Work & Activity First Aid Ltd

WAFA Emergency Medical Vehicles

Quality Report

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Date of inspection visit: 6 and 7 October 2016
Date of publication: 20/04/2017

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Work & Activity First Aid Limited, (trading as WAFA Emergency Medical Vehicles) was a private, family-run ambulance service that provided patient transport and high-risk transfer services. They had a contract to provide patient transport services for the local council, they carried out various patient transport and transfer work for the NHS on a sub-contractor basis, and provided services on request from organisations and individuals.

We carried out an unannounced inspection of Work and First Aid Activity (WAFA) on 6 and 7 October 2016. This was a focused unannounced inspection (focusing on key areas of the service) in response to concerns received about the safe care and treatment of service users.

Our inspection focused on three out of the five key questions to assess whether the ambulance services provided were safe, effective, and well-led. During the inspection, we noted information relevant to the responsive domain and this is included in this report. We did not inspect the caring domain.

The provider operated from a single location, an ambulance station. There were no other locations registered as part of this business.

CQC does not currently have the power to rate independent ambulance services.

Our key findings were as follows:

- Staff did not always recognise concerns, incidents or near misses. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient. There was little evidence of learning from events or action taken to improve safety.
- There were no mechanisms in place to provide staff with appropriate training to perform their role, and no assurance that all staff had received mandatory or other role specific training.
- WAFA did not have systems and processes implemented for identifying and reporting safeguarding concerns and staff did not fully understand how to raise or report safeguarding concerns.
- There was a failure to assess the risk of, and to prevent, detect and control the spread of infection.
- Premises, equipment and facilities were not risk assessed, maintained or serviced in a way that kept people safe from harm.
- WAFA failed to ensure the proper and safe management of medicines. Arrangements for managing medicines and medical gases did not keep patients safe.
- Management, storage, completion or retrieval of patient records was not sufficient to keep people safe from harm.
- Managers did not have an understanding of risk or its management relating to patient safety or the business. There were no processes or systems in place for the identification of, capturing, and managing of risks to people who use the services. Opportunities to prevent or minimise harm were missed.
- WAFA failed to ensure all staff had the relevant employment and registration checks before or during their employment. This put vulnerable patients at risk of abuse or harm.
- Safety was not a sufficient priority. There were no systems in place to assess, monitor and improve quality and safety. There was no evidence of measurement or monitoring of safety performance.
- There was insufficient assurance in place to demonstrate that people received effective care. There was no system in place for monitoring people's outcomes of care and treatment.
- WAFA did not provide any evidence that relevant and current evidence-based guidance, standards, best practice and legislation were used to develop how services, care and treatment were delivered. Care or treatment was based on discriminatory decisions rather than an assessment of a person's needs.
- WAFA did not operate an effective system to ensure the staff employed were suitably qualified and competent as required under Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Arrangements for recruitment and for using temporary staff did not keep people safe at all times.

Summary of findings

- There was limited understanding of the Mental Capacity Act 2005 and consent. Processes and systems did not allow for concerns to be recorded and acted upon.
- Restraint and deprivation of liberty were not recognised and there were no processes or systems in place to guide staff where restraint and deprivation of liberty may apply.
- There were no systems and processes to manage concerns or complaints and no evidence the service used concerns and complaints to improve the quality of care.
- Leaders did not have the necessary knowledge, or capability to lead effectively. The registered manager had no understanding of the Health and Social Care Act 2008, or what his responsibilities were to ensure compliance.
- Governance systems and processes were not in place or operated effectively to assess, monitor and improve the quality and safety of the service.
- There was no process for carrying out audit, and opportunities for continuous improvement and learning were missed.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		CQC does not currently have the power to rate independent ambulance services. We found that: • Staff did not always recognise concerns, incidents or near misses. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient. There was little evidence of learning from events or action taken to improve safety. • There were no mechanisms in place to provide staff with appropriate training to perform their role, and no assurance that all staff had received mandatory or other role specific training. • WAFA did not have systems and processes implemented for identifying and reporting safeguarding concerns and staff did not fully understand how to raise or report safeguarding concerns. • There was a failure to assess the risk of, and to prevent, detect and control the spread of infection. • Premises, equipment and facilities were not risk assessed, maintained or serviced in a way that kept people safe from harm. • WAFA failed to ensure the proper and safe management of medicines. Arrangements for managing medicines and medical gases did not keep patients safe. • Management, storage, completion or retrieval of patient records was not sufficient to keep people safe from harm. • Managers did not have an understanding of risk or its management relating to patient safety or the business. There were no processes or systems in place for the identification of, capturing, and managing of risks to people who used the services. Opportunities to prevent or minimise harm were missed. • WAFA failed to ensure all staff had the relevant employment and registration checks before or during their employment. This put vulnerable patients at risk of abuse or harm.

Summary of findings

- Safety was not a sufficient priority. There were no systems in place to assess, monitor and improve quality and safety. There was no evidence of measurement or monitoring of safety performance.
- There was insufficient assurance in place to demonstrate people received effective care. There was no system in place for monitoring people's outcomes of care and treatment.
- WAFA did not provide any evidence that relevant and current evidence-based guidance, standards, best practice and legislation were used to develop how services, care and treatment were delivered. Care or treatment was based on discriminatory decisions rather than an assessment of a person's needs.
- WAFA did not operate an effective system to ensure the staff employed were suitably qualified and competent as required under Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Arrangements for recruitment and for using temporary staff did not keep people safe at all times.
- There was limited understanding of the Mental Capacity Act 2005 and consent. Processes and systems did not allow for concerns to be recorded and acted upon.
- Restraint and deprivation of liberty were not recognised and there were no processes or systems in place to guide staff where restraint and deprivation of liberty may apply.
- There were no systems and processes to manage concerns or complaints and no evidence the service used concerns and complaints to improve the quality of care.
- Leaders did not have the necessary knowledge, or capability to lead effectively. The registered manager had no understanding of the Health and Social Care Act 2008, or what his responsibilities were to ensure compliance.
- Governance systems and processes were not in place or operated effectively to assess, monitor and improve the quality and safety of the service.
- There was no process for carrying out audit, and opportunities for continuous improvement and learning were missed.

WAFA Emergency Medical Vehicles

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Detailed findings

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Background to WAFA Emergency Medical Vehicles

We carried out a focused, unannounced inspection of WAFA based on information received with concerns about unsafe working practices that increased the risks to service users. CQC contacted WAFA to request information and evidence about the service to assist in determining the level of risk to service users. The required information and evidence was not forthcoming or adequate, and as a result, we carried out an unannounced inspection on 6 and 7 October 2016.

Our inspection team

Our inspection team included:

Julie Foster, Inspection Manager

Two inspectors

One paramedic specialist advisor

How we carried out this inspection

During this focused inspection, we spoke with the executive directors, including the registered manager, staff (workshop manager and emergency medical technician), an assistant operations manager, ambulance crew, and two bank paramedics. We also spoke with a freelance GP who had been involved with giving advice to the service. As part of our planning for this inspection, we also spoke with relevant key stakeholders. We did not visit any hospitals and did not speak with any patients. We did not accompany any WAFA personnel on any patient transfers or discharges.

We inspected ambulance vehicles, the premises, equipment and the storage of medicines. We reviewed policies and procedures and looked in records, including all available staff files, incident forms and all available patient transfer records.

CQC does not currently have the power to rate independent ambulance services. Therefore, the report will not contain any ratings.

Facts and data about WAFA Emergency Medical Vehicles

Detailed findings

Work & Activity First Aid (WAFA) was first established in October 2009, and received its letters of incorporation in July 2010. In November 2012, the company moved to new premises and separated its two core services, each with an individual trading name prefixed with WAFA:

- Work & Activity First Aid Limited, T/a WAFA Emergency Medical Vehicles
- Work & Activity First Aid Limited, T/a WAFA Emergency Response Training (not registered with CQC and therefore not inspected)

WAFA moved from Unit 5, Creedy Vale, Lords Meadow Industrial Estate, Crediton, Devon EX17 1HN to Marsh Road, Lords Meadow Industrial Estate, Crediton, Devon EX17 1EU between July and October 2016. At the time of inspection, WAFA were in the process of completing the transition across to the new premises, and WAFA told us that all services at the time of inspection were being provided from the new premises. WAFA had not formally notified CQC of this change of address as required, and was prompted to do so prior to the unannounced inspection taking place.

WAFA were registered to provide the following regulated activities:

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

The service was based in Crediton, Devon, and provided patient transport services across the south west region. They had a contract with the local authority for patient transport services and they accepted requests for transport from other organisations and private individuals.

WAFA's Statement of Purpose said they provided the following services:

• Non-emergency patient transport

• Tiers 1, 2 and 3 high dependency (qualified crew) transport

• Routine and 'higher' mental health transfers

• Long distance qualified and non-qualified crew transfers

• Paediatric transfers

• Event cover (not regulated by CQC and therefore not inspected)

WAFA also offered a 'Challenging Transfer' service. This service was aimed specifically at situations where a patient had to be moved up or down narrow, steep, winding or lengthy staircases or flights of external steps and where standard levels of patient handling training and equipment were inadequate to ensure a safe transfer. It also covered situations where normal ambulance or road vehicle access was limited or restrictive, or where a patient needed to be carried some distance over rough or steep terrain.

WAFA operated seven days a week and were open 8am to 8pm. They also offered out-of-hours emergency cover.

Following our inspection we issued WAFA with a letter of intent on 14 October 2016, which set out the concerns we had about the quality of the services being provided and the risk to service users. The letter requested that WAFA provide an action plan within a specified timeframe, setting out how it was going to address and remedy those problems. WAFA informed us at this time that it would suspend all high-risk services until further notice. The action plan subsequently submitted by WAFA was not adequate and did not provide the necessary assurance that sufficient or timely action would be taken. As a result, on 2 November 2016 we issued WAFA with a notice of decision that all regulated activities had been suspended until 9 December 2016. On 9 November 2016, WAFA submitted an application to CQC to cancel their registration, and will no longer carry out regulated activities.

Patient transport services (PTS)

Safe	
Effective	
Responsive	
Well-led	
Overall	

Information about the service

Work & Activity First Aid Limited (trading as WAFA Emergency Medical Vehicles) was a private, family-run ambulance service providing patient transport and a high-risk transfer service. There were two executive directors and five additional members of staff employed by the service on a full time basis. There were at least eight bank staff employed, although exact numbers could not be accurately obtained during our inspection as this information was not collated or available to our inspection team.

They had a contract to provide patient transport services for the local council, they carried out various patient transport and transfer work for the NHS on a sub-contractor basis, and provided services on request from organisations and individuals. WAFA provided patient transport services for service users between their own homes and acute hospitals, and out of county transfers between acute hospitals.

It was not possible to accurately determine the numbers or types of transport and transfer services undertaken because this information was not collated or made available to the inspection team.

They provided first aid for a range of private events and provided private first aid training; neither of these activities are regulated by CQC and therefore were not inspected and are not included in this report.

Summary of findings

CQC does not currently have the power to rate independent ambulance services.

We found:

- Staff did not always recognise concerns, incidents or near misses. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient. There was little evidence of learning from events or action taken to improve safety.
- There were no mechanisms in place to provide staff with appropriate training to perform their role, and no assurance that all staff had received mandatory or other role specific training.
- WAFA did not have systems and processes implemented for identifying and reporting safeguarding concerns and staff did not fully understand how to raise or report safeguarding concerns.
- There was a failure to assess the risk of, and to prevent, detect and control the spread of infection.
- Premises, equipment and facilities were not risk assessed, maintained or serviced in a way that kept people safe from harm.
- WAFA failed to ensure the proper and safe management of medicines. Arrangements for managing medicines and medical gases did not keep patients safe.
- Management, storage, completion or retrieval of patient records was not sufficient to keep people safe from harm.
- Managers did not have an understanding of risk or its management relating to patient safety or the business. There were no processes or systems in

Patient transport services (PTS)

place for the identification of, capturing, and managing of risks to people who use the services. Opportunities to prevent or minimise harm were missed.

- WAFA failed to ensure all staff had the relevant employment and registration checks before or during their employment. This put vulnerable patients at risk of abuse or harm.
- Safety was not a sufficient priority. There were no systems in place to assess, monitor and improve quality and safety. There was no evidence of measurement or monitoring of safety performance.
- There was insufficient assurance in place to demonstrate people received effective care. There was no system in place for monitoring people's outcomes of care and treatment.
- WAFA did not provide any evidence that relevant and current evidence-based guidance, standards, best practice and legislation were used to develop how services, care and treatment were delivered. Care or treatment was based on discriminatory decisions rather than an assessment of a person's needs.
- WAFA did not operate an effective system to ensure the staff employed were suitably qualified and competent as required under Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Arrangements for recruitment and for using temporary staff did not keep people safe at all times.
- There was limited understanding of the Mental Capacity Act 2005 and consent. Processes and systems did not allow for concerns to be recorded and acted upon.
- Restraint and deprivation of liberty were not recognised and there were no processes or systems in place to guide staff where restraint and deprivation of liberty may apply.
- There were no systems and processes to manage concerns or complaints and no evidence the service used concerns and complaints to improve the quality of care.
- Leaders did not have the necessary knowledge or capability to lead effectively. The registered manager had no understanding of the Health and Social Care Act 2008, or what his responsibilities were to ensure compliance.
- Governance systems and processes were not in place or operated effectively to assess, monitor and improve the quality and safety of the service.
- There was no process for carrying out audit, and opportunities for continuous improvement and learning were missed.

Patient transport services (PTS)

Are patient transport services safe?

CQC does not currently have the power to rate independent ambulance services.

We found:

- Staff did not always recognise concerns, incidents or near misses. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient. There was little evidence of learning from events or action taken to improve safety.
- There were no mechanisms in place to provide staff with appropriate training to perform their role, and no assurance that all staff had received mandatory or other role-specific training.
- WAFA did not have systems and processes implemented for identifying and reporting safeguarding concerns and staff did not fully understand how to raise or report safeguarding concerns.
- There was a failure to assess the risk of, and to prevent, detect and control the spread of infection.
- Premises, equipment and facilities were not risk assessed, maintained or serviced in a way that kept people safe from harm.
- WAFA failed to ensure the proper and safe management of medicines. Arrangements for managing medicines and medical gases did not keep patients safe.
- Management, storage, completion or retrieval of patient records was not sufficient to keep people safe from harm.
- Managers did not have an understanding of risk or its management relating to patient safety or the business. There were no processes or systems in place for the identification of, capturing, and managing of risks to people who use the services. Opportunities to prevent or minimise harm were missed.
- WAFA failed to ensure that all staff had the relevant employment and registration checks before or during their employment. This put vulnerable patients at risk of abuse or harm.
- Safety was not a sufficient priority. There were no systems in place to assess, monitor and improve quality and safety. There was no evidence of measurement or monitoring of safety performance.

However:

- All vehicles had valid ministry of transport roadworthiness test (MOT) certificates and these were appropriately issued by a local garage.
- All vehicles appeared visibly clean on inspection.

Incidents

- The registered manager and other staff we spoke with at WAFA were unable to provide us with assurance that the processes and systems for identifying, reporting and responding to incidents or near misses were implemented or understood. For example, over a four-year period only eight incidents or near misses had been recorded; two were from 2013 and three from 2014. Only one incident was recorded in 2015, and this was following a complaint by a patient that an incident form had not been completed at the time of the incident. No incidents were recorded up to the point of inspection in 2016.
- WAFA had no record of any investigations into reported incidents. In three of the incidents we reviewed, we had concerns that the patients involved did, or may have suffered harm because of the incidents, but WAFA had not referred these patients for medical review. For example, one patient who had sustained a deep cut was transported home, and another had been dropped and injured, but had not been referred for medical treatment.
- WAFA told us most of the incidents they reported were about the failings of other ambulance services, and we saw seven such records of complaints from ambulance crews about other providers. There was no evidence that WAFA raised these concerns with the other providers and no accompanying record of any response, or learning.
- The registered manager could not explain the difference between types or severity of incidents and was not able to tell us how WAFA would approach investigation of these. For example, WAFA told us prior to the inspection they had two never events recorded. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong protective systems are available at a national level and should have been implemented by all healthcare providers. A never event relevant to the service, for example, would be an incorrect drug

administered intravenously. During the inspection, we found that no never events had been reported and the registered manager and director could not explain to us what a never event was.
- The type of incident that needed reporting or incidents that required notification to CQC were not understood. The registered manager described the requirement to report certain incidents to CQC as 'anything we perceive as a concern regarding welfare or malpractice'.
- The registered manager told us they made sure staff working with patients knew about any incidents or changes in policy or procedure that had been made following safety incidents or safety alerts through a debrief session. The service was unable to provide us with records, examples or minutes of meetings where this had occurred.
- There was no policy or guidance for staff, or training on how to identify or report incidents or near misses.
- Staff were not able to describe something that had changed as a result of an incident.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 wasintroduced in November 2014. This Regulation requires a provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- WAFA did not have a policy or any guidance for staff in relation to duty of candour and the registered manager was unable to explain how duty of candour applied to WAFA.
- The service was unable to provide us with evidence that patients who used the service were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. We saw one incident where duty of candour should have been applied but there was no evidence that it had been.

Mandatory training

- There were no mechanisms in place to provide staff with appropriate training to perform their role, or to ensure that temporary bank staff had undertaken appropriate training.
- The registered manager told us WAFA was accredited by an independent company as an emergency response training centre, which entitled WAFA to provide and deliver specific accredited courses. We were told mandatory training was delivered to all staff in this way.
- WAFA was unable to provide evidence of this accreditation during the inspection and we were unable to ascertain which courses WAFA was accredited to deliver in-house, which courses were actually delivered, or the content (aims, objectives or lesson plans) of those courses.
- We were told training courses ran weekly. WAFA could not supply us with evidence of any courses having taken place, attendance lists, sign-offs or certificates issued.
- We were unable to ascertain the mandatory training needs by job role for each member of staff as this detail was not included in the training policy. The majority of staff records we viewed during the inspection did not contain evidence of the training required, received or due. We were therefore unable to map training requirements or evidence of competence to the staff employed.
- We reviewed seven training records for WAFA staff and were only able to find training information for four of these. Of those four, the training records were incomplete, for example, there was no evidence of training on manual handling or safeguarding. These courses were required for all WAFA staff in accordance with the contract they held with the local authority.
- WAFA offered routine and 'higher' mental health transfers but no staff had received any training in caring for, or managing, patients living with mental health issues.
- There was no evidence of any training for bank or temporary staff.
- WAFA offered a challenging transfer service for difficult transfers that many other ambulance providers refuse. For example, retrieval from hard to reach places with rough terrain that may require a patient to be carried on a stretcher over a long distance. Of those staff that had completed manual handling training, these were generic e-learning courses provided by the local authority and not specific to this kind of task; apart from the registered manager, there was no evidence that any staff had completed any practical training in manual handling.

Patient transport services (PTS)

- The registered manager's emergency medical technician qualification had lapsed, and he told us he did not intend to renew this because he was working on developing a better training course that would surpass the training offered externally.
- The registered manager told us he did not routinely request evidence of training for temporary or bank staff, because they were all community first responders or paramedics with an NHS ambulance service and therefore they would have received the necessary training via that route.
- The registered manager told us all staff working for WAFA were encouraged to become community first responders so they could receive the relevant training and updates from the NHS ambulance service, and that it had been agreed with the NHS ambulance service that he could rely on this training. We spoke with the NHS ambulance service and found that no such agreement was in place, and that an arrangement of this sort would not be sanctioned.
- Following the inspection we requested training information for all staff, temporary and permanent, and the information returned to us was inadequate and incomplete. For example, only two staff had completed any infection control and prevention training. There was no evidence of training for any temporary bank staff returned.
- We saw first aid certificates for three staff that had been provided by an external company. These lasted for three years, but there was a stipulation that annual updates were undertaken. There was no evidence these staff had completed the required annual updates.
- Further to our request for additional information following the inspection, we were provided with e-learning certificates for three staff, and these were dated and printed on the day the information was due to be returned to us. A number of other certificates submitted were not signed or certified, and it was not apparent from the certificates which training body had provided these certificates. Two certificates we saw had been awarded to staff by the registered manager.
- WAFA had a section within the training policy regarding the process for induction. It said all new staff would undergo vehicle conversion training, equipment conversion training (ensuring new staff who were trained elsewhere were competent to use WAFA vehicles and equipment), patient handling training and first aid training. There was no provision within the policy for ongoing assessment of these skills for existing staff, and WAFA were unable to provide us with any assurance that new or existing staff had these skills and competencies.

Safeguarding

- WAFA did not have systems and processes in place for identifying and reporting safeguarding concerns. Staff did not fully understand how to raise or report safeguarding concerns. For example, when asked how WAFA managed safeguarding concerns, the registered manager told us he would report all safeguarding concerns to CQC rather than to the local authority. Other staff we spoke with told us they would tell the registered manager.
- When pressed, the registered manager told us he would follow WAFA policy which said staff should follow the process set out by the local authority, which can be found on the local authority website.
- Whilst reviewing the incident reports, we found a serious safeguarding concern that was reported to the registered manager by the ambulance crew. It was not apparent from the record of events if this was reported externally. The registered manager told us this concern had been reported to another private ambulance provider because WAFA had transferred the patient at their request. A safeguarding alert had not formally been raised and the local authority had not been notified. The registered manager could not tell us what, if any action had been taken about this concern by the other ambulance provider. This course of action was contrary to WAFA policy and potentially placed vulnerable people at risk of harm.
- The registered manager was unable to explain what a statutory notification was for a safeguarding incident.
- The registered manager said staff completed online safeguarding training provided by the local authority. We were unable to verify this from training records we requested as there was no evidence available for us to review.
- There were no effective procedures to update front line staff when changes occurred with safeguarding procedures.

Cleanliness, infection control and hygiene

- There was a failure to assess the risk of, and to prevent, detect and control the spread of infection.

Patient transport services (PTS)

- We were not assured there were reliable systems in place to prevent and protect people from a healthcare-associated infection.
- WAFA did have an infection control policy; however, this was generic and did not provide staff with any specific guidance. It set out general information about infection and the need to control it.
- The policy specified that a comprehensive clean should be conducted on a weekly basis and staff were reminded to regularly clean vehicles during each shift. There was no instruction as to how this should be done, what should be cleaned or what products should be used. There was no stated process for recording this had been done, no cleaning schedules were available, and we found no evidence during inspection that vehicles had been cleaned, either during each shift or weekly. However, the vehicles appeared visibly clean on inspection.
- The policy did not include any information on decontaminating vehicles following exposure to a potentially or known infected patient. There was no evidence in the transfer record or patient information reviewed that information about patient infection status was being requested or recorded.
- There were some cleaning products on vehicles such as surface wipes to maintain cleanliness of a vehicle during the course of a shift.
- There was no system in place to indicate when equipment was last cleaned, either on the vehicles or in the depot. Some equipment was visibly dirty, for example stretchers and wheel chairs.
- Minimal hand cleaning facilities were readily available. Staff used a single sink located in the crew rest room for use before and after patient transfers. We did not see any hand gel stations for staff to use, although we did see decontamination wipes on vehicles.
- There was no separate sink for disposing of contaminated waste. Staff told us they used a drain outside the building to empty out contaminated water from mop buckets. There was no sink or facility large enough to clean the mop buckets, or other cleaning receptacles after use.
- Biohazards, for example bleaches and disinfectants were not securely stored or separated from general cleaning products.
- There was no facility for disposal of contaminated waste, for example, used dressings or soiled linen. There were no clinical waste bags or tags, and staff told us waste was taken to a local hospital for disposal. The service did not have a formal agreement with a local NHS trust or other organisation for disposal of dirty linen or other clinical waste, such as used dressings or sharps boxes.
- Clean linen was stored in a dirty cupboard in the main depot near to the ambulances, and some linen was stored on the floor of this cupboard.
- Consumables were stored in dirty containers and dirty drawers.
- We saw sharps boxes in use for disposal of used needles. They were unlabelled so could not be tracked during their usage.
- There was no guidance for staff on what to do in the event of a needle stick injury.
- The registered manager told us there had been infection prevention and control training for staff through an online e-learning system provided by the local authority. However, we were not provided with records demonstrating completion of the training.
- There was no infection prevention and control lead.
- WAFA were not able to provide any evidence of infection control audits and the registered manager told us these were not completed regularly or recorded.
- The premise itself was not in a clean state. There was a pile of dirt swept into a mound on the floor of the depot and the depot was being used to store a considerable number of unrelated items, such as simulator machines, old car engines and boxes of miscellaneous items. There were used building materials in the vehicle garage, which were leaning against walls. Equipment, such as stretchers, were stored against walls and on the floor of the depot, which was visibly unclean.

Environment and equipment

- WAFA had not conducted a risk assessment on their new premises. The registered manager told us they had planned to ask their small business advisor to come and conduct a Health and Safety Assessment as part of their mentorship scheme for small businesses, but this had not been arranged at the time of inspection.
- During a CQC registration visit on 20 September 2016 the registered manager was told that a recorded risk assessment should be compiled for the new location in line with good practice recommendations. This would

record the work already done to identify and mitigate risk, as well as the work planned to ensure it was completed. During our inspection on 6 and 7 October 2016, the risk assessment had still not been requested.

- There were a number of risks to staff including an untidy and chaotic environment. There were also potential risk to patients from dust and dirt on clean linen and equipment.
- During our inspection we saw a bird flying around in the garage. We were not assured that blankets or equipment were clean because the areas for storage did not prevent birds being able to land on clean blankets or other items of equipment.
- We were not provided with assurance that the maintenance and use of equipment kept people safe. The registered manager told us there was an inventory of equipment but it was not up-to-date. When we asked to see it, it could not be accessed from the electronic system used to store the information. Following the inspection, we requested a copy of the inventory but the registered manager told us there was not one in existence.
- There was no regular, documented formal process for scheduling repairs or maintenance of equipment. During the inspection, the registered manager could not provide us with evidence of when equipment had last been serviced, or when it was next due to be serviced. There was a folder with evidence to show that a member of staff had serviced some equipment, for example the carry chair. However, somebody with the necessary qualifications to carry out that service should service this type of chair; the member of staff who had serviced the chair did not have appropriate training for this.
- The registered manager told us there was no schedule for servicing the ambulances, but said they were serviced. We reviewed the vehicle records and were not able to see any evidence of regular servicing taking place for all vehicles. We were told servicing was done on a six-monthly basis. We saw two vehicles had been serviced but with a period of eight months between them. We saw evidence of some daily checks of ambulance vehicles; the last records were 2 August 2016 and 22 September 2016. The registered manager and other staff told us this was done every time the vehicle went out, but was not always recorded.
- We asked for evidence of the daily vehicle checks such as oil, water and other fluids, and medical gases. The registered manager could not provide us with any assurance the checks were being carried out regularly. For example, one vehicle had only two checks over a two-month period. The registered manager said this was because it was only checked when the vehicle was taken out on a transfer. We asked to see the record of how many times this vehicle had been on the road during that period but the registered manager was unable to tell us because there was no central record of which vehicles went out to transport patients or when.
- All vehicles had valid ministry of transport roadworthiness test (MOT) certificates and these were appropriately issued by a local garage.
- One member of staff had completed a level one diploma in motor studies; he was also a qualified emergency medical technician and spent half of his working day split between servicing vehicles and equipment and conducting patient transport services. The registered manager told us he was the in-house mechanic who did all servicing and maintenance on vehicles and equipment. The qualification he held was not an appropriate qualification and did not provide us with assurance that the vehicles and equipment were safe.
- The mechanic and the registered manager made decisions about faulty equipment on vehicles and whether an equipment fault should result in the equipment or vehicle being taken out of service.
- There was potential for harm to patients because equipment and drugs were out for date. We found a large number of stock items that were out of date on the vehicles and in the equipment bags. This included bandages, needles and endotracheal tubes. The stock in store cupboards was also found to contain a considerable number of out of date items. Some of the stock had expiry dates of 2004 and 2005.
- We asked to see evidence of regular checks on stock for expiry dates but were told although this was done it was not recorded. On the first day of the inspection we asked for the out of date stock to be removed, but this was not done.

Medicines

- There were not systems and processes to ensure the proper and safe management of medicines. Arrangements for managing medicines and medical gases did not keep patients safe.

Patient transport services (PTS)

- We were not provided with evidence of any process for checking drugs stored in emergency bags. The registered manager told us drug bags were checked regularly but these checks were not documented. Other staff we spoke with confirmed this.
- We saw out of date drugs in the main stock. For example, two adrenaline ampoules for cardiac conditions and 12 adrenaline ampoules for relieving anaphylaxis or allergic conditions were out of date. We also found other out of date drugs in the paramedic bags, including amiodarone, which is a medicine used for cardiac arrest. We told the registered manager to rectify this issue with immediate effect and we stated this must be done by midday the following day. When we checked the bags the following afternoon we found none of the out of date drugs had been replaced. The registered manager told us they had asked one of the bank paramedics to come in and do this, but it would not be for another three days. We told the registered manager again this should be done with immediate effect. Later that afternoon we noted the out of date drugs had been replaced but had been moved to the main drug cupboard along with the in date drugs. They had been sealed in a separate zipped bag but were not labelled as out of date or marked in any way to prevent staff from using them. We were told these would be taken to the pharmacy for destruction.
- During a CQC registration visit on 20 September 2016 the registered manager was told about good practice recommendations concerning controlled drug safe handling, storage and management. The registered manager said they would check the Home Office guidance in relation to registered managers' responsibilities for the safe handling, storage and management of controlled drugs. The CQC registration inspector and other inspectors prior to our unannounced visit confirmed with the registered manager that WAFA needed a controlled drugs accountable officer, or an exemption from this. The registered manager told us they would ensure this was done.
- The service's Therapeutic Drugs Management Policy (WAFA-EMV, V.2, June 2016) stated 'WAFA …are applying to CQC for exemption from the need to appoint a CDAO [controlled drugs accountable officer]; as per the Controlled Drugs (supervision and management of use) Regulations 2013'. However, during our inspection the registered manager told us they had not yet applied to do this because they did not know how to go about it. We assisted the registered manager with accessing the correct section of the website in order to complete this during the inspection.
- Any provider storing controlled drugs must have a home office licence for controlled drugs but WAFA had not applied for one.
- The medicine policy WAFA had in place stated therapeutic drugs (medicines) could only be prescribed or ordered by Health Care Professionals Council registered paramedics or doctors employed by the service. This included any registered staff who had signed an employment contract with the service. Medicines for use within the service had been prescribed by a freelance GP in June 2016. The GP was not employed by the service and had not signed any agreement with the service for the ongoing supply or monitoring of those drugs obtained through such a prescription.
- We spoke with the GP concerned. They told us they were not employed by the service in any capacity, and said there was no written or verbal follow-up agreement in place to monitor the use of the drugs, or the repeat prescription.
- We asked for access to the controlled drug store but were told the registered manager kept the key and he was not on site at the time. Staff told us they would ring him if they needed the key.
- The registered manager told us the ordering, storage and management of controlled drugs was the responsibility of the paramedics who were part-time and employed ad hoc on a bank basis. It was not clear who was responsible for checking the drugs.
- We saw evidence of a medicines briefing by the GP, for two paramedic staff employed by the service to use a drug called Salbutamol. The drug was used for relieving difficulty in breathing. Salbutamol was an example of a drug that should either be administered against a prescription for an individual patient from a prescriber or under a patient group directive. There was not a patient group direction in place for Salbutamol.
- The briefing for Salbutamol did not include all staff who would have access to, or permission to administer the drug; it did not contain any detail of what had been covered in the session, or evidence of any assurance of competency. The commentary merely said the staff present were comfortable with using the drug. The

registered manager could not tell us of any plan to ensure all necessary staff would receive the relevant instruction or training in using this drug, or any system for updates.

Records

- There was no evidence that patients' individual care records were written and managed in a way that kept people safe. Keeping patients safe through their records includes ensuring that accurate and complete accounts are documented, signed and dated, legible, up-to-date and stored securely.
- We asked for examples of patient records that provided evidence of good practice for the following aspects of the service provision:
  - Non-emergency patient transport requiring an ambulance care assistant
  - Tiers one, two and three high dependency (qualified crew) transport. Tier one required the presence of a qualified emergency medical technician as part of the crew. Tiers two and three required the presence of a paramedic.
  - Routine and 'higher' mental health transfers
  - Long distance qualified and non-qualified crew transfers
  - Paediatric transfers
- The registered manager was unable to provide us with complete, accurate and contemporaneous patient records. The registered manager told us this was because they had been mislaid during the move to the new premises. We were told that records were archived for preceding weeks and months. The registered manager and another executive director were unable to locate the archives.
- We were provided with ten recent patient clinical records. Of these ten records, none were accurately or comprehensively completed. Most of them contained no, or very little detail in the sections for 'patient illness, injury or condition' and 'special considerations'.
- Some observations, such as blood pressure and respiration rate, were not recorded at all while other observations, such as a pulse rate, were missing in several of the patient records. In a number of these records, the outcomes for the patients were not documented. We were therefore not assured that appropriate care had been provided for these patients.
- Some records did not contain any details of interventions that had been carried out, or any medicines that had been administered, including oxygen, and did not contain signatures of the staff involved. We asked the registered manager about five such records and he told us he was aware that a particular individual was not good at completing records. He was unable to provide us with evidence in the form of an appraisal or otherwise, to confirm these issues had been, or were in process of being, addressed.
- We reviewed two lever arch files of non-emergency patient transport bookings and patient transfer records. They were incomplete. The job query and progress tracking form used for these bookings and subsequent recordings contained a section for adding in patient details, but of the forms we reviewed, very few had any details of the patient conditions recorded on them. The registered manager told us these did not need to be completed as they were routine patient transfers.
- In the event that the service was asked to transfer a patient at the end of their life, we were told that up-to-date do not attempt resuscitation orders and end of life care planning would be appropriately recorded and communicated when patients were being transported. However, there was no process for staff to have sight of these forms and therefore no assurance that what they were being told was current information. We saw the record from one end of life patient where this information had not been obtained or recorded. This transfer took place during our inspection and we heard the handover being taken by a member of staff.
- We asked the registered manager to provide us with a list of any blue light transfers that had been undertaken in the last 12 months. We also requested patient records for tier one, two and three high dependency (qualified crew) transport. The registered manager was unable to provide us with a list of blue light transfers as they do not routinely monitor or record this information. The records we requested were not available and could not be located for us to review.
- We asked the registered manager to tell us the number and types of transfers that had been undertaken in the last 12 months. Although we could obtain the number of jobs by reviewing two lever arch folders containing invoices, these documents did not specify what type of transfers they were. The registered manager told us they did not routinely collate or analyse this information. From the records available to us we were unable to ascertain if the correct crew members were being dispatched to the correct jobs.

- There were no job logs and records were not organised so they were searchable or auditable.

Assessing and responding to patient risk

- There were not systems in place to assess and respond to patient risk and the registered manager could not provide assurance that it was providing a safe service.
- We did not see any comprehensive risk assessments or risk management plans developed in line with national guidance. The registered manager said they expected bank paramedics to act appropriately concerning risk assessments, but there was no evidence of risk assessments in care records.
- We were told by staff there was no policy or guidance for staff to follow to support risk assessment or any response. This was confirmed by the registered manager who said that this information was not written down.
- There was limited information collected by the service to determine risks and to assess the skills required for any job. There were no mechanisms in place to ask the callers questions about the service users; instead the service relied on the person booking the transport to inform them of any concerns or issues.
- Staff we spoke with could not describe a formal framework for assessing and responding to patient risk. When we asked the registered manager if there was a list of prompts or a process for taking information about patients, we were told that staff knew what to ask. There was no prescribed list or process for staff to follow, and the records we reviewed indicated this information was not routinely recorded.
- We saw a document entitled Policy and Standard Operating Procedure (WAFA EMV,V.1, July 2016) which had a heading 'Dynamic Risk Assessments'. This was a bullet-point list of generic things to do, for example, 'evaluate the situation, the tasks to be carried out, and the persons potentially at risk'. It did not provide any specific guidance about how to assess and mitigate risks, and there was no requirement to record such evaluations.
- The above document prompted the reader to consider 'existing protocols' that applied to the situation. The registered manager told us 'protocols' were taught in training, but were not written documents that staff could refer to.
- When we asked how patients on long journeys were monitored for signs of deterioration, we were told that staff used their eyes and ears. The registered manager told us the service did not have any clinical guidelines for staff to refer to.
- We asked the registered manager how staff in transit could obtain clinical advice and support if a patient was deteriorating. We were told staff could contact the registered manager in the office or phone 999. Paramedics were able to phone the local ambulance trust's clinical hub and receive advice from their clinical experts. The registered manager told us the service did not have a formal agreement in place for this.

Staffing

- There were not effective systems in place to ensure the staff employed were suitably qualified and competent as required under Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Arrangements for recruitment of permanent staff, and for using temporary staff did not keep people safe at all times.
- The service's recruitment policy (WAFA-EMV 2012) set out a list of the organisation's expectations for all new recruits, including an application form, proof of qualifications, health declaration, full curriculum vitae, proof of identity, enhanced disclosure and barring service check and two referees. We examined all seven available staff records and we found these were largely incomplete.
- We were not provided with evidence that disclosure and barring service checks had been carried out for all permanent staff. We were provided with this evidence following the inspection, although one member of staff had not had a check to ensure that they were safe to work with children.
- There were no references filed against any of the staff employed, nor any CVs.
- The registered manager could not provide us with any copies of job descriptions or contracts for permanent staff.
- We saw one casual worker contract for a member of the bank staff. It stated that hours of work would be notified at the start of any shift, along with any break entitlements.

Patient transport services (PTS)

- The registered manager told us he relied on the knowledge that his bank staff were employment with a NHS trust to provide assurance they had completed the relevant registration and had disclosure and barring checks and training.
- The recruitment policy did not set out any processes for ongoing checks on the integrity or suitability of staff, or the frequency with which such checks should be conducted and monitored.
- There was not a systematic approach to determining the number of staff or the range of skills required in order to meet the needs of service users and keep them safe at all times. For example, there were not records in place to be able to check staff with the correct skills and competence had been sent to the correct sort of transport or transfer jobs.
- During the inspection we were unable to accurately determine how many staff were employed by WAFA. This was because the staff records did not reflect details of which staff were employed on a permanent basis, and which staff were temporary. We were told there were seven permanent staff, and we ascertained there were at least eight bank staff who were used regularly. We were told different information in relation to staffing by members of the executive team. We were given names of other temporary staff who were used on occasion, for example, when they were in the area during holidays from university. There was no information recorded in the staff files for these individuals.
- The registered manager told us that often a paramedic crew was requested inappropriately. They told us the person accepting the work would review the information provided and was often able to persuade the referrer that the job was suitable for an emergency medical technician crew rather than a paramedic crew. We were told a number of paramedic jobs were downgraded in this way. We were unable to see records of when this had happened because this information was not kept.
- The registered manager confirmed WAFA did not have a policy or procedure to cover shift start and end times, or which identified safe driving times. They told us this would depend on each transfer, and sometimes long distance transfers were unpredictable.
- Staff told us they were driving long hours without any opportunity to take a break in order to meet pick up and drop off times. There was no guidance on this and it was not set out in any contract or policy document. This information was not routinely collated, audited or monitored to make sure that patients and staff were kept safe.
- We were unable to find evidence that staff driving using blue lights were trained to do so, and that the journeys where blue lights were used were appropriate, as this information was not kept or monitored in any way. This meant that the use of blue lights was open to misuse.

Anticipated resource and capacity risks

- The registered manager not assessed the impact on safety, or monitored the implications for non-emergency patient transport service, when they moved from one location to another. There was no available plan for the relocation or understanding of the changes to the service or the staff.
- The service had not assessed the impact on safety, or monitored implications for other work including patient transfers, that required paramedic or emergency medical technician skills.
- There was no evidence of any planning or training in terms of how the service would respond to, or manage, foreseeable risks, including:
  - Changes in demand
  - Deteriorating patients
  - Changes in behaviour or needs of patients during transfer
  - Seasonal or weather changes
  - Loss of facilities or infrastructure
  - Disruption to staffing levels
  - Vehicle breakdowns or accidents

Are patient transport services effective?

CQC does not currently have the power to rate independent ambulance services.

We found:

- There was insufficient assurance in place to demonstrate people received effective care.
- There was no evidence that relevant and current evidence-based guidance, standards, best practice and legislation were used to develop how services, care and treatment were delivered. Care or treatment was based on discriminatory decisions rather than an assessment of a person's needs.

Patient transport services (PTS)

- There was no system in place for monitoring people's outcomes of care and treatment.
- There was not an effective system to ensure the staff employed were suitably qualified and competent as required under Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Arrangements for recruitment and for using temporary staff did not keep people safe at all times.
- There was limited understanding of the Mental Capacity Act 2005 and consent. Processes and systems did not allow for concerns to be recorded and acted upon.
- Restraint and deprivation of liberty were not recognised and there were no processes and systems in place to guide staff where restraint and deprivation of liberty may apply.

Evidence-based care and treatment

- There was no evidence that relevant and current evidence-based guidance, standards, best practice and legislation were used to develop how services, care and treatment were delivered.
- The registered manager told us he relied on his peers who work for an NHS ambulance service to update him on any changes to national guidance, best practice or the law.
- The policies in place were generic and did not contain specific guidance for staff to follow.
- The registered manager told us all 'protocols' were in his head, and that he taught these to staff. He confirmed they were not written down which meant they could not be referred to, audited or monitored.
- The registered manager told us that they did not have clinical guidelines in place for staff to follow. We were told some paramedics followed the Joint Royal Colleges Ambulance Liaison Committee guidance. We asked to see a copy of this and were shown the guidance dated 2013. The registered manager told us it was too expensive to purchase the 2016 guidance, and that very little had changed in any event.
- The registered manager told us paramedics were professionally accountable to keep up-to–date with legislation and national guidance. We were told the remaining staff who were emergency medical technicians or ambulance care assistants were also trained as community first responders, which provided them with the necessary guidance they required. We were not provided with evidence that this was the case.
- The registered manager was unable to show us any evidence of safety, quality or risk information that was collated, and he told us there were no audits we could review to demonstrate staff were working to best practice, national guidance or within the law.

Assessment and planning of care

- When WAFA received a non-emergency patient transport referral, staff did not use standard acceptance criteria. The service relied on referring organisations to understand what the needs of the patient were.
- The registered manager told us they did not risk assess the work undertaken because the transfers that were phoned through had already been risk assessed by the person referring the patient, and the service was entitled to rely on those risk assessments.
- We observed staff receiving a challenging transfer referral and heard the discussion between staff about who should go and how it should be managed. No formal risk assessment was undertaken and one member of staff was heard asking an executive director "is there anything special I need to do when I get there?"
- Because no formal risk assessment was in place when receiving referrals, not all the information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. This included care and risk assessments, care plans, case notes and test results. Records where assessment and planning of care should have been recorded were not completed.
- There was no system to manage information about service users. This meant support for staff to deliver effective care and treatment was not available.
- There was no system to flag patients who had special requirements, disabilities or needs. This included mental health problems or patients living with dementia. We saw no evidence that special notes were flagged and available for patients or addresses on any records we reviewed.
- The rights of people subject to the Mental Health Act 1983 were not protected and there was no evidence that staff had regard to the Mental Health Act Code of Practice. This was not documented in any policy and information about mental health was not routinely requested or recorded.
- Patient's nutrition and hydration needs were not assessed ahead of long distance journeys. In one case we reviewed, a patient who was not able to take food or

fluids orally was given oral fluids during a long distance journey. There was no investigation or response to this situation, which may have caused harm to the patient. No learning was identified from the event nor actions put in place to prevent this from happening again.
- There was no formal process or guidance in place for staff when handing over a patient upon arrival at their destination, and no record of any handovers having taken place.

Response times and patient outcomes

- There was no documentation of patient outcomes recorded in the records we reviewed. The provider did not benchmark and compare patient outcomes to other providers because they were not routinely collecting data.
- We were unable to establish what the performance of the service was like based on outcome data because this was not collected. For example, we could not ascertain:
  - the number of patient journeys completed;
  - the nature of injury or illness of patients being carried;
  - the treatment or interventions that had been provided;
  - the condition of the patient before, during, or at the end of the transfer;
  - the ambulance response times;
  - the length of time patients spent on vehicles;
  - the number of bookings that were completed on time;
  - the numbers of same-day bookings.
- The service did not routinely collect information about the outcomes of people's care and treatment when transferring patients requiring monitoring.

Competent staff

- There was no effective system to ensure the staff employed were suitably qualified and competent as required under Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Only three of the staff records we reviewed contained some evidence of qualifications or photographic identification.
- Checks had not been carried out or documented to make sure any permanent or bank staff had registrations with the appropriate professional bodies. There were also no checks to ensure staff responsible for driving the vehicles had the appropriate categories of vehicle noted on their driving licences.
- The registered manager informed the inspection team that they took the qualification and competence of the bank staff at face value, because they knew they worked for a local NHS ambulance service as a member of their bank staff. We asked if the relevant information had been requested, seen and copies retained but were told by the registered manager they had not.
- We were not provided with evidence of staff appraisals or supervision. Staff training or development plans to meet their learning needs were also not provided.
- We were shown two staff appraisals for permanent staff, but these were dated 2014 and the registered manager was not able to locate current appraisal information. He told us there was not a process in place for ensuring the executive directors had regular appraisals and he was uncertain as to who should do these.
- There was no evidence that poor or variable staff performance was identified or managed. For example, we saw some patient records that were incomplete. The registered manager told us they were aware of a member of staff with poor record keeping but he had not supported the staff member to improve or initiated any form of performance management.
- The service's statement of purpose (WAFA-EMV, V.2, July 2016) stated "As a by-product of high levels of training and a philosophy of innovation with vehicles and equipment, we are able to offer a 'challenging transfer service'. This service is aimed specifically at situations where a patient has to be moved up or down, narrow, steep, winding or lengthy staircases, or external steps; and where standard levels of patient handling training and equipment would be inadequate to ensure a safe transfer … or may have to be carried some distance over rough or steep terrain." The registered manager told us the service received and undertook a number of such transfers that other ambulance services did not accept because they were not sufficiently skilled and did not have the correct equipment. However, the registered manager was unable to provide evidence to demonstrate that any staff had suitable qualifications, skills and experience to undertake such transfers.
- The training policy (WAFA-EMV, V.1, July 2016) stated that "New members of staff were originally put through a National Framework Manual Handling Course as part of

their induction training program, but this was quickly discovered to be inadequate and a new strategy was adopted, in which the candidate received instruction and assessment as part of their Third Manning Phase and during their first staff training session."
Third-manning is where a trainee or new recruit accompanies an established crew for training purposes. We were unable to view any evidence of initial or ongoing assessment of competency for manual handling during third-manning in any staff records. The registered manager told us these were not written down.

- The training policy stated that WAFA, in addition to its ambulance services, was an accredited emergency response training centre. We were told during the inspection that WAFA was accredited to provide in-house training by an external company. This accreditation entitled WAFA to be a registered training centre, and to provide specific accredited courses. The provider was not able to provide any evidence of this accreditation during the inspection and we were unable to ascertain which courses WAFA was accredited to deliver in-house, which courses were actually being delivered, or the content (aims, objectives or lesson plans) of those courses. We were told courses ran weekly but the provider was not able to provide any evidence of any courses having taken place, attendance lists, sign-offs or certificates issued.
- We were unable to ascertain the training needs by job role for each member of staff as this detail was not included in the training policy. The majority of staff records we viewed did not contain evidence about the training required, received or due. We were therefore unable to map training requirements or evidence of competence to the staff employed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The registered manager, and other staff we spoke with, did not understand the relevant consent and decision-making requirements of legislation and guidance including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. There were no policies or procedures that referred to obtaining and assessing consent of service users.
- None of the staff we spoke with were able to explain what deprivation of liberty safeguards were. This meant they would be unlikely to identify if some was being deprived of their liberty and could illegally deprive someone of their liberty or fail to seek appropriate authorisation to do so.
- The service offered routine and 'higher' mental health transfers but did not have any guidance or training for staff in relation to managing these patients. Staff told us that they did not restrain patients. There was no policy or guidance for staff to follow about how to restrain a patient to keep them safe, for example if they were at risk of avoidable harm or self-harm, or what to do if they posed a risk to staff members during transfer.

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

CQC does not currently have the power to rate independent ambulance services. We did not inspect this domain in its entirety, only reviewing the complaints and concerns procedures.

We found:

- There were no systems and processes to manage concerns or complaints and no evidence that services users' concerns and complaints were used to improve the quality of care.

Learning from complaints and concerns

- The registered manager told us there had been no complaints made against WAFA in the four years prior to our inspection. However, we found a complaint that had been attached to an incident form. There was no evidence that an investigation had been undertaken, and there was no report or formal response to the patient. An email response had been sent to another ambulance provider, which was defensive and did not accept any learning points for staff, despite the evidence that harm had resulted from this incident to the patient involved. The response indicated it was the fault of the patient who had not acted in a way that staff had expected them to act. From the nature of the complaint, and on discussion with the registered manager, we did not accept there were no opportunities for learning.

- We were told of other complaints, but these had not been recorded or investigated. The registered manager did not feel the provider had done anything wrong so decided not to take any action in response to the complaints.
- There was a brief complaints policy, which advised staff to report complaints to the registered manger. There was no further guidance for staff, or process to follow. The policy did not set out timescales, any process for being open, or how any learning from complaints would be shared with staff.

There was no process for telling patients about how to make a complaint.

Are patient transport services well-led?

CQC does not currently have the power to rate independent ambulance services.

We found:

- Leaders did not have the necessary knowledge, or capability to lead effectively. The registered manager had no understanding of the Health and Social Care Act 2008, or what his responsibilities were to ensure compliance.
- Governance systems and processes were not in place, or operated effectively to assess, monitor and improve the quality and safety of the service.
- There was no effective system for identifying, capturing and managing issues or risks at any level within the organisation.
- There was limited evidence of incident reporting and no evidence that incidents had been acted upon, or used for learning.
- There was no process for carrying out audit, and opportunities for continuous improvement and learning were missed.

Governance, risk management and quality measurement

- There was not an effective governance framework to support the delivery of the service and ensure good quality care. The service was unable to provide any evidence of a governance or assurance framework.
- There was no effective system for identifying, capturing and managing issues or risks at any level within the organisation. For example, no risk register was in place and there was no evidence of any risk assessments having been recorded, either in relation to patient transport services, or in relation to the business as a whole. The registered manager had not completed any risk assessments on the new premises, despite having been advised to do so some weeks prior to our inspection.
- There were no systems or processes in place to enable them to identify and assess risks to the health, safety, or welfare of people who use the service.
- There were no systems or processes in place for the registered manager to monitor the service against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- There were no systems or processes in place, such as regular audits of the service, and no method to assess, monitor and improve the quality and safety of the service.
- Policies were written in a generic way and did not provide guidance for staff to use them. Protocols and processes were not written down for staff to reference. Clinical guidelines specific to the service were not developed, approved or in use.
- There were not accurate or complete records in relation to work carried out during the previous 12 months. For example, there was no record of the types of transfers (for example high or low risk), and there was no record of how many blue light transfers they had undertaken. Therefore we were unable to ascertain from the records reviewed, if those transfers had been carried out by correctly trained staff, or if the blue lights had been used appropriately. This meant that the provider was not monitoring this information or using it to assure themselves of the quality or safety of the services provided.
- There was no evidence of any learning taking place or any process in place for continual improvement in practice and service delivery.
- There was no guidance or information as to how staff working out of hours on long distance transfers were supported, and no risk assessments undertaken or recorded for staff who were lone working.
- Some staff were unclear about their roles and did not understand what they were accountable for. For example, it was not clear who was responsible for checking medicines. The registered manager told us it was the responsibility of the bank paramedics to check and maintain the controlled drugs.

Patient transport services (PTS)

Leadership of service

- Leaders did not have the necessary knowledge, or capability to lead effectively. The registered manager had no understanding of the Health and Social Care Act 2008, or what his responsibilities were to ensure compliance.
- The registered manager was advised on two separate occasions by CQC inspectors, prior to the inspection, that he needed to obtain and read the guidance for providers on the regulations. At the time of the inspection, he still had not done so, and was unable to describe any of the regulations or how they related to the services provided.
- The registered manager told us he relied on conversations with his peers to find out about any legislative or national guidance changes, and there was no formal system in place to ensure that these would be incorporated into practice.
- The registered manager did not have oversight of how care, treatment or transport was provided.
- There was no process for ensuring that all staff employed were fit and proper persons, or competent to carry out their role. Additionally, there was evidence that staff were commencing in employment without the relevant employment, qualification, training or character checks being completed.
- The managing director for WAFA presented himself as a qualified emergency medical technician and was wearing a uniform with emergency medical technician identification. However, he acknowledged his qualification had lapsed in June 2016. When asked if he had been undertaking jobs in this role he stated he had. He believed this was entirely acceptable because he had been informed by an NHS ambulance service that his community first responder qualification was equivalent to, if not in excess of, the emergency medical technician qualification. We saw evidence he had undertaken transfers requiring this skill level since his qualification had lapsed. He was advised to stop representing himself as a qualified emergency medical technician and he agreed to do this. Following the inspection we received confirmation from the NHS ambulance provider this was not the case, and was strictly prohibited.
- There was no process for the executive team to have annual appraisals.