was not clear that the service was aware of this so they could highlight additional issues to rectify or drive improvement.

The management team had completed one audit of patient journey records in February 2020; therefore, it was not evident that the process was effective in improving the service. Furthermore, there was no associated procedure or process to accompany the audit. We were told that patient journey record audits would be undertaken every month, themes established and support offered to staff make improvements. However, this was not documented anywhere. This meant that it was unclear how compliance in relation to the audits would be monitored or recorded.

We saw that as part of the patient journey record audit, the management team were auditing the time each routine patient transport journey was booked for, the time the ambulance crew arrived and what (if any) the deviance was. This meant that the team would be able to monitor the service's performance against the requested booking time. For example, we saw that one journey had a deviation time of 60 minutes. However, as there was no associated procedure or process to accompany the audit, it was unclear what the accepted standard was and as a result it was therefore unknown what action should be taken in order to rectify or improve this.

Patient transport services

We saw that the service had put a formal system in place to assess, mitigate and control both clinical and non-clinical risks. In addition, the service had sought external input and advice in relation to implementing a risk register and had purchased a specific electronic health and safety suite to log, assess, monitor and control operational risks. However, we saw that not all risks to the service were recorded; for example, not all records were available to view during the inspection as records were not kept on site. This meant that if information was required urgently in relation to a patient journey undertaken by the service, it was not clear if this could be retrieved easily or promptly. This was not detailed as a risk on the risk register. Following the inspection, we saw that the service had begun a process to move all records to the registered location in order to negate this risk going forwards. During the inspection, we were told that a review of the risk register was ongoing and additional risks (both clinical and non-clinical) were to be added.

During the inspection we saw that the management team had produced a detailed 78-point action plan as a result of the inspection report from April 2019. Each action point was colour coded according to whether it was complete, awaiting clarification or further information or not yet actioned. Each point had a designated owner and we saw that only four action points remained coloured as not yet actioned. However, we saw that two action points were coloured green as complete, yet further action was detailed within the comments field as required before completion. For example, point 19 in relation to checking the suitability of patients had a note against it that “other parameters needed to be decided on”. This was a risk because it was unclear that the action point would be fully completed, as it was already coloured green as complete. This meant there was a risk that actions would not be fully completed before the action plan had been deemed complete.

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 service must ensure that there is a fully effective system in place to make sure that only suitable patients are transported. This was a breach of Regulation 17(2)(a).
- The service must ensure that there are effective monitoring systems in place so that areas for improvement can be identified and acted upon in a timely manner. This was a breach of Regulation 17(2)(b).
- The service must ensure that an up to date, contemporaneous record is kept for all patient journeys that have taken place. This was a breach of Regulation 17(2)(c).

Action the provider SHOULD take to improve

- The service should ensure that there is a clear system for staff to follow if patients become unwell during journeys, both from event sites and during routine patient transport journeys.
- The service should ensure that all policies and procedures include direct references to dated legislation and best practice guidance.

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 17 HSCA (RA) Regulations 2014 Good governance