E-Zec Medical Transport Services Ltd

E-Zec Hereford

Inspection report

Unit 4B
Bridge Business Centre, Burcott Road
Hereford
HR4 9LW
Tel: 01432842993
www.E-Zec.co.uk

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We did not rate this focussed inspection.

We found:

The service did not always control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment, vehicles and premises visibly clean.

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Although, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service did not always manage patient safety incidents well. Staff did not consistently report incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. Managers did not always ensure that actions from patient safety alerts were implemented and monitored. However, when things went wrong, staff apologised and gave patients honest information and suitable support.

The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people safe.

People could not always access the service when they needed it and receive the right care in a timely way.

Leaders did not have all the skills and abilities needed to run the service. They did not understand and manage the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

The service did not have a service level vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

Although staff were focused on the needs of patients receiving care, not all staff felt respected, supported and valued. The service did not always promote an open culture where patients, their families and staff could raise concerns without fear.

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

Leaders and teams did not consistently use systems to manage performance effectively. They did not consistently identify and escalate relevant risks and issues and identify actions to reduce their impact.

Not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Leaders and staff did not actively and openly engage with staff to plan and manage services.

Summary of findings

However:

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

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The service followed best practice when administering and recording medicines. However, they did not always store them safely.

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

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations. However, it was not made clear to patients how to make a complaint or raise concerns.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inspected but not rated	We did not rate this focussed inspection. We found: The service did not always control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment, vehicles and premises visibly clean. The service did not have enough managerial staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Although, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction. The service did not always manage patient safety incidents well. Staff did not consistently report incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. Managers did not always ensure that actions from patient safety alerts were implemented and monitored. However, when things went wrong, staff apologised and gave patients honest information and suitable support. The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people safe. People could not always access the service when they needed it and receive the right care in a timely way. Leaders did not have all the skills and abilities needed to run the service. They did not understand and manage the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

Summary of findings

The service did not have a service level vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
Although staff were focused on the needs of patients receiving care, not all staff felt respected, supported and valued. The service did not always promote an open culture where staff could raise concerns without fear.
Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.
Leaders and teams did not consistently used systems to manage performance effectively. They did not consistently identify and escalate relevant risks and issues and identify actions to reduce their impact.
Not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
Leaders and staff did not actively and openly engage with staff to plan and manage services.
However:
The service provided mandatory training in key skills to all staff and made sure everyone completed it.
Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff completed and updated risk assessments for each patient and removed or minimised risks.
Staff identified and quickly acted upon patients at risk of deterioration.
Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
The service followed best practice when administering and recording medicines. However, they did not always store them safely.

Summary of findings

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

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations. However, it was not made clear to patients how to make a complaint or raise concerns.

Summary of findings

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Summary of this inspection

Background to E-Zec Hereford

E-Zec Hereford is operated by E-Zec Medical Transport Services Ltd. E-Zec Hereford provides non-urgent, planned transport for patients with a medical need who need to be transported to and from NHS services, who are registered with a GP in Herefordshire, Worcestershire and surrounding areas including parts of Wales. Patients need to meet the eligibility criteria agreed with the Clinical Commissioning Group.

The E-Zec Hereford fleet consists of 19 vehicles, including cars, vehicles for transporting people in stretchers, and vehicles with wheelchair access.

On the 1 April 2020, E-Zec Hereford were contracted to provide patient transport services across Worcestershire. This contract provides a non-urgent, planned transport service for patients with a medical need who need to be transported to and from NHS services. The service is primarily for patients registered within Worcestershire and surrounding areas, who meet eligibility criteria agreed with the Clinical Commissioning Group.

The location has had a registered manager in post since 2016. Registered managers have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

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 CQC at any time during the 12 months prior to the inspection. The latest inspection was carried out at this location on 6 March 2018 and an unannounced inspection on 15 March 2018. The findings were published on 11 May 2018.

We inspected the Worcestershire service as part of E-Zec Hereford, using our focussed inspection methodology because we received information of concern. We carried out the unannounced inspection on 29 October 2020.

How we carried out this inspection

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

Outstanding practice

None identified during this inspection.

Summary of this inspection

Areas for improvement

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. We issued the provider with a Letter of Intent, however, the provider response did not provide us with assurance. We followed this with a Section 29 Warning Notice that affected E-Zec Hereford.

Action the provider MUST take to improve

The provider must ensure infection, prevention and control systems, processes and practices are developed, implemented and communicated to staff effectively. Including protecting patients at risk of harm from cross infection. (Regulation 12 (1) (2)).

The provider must ensure staff have the knowledge to improve the hygiene standards within the organisation. (Regulation 12 (1) (2)).

The provider must ensure medical gases are stored safely and in accordance with national guidance. (Regulation 12 (1) (2)).

The provider must ensure the maintenance and use of equipment to keep people safe. (Regulation 15 (1) (2)).

The provider must ensure governance systems and processes operate effectively. Including the organisation having oversight of key risks and implementing mitigating actions to reduce the risk of harm to patients and/or staff. (Regulation 17 (1) (2)).

The provider must ensure that all incidents are reported and dealt with appropriately. Including effective dissemination of lessons learned from incidents. (Regulation 17 (1) (2)).

The provider must ensure staff receive appropriate support, training and supervision necessary to enable them to carry out the duties they are employed to perform to keep people safe from harm or abuse. (Regulation 18 (1) (2)).

Action the provider SHOULD take to improve

The provider should ensure staffing fill rates are appropriate to keep patients safe from avoidable harm and to provide the right care and treatment. (Regulation 18).

The provider should ensure the medicine management policy is appropriate to the service. (Regulation 12).

The provider should ensure patients experience timely patient transport services. (Regulation 12).

The provider should ensure it is clear to patients how to make a complaint to raise concerns. (Regulation 16).

The provider should ensure leaders are visible and approachable to support staff to perform their duties. (Regulation 18).

The provider should consider a local vision for the service.

Summary of this inspection

The provider should ensure staff are aware of their responsibilities, roles and systems of accountability to support good governance. (Regulation 17).

The provider should ensure there are processes in place for staff engagement. (Regulation 18).

The provider should consider a process where staff feel safe to raise concerns.

The provider should consider a process where they can evaluate an overarching system to establish overall staff training data.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated

Inspected but not rated

Patient transport services

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

Are Patient transport services safe?

Inspected but not rated

We did not rate this focussed inspection.

Mandatory training

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

All staff received an annual programme of mandatory training. This included face-to-face and e-learning. All staff started from the beginning of April 2020 and the mandatory training formed part of their induction programme. Topics included conflict resolution, capacity of consent, safeguarding adults and children, fore awareness, greener driving, infection prevention control, sharps procedure, vehicles types and equipment familiarisation.

Most staff said the mandatory training was effective, although some said the driving training could have been more robust for less experienced drivers.

Managers maintained a system to monitor the uptake of mandatory training against the provider's target. They ensured all staff were up-to-date with their mandatory training before allocating staff to shifts.

Processes were in place to remind staff when their mandatory training was expiring. The central human resources system informed managers and supervisors a month in advance. This gave them the opportunity to remind the staff member.

Senior staff were unable to show or evidence a system for tracking mandatory training compliance. The contract manager at the time of the inspection was not aware of any system in place and told us they interrogated each staff member's file to determine compliance. Following our inspection, the registered manager told us there was a tracking system showing all training and when renewals were due.

Staff received a structured and supportive introduction to the organisation. It introduced the providers strategic directions, policies and procedures to staff and included an introduction to their role and their immediate work area. All staff had received an induction in which the mandatory training was included.

Staff told us they received varying amounts of time shadowing experienced staff. For example, one staff member had one day. This was not line with the provider's policy, which stated all staff should receive this for the first two weeks. A

discussion should then happen at the end of each week before they drop into their actual shifts to ensure both parties were happy and confident in capabilities. Managers at E-Zec Hereford said this certainly was not the way they usually ran and that with the recent increase in vehicle capacity they were back to implementing the shadowing. To counter this in the Worcester satellite location they had experienced staff travelling from all other local areas to try and help mentor.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

All E-Zec staff based at the Worcestershire satellite site had completed their safeguarding training. Reliable systems, processes and practices were in place to protect adults, children and young people from avoidable harm.

All staff received level two safeguarding training. The level of training was specific to their role and in line with the national guidance from the Intercollegiate Document for Healthcare Staff (2014). Female genital mutilation (FGM) was included in level two safeguarding training, which all clinical staff attended. This ensured staff were aware that they had a mandatory reporting duty to report any cases of FGM.

The service had an appointed safeguarding lead for vulnerable adults and children. They had been trained to level four.

Staff were knowledgeable about what constituted adult or child abuse and knew how to report any concerns. All staff spoken with were aware of what to report and how to make a safeguarding referral when required. Staff we spoke with shared examples of safeguarding referrals they had made.

The E-Zec safeguarding policy was accessible online and outlined what safeguarding was, its importance, identified adults and children at risk and provided definitions of types of abuse. The policy provided a flow chart to advise staff of immediate actions to take to raise a safeguarding alert.

There was a standard operating procedure for the transport of patients under the age of 18. A further policy outlined the need for an escort if the patient was under 16 years of age. Patients under the age of 18 would not be transported in an ambulance with other patients.

Staff told us there was a robust recruitment procedure that included face-to-face interviews. The provider carried out checks to ensure the applicant was suitable to work with vulnerable adults and children. These checks included references from previous employers and a Disclosure and Barring Service check.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment, vehicles and premises visibly clean.

All staff had received infection control training as part of induction and annual mandatory training.

Inspected but not rated

Patient transport services

Infection prevention and control systems, processes and practices had not been developed, implemented or communicated to staff effectively. There were poor hygiene standards within the organisation and infection prevention and control, which put patients at risk of harm from cross infection. For example, we saw the premises at two of the three satellite units to be visibly dirty. The toilet and kitchen at the Worcester site were both visibly dirty, as were the toilets at the Stourport site.

Staff did not have the knowledge to improve the hygiene standards of the premises. There was one member of staff that was responsible for cleaning the whole of the base premises at Worcester and Stourport sites; with the Redditch site being manged as part of the building service provision. Ambulance crew staff were expected to help clean all three premises when they were free. However, there was no formal process or rota in place and cleaning appeared to be ad hoc.

Staff had not received effective training for cleaning the bases. For example, there was no formal training in place for staff on how to clean the base effectively and no formal process for staff to follow. This was evident when speaking to staff and their lack of knowledge regarding different coloured mop heads and when each should be used.

Staff put patients at risk of harm from cross infection. For example, ambulance crew staff carried out cleaning duties in the same work uniform they wore for patient contact throughout the day.

None of the cleaning checklists at all three sites we reviewed were up-to-date to demonstrate regular cleaning. For example, at the Worcester site there were gaps in the checklists that indicated no cleaning took place on many days, (5 and 6 August 2020 were completed then there was a gap until 18 August 2020; 8 September 2020 was complete and then not again until 5 October 2020). The last time it had been completed was 19 October 2020. These, along with the premises being visibly dirty, provided evidence that cleaning was not carried out regularly and effectively.

Ambulance vehicles were not always cleaned in line with policy. Staff were required to clean vehicles at the end of each shift ready for the next shift. However, several staff, both before and during the inspection, told us that they often did not have time to clean the vehicles at the end of their shift. This meant that poor hygiene standards within the organisation where not inline within the organisation's policy.

Staff did not always keep vehicles clean and there was a risk of cross contamination. There was evidence that staff had been having their meal breaks within the vehicles used to transport patients. We saw empty food wrappers left in the vehicle driver compartments in an ambulance at the Worcester site. Staff said sometimes empty food packaging and the smell of food was in the vehicles from the previous shift when starting their shift.

Managers did not have processes in place to maintain oversight of how many times staff did not clean vehicles at the end of their shift in line with policy. Managers told us staff did not report incidents where a vehicle had not been cleaned ready for the next shift. Staff were required to notify a supervisor if they finished late to complete a clean. The supervisor would then allow time at the start of the next day for the vehicle to be cleaned by either the ambulance fleet assistant (AFA) or the crew working on it the next day. The manager told us they had asked the team in Worcester to record each incident so they could attempt to have oversight of this risk.

Staff did not store personal protective equipment in line with best practice guidance and put patients at risk of harm from cross infection. Personal protective equipment was not always stored appropriately at the Worcester site. There was a risk it could become contaminated within the environment that was not cleaned effectively. Following our inspection, the registered manager told us they had put a process in place to address this risk. The shelves which stored the PPE was now cleaned as a touch point.

Inspected but not rated

Patient transport services

Patients and staff were at risk from healthcare associated infections, including COVID-19. Systems in place were not always reliable to prevent and protect people from healthcare associated infection and COVID-19. This put patients at risk of harm from cross infection. For example, there was a lack of understanding regarding what was required of staff/ service during a pandemic and there was no COVID-19 risk assessment in place. However, managers had risk assessed staff and those at high risk were not required to transport confirmed or suspected COVID-19 patients.

Patients and staff were at risk from healthcare associated infections spread through surfaces, including COVID-19. There were no additional infection prevention and control procedures in response to COVID-19 implemented and we were not assured that extra precautions had been taken to protect staff from contracting COVID-19. For example, staff had handheld mobile electronic devices allocated to them at the beginning of each shift. There were no clear processes in place to clean them in between use and on review of some devices, we were not assured these were being cleaned regularly as they were visibly dirty and covered in finger prints.

Provisions within the organisation were not enough to promote good hand hygiene in line with best practice guidance. This meant there was a risk of spread of infection. At the Worcester site, staff were not provided dispensed liquid soap within the kitchen areas to maintain good hand hygiene. There was an old dried bar of soap available. This was not suitable as bar soaps become very easily and heavily contaminated. There was no separate hand washing sink from the sink used to prepare food within the kitchen area at the Worcester site.

Facilities within the organisation did not support good hygiene in line with best practice guidance and there was a risk of spread of infection. For example, staff were not provided with appropriate changing areas. At the Worcester site, staff were expected to change out of their uniforms into their own clothes in the toilets, which were visibly dirty and not cleaned regularly.

Staff did not always follow processes in place to ensure uniforms were cleaned sufficiently to protect patients and staff. The E-Zec infection prevention and control policy detailed staff should wash uniforms at 60 degrees centigrade to remove microorganisms (any small living thing like bacteria, protozoa, or fungi that cannot be seen with the naked eye). However, staff we spoke with were not aware of the policy on washing uniforms and there was a risk of spread of infection. Staff were not always clear about how staff uniforms were cleaned. We saw a bag of uniforms on the floor in an area of the Worcester site. When we asked a staff member what the uniforms were doing there and how uniforms were cleaned, we were told that the dirty uniforms were taken back to the staff member's domestic residence at the end of the shift to clean them. Following our inspection, the registered manager told us the uniform washing process and safe temperatures bulletin had been issued to staff.

Not all staff followed infection prevention control processes in place to minimise the chance of cross infection. Staff wore jewellery, such as rings and watches. The wearing of hand/wrist jewellery increases the bacterial load on hands and impedes effective hand decontamination. Jewelled rings can collect dirt and grime in the stoned settings that also provides a breeding ground for microorganisms (they also pose a risk to fragile skin of vulnerable patients).

As the service completed only pre-planned transfers, staff were informed of any communicable infection risks prior to completing the transfer. Additional precautions, such as goggles and masks, were available if necessary.

A deep clean was performed on all vehicles once a month, by a trained AFA. This included completing recorded protein tests.

Patient transport services

The service had systems in place to ensure COVID-19 and non-COVID-19 patients were not transported in the same vehicles. Staff followed the NHS England guidelines regarding protocol and procedures around using vehicles for COVID-19 positive and non-COVID-19 patients. Managers told us they generally tried to have a dedicated vehicle for COVID-19 positive patients where possible and that this vehicle followed national guidance in between patients regardless of whether COVID-19 was suspected or confirmed.

If staff were busier than usual and required additional COVID-19 support, they could utilise one of the other bulkhead vehicles. After taking any suspected or confirmed patient they would also have to follow the above process before moving any other patients. Staff did not take any patients involving aerosol generating procedures as they were only a basic patient transport service. Staff were instructed to wear gloves and masks and to provide the patients with a mask. The provider required staff to perform a wipe down of high touch points using sanitised wipes after each journey.

Infection prevention and control processes were in place for vehicles when COVID-19 positive patients had been transported. The vehicle required an enhanced clean between patients clean, ensuring thorough decontamination of all exposed surfaces, equipment and contact areas before it was returned to normal operational duties, with universal sanitising wipes or a chlorine-based product. Appropriate personal protective equipment needed to be worn to decontaminate the vehicle, as a minimum, this included an apron and gloves. Any exposed equipment (that was not within closed compartments) including stretchers on the vehicle required decontamination with universal sanitising wipes or equivalent. This was in the infection prevention control policy. All contact surfaces (cupboards, walls, ledges), working from top to bottom in a systematic process, required decontamination.

Staff were expected to pay special attention to all touch points. These were the areas that acted as routes for the spread of viruses, such as COVID-19.

Following our inspection, we issued the provider with a Letter of Intent. In response the provider submitted an action plan to address areas of non-compliance. This included actions, such as contracting an external cleaning company to complete all deep cleaning requirements until a part time AFA could be recruited. However, although we received some assurance that cleaning effectiveness would be audited, there was no timeframe for the frequency of these or where issues would be escalated to. This meant we were not assured staff would have the knowledge to improve the hygiene standards within the organisation. We therefore, issued a Section 29 Warning Notice.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people safe. Staff were trained to use them. Staff did not always manage clinical waste well.

Although the equipment was in date and serviceable, the maintenance and use of equipment did not always keep people safe. This put patients at risk of harm.

Maintenance concerns were not always responded to in a timely manner and there was a risk this would impact on the comfort of the environment for the patient. For example, at the Worcester site, we found the heating was not working in one ambulance. A staff member told us they had reported this to management and that an end-of-life care patient had been transported in the vehicle with no heating. Although managers took the vehicle off the road the morning of the inspection, this was because inspectors intervened. The vehicle had already left the premise to collect a patient and had to be recalled back to the base. This would indicate that the process was not effective. Managers told us that the manufacturer of the heating systems were part way through a service programme across all E-Zec contracts. There was no risk assessment in place to mitigate the ongoing risk.

Inspected but not rated

Patient transport services

There was a risk that vehicles were not always providing secure transport for patients and mitigating actions had not been identified or implemented via a risk assessment. For example, we found the mechanism that secured the stretcher to the floor of the ambulance was defective in the bariatric vehicle. Staff said they had reported this to managers a couple of days before, but nothing had been done.

We found staff were not storing the wheelchair restraint belts correctly. Instead of storing them all together in a basket provided they were connected to chair hand holds by a karabiner. This meant that if the vehicle came to a sudden stop, there was a risk the seatbelt could swing around and hit the patient. We raised this risk with managers, and they addressed this risk immediately. For example, they produced bulletins to ensure that staff did not secure wheelchair clamps to crew seats.

We found one empty gas cylinders stored in the 'full' cage. This was resolved whilst the inspection team was on site. However, there was no process to ensure that this did not happen again.

At the Worcester site, we found that clinical waste and cleaning was not managed effectively. Bins were not always closed or clearly labelled for what they were to be used for, for example, clinical waste. The meant that there was a risk waste would not be disposed of correctly.

The management of control of substances hazardous to health (COSHH) standards within the organisation were not in line with best practice guidance. At the Worcester site, there was no guidance for staff on display regarding the use of COSHH. We found COSHH equipment was not locked away. There were no safety data sheets required by COSHH available where an aqueous urea solution was stored, for example to monitor the storage temperature.

There were no robust processes in place to ensure staff did not use defective equipment. At the Worcester site, we found the equipment storage cupboard was also used to store defective items. There was no system in place to denote which items were clean and ready to be used, compared to items that required cleaning. There was a risk defective items could be mistaken for ready to use items. We only saw one item had a 'red tag' to denote that it was defective.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

There were appropriate systems and processes in place to assess and respond to patients who were at risk.

Control room staff completed risk assessments for all planned activities. This included a risk assessment of the patient's conditions, their location, and access to the building. However, staff told us it was common to arrive at a patient's house and find there were unexpected access issues. Control room staff and frontline staff worked together to co-ordinate the safe movement of patients on these occasions. Staff said they would always contact control staff in these situations and wait for another staff member to arrive and help them. This meant staff did not puts patients at risk. The service had 65 patients booked with incorrect mobility between 1 July and 30 September 2020. This meant single crew were sent instead of a double crew.

Most staff knew what to do if a patient became unwell during their journey. All staff had been trained in basic first aid, which gave them initial skills to notice if a patient was deteriorating, and when to call for emergency help. Staff told us if a patient became unwell during a journey, they stopped their vehicle when safe to do so and then assessed the severity of the situation. If a patient had deteriorated or suffered a cardiac arrest, they would call 999 and request support.

Patient transport services

The service did not transfer patients detained under the Mental Health Act or any patient who had a history of violence or aggression. However, the E-Zec provider wide environmental risk assessment for all the E-Zec premises included violence and aggression towards staff. Control measures included advice that staff must go to a safe place and report all details to their line manager, control, or supervisor immediately.

Staff received training in conflict resolution and were encouraged to risk assess patients who may be aggressive or violent during their journey. Where necessary, drivers on single-crewed vehicles could request a double-crewed ambulance to transport a patient if they did not feel safe on their own.

Staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Managers told us that along with the COVID-19 restrictions when taking on the Worcestershire service, they were due a full accompaniment of staff to TUPE (transfer of undertakings (protection of employment)) over to them from a national ambulance service. However, with less than a month to go before the new contract started, over 90% of the transferring staff were removed. This left E-Zec Hereford very short on experienced staff for the Worcestershire service. The purpose of TUPE is to protect employees if the business in which they are employed changes hands. Its effect is to move employees and any liabilities associated with them from the old employer to the new employer.

Managers had systems in place to calculate safe staffing. At the start of the contract the required mileage and amount of patient journeys from historic data were put into a calculator to work out the required hours, vehicles, and staffing. This varied due to no week being the same so managers built in relief staff as a backup. Managers also recruited bank staff with the aim of 15% potential coverage compared to full time staff. These were used to cover out of area journeys and sickness or annual leave.

In June, July and August 2020, managers covered 77%, 80% and 83% of shifts respectively. Managers recruited bank staff to ensure staffing was safe.

There were two vacancies at the time of our inspection. These were for operational staff. The registered manager told us in November 2020, following the inspection that one staff member was due to start their training on 6 December 2020 and they were interviewing for the other staff member.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

All patient records were stored electronically on computer-aided despatch and booking systems. The service did not use any paper records for patient journeys.

E-Zec used a nationally recognised system of information technology that provided software for patient transport services. The system provided support to the call centre during call taking, dispatch and incident tracking. Each crew member had a personal identification number to access the system, which provided them with information and detail relating to each patient journey.

Patient transport services

Patients' paper records from other healthcare organisations were stored within the patients' property and carried by the individual. Specific information relating to the patient was passed from control staff to operational staff through hand held electronic devices. Information sent included patients' names, contact telephone number, collection and destination addresses, and any special notes about the patients' mobility needs or medical conditions.

Staff recorded details of care and treatment provided to patients transported throughout the day on their electronic hand-held device. If a patient required an intervention during the journey, it was passed on verbally to staff receiving the patient and they would later update the patient records.

Information on whether a patient had a do not attempt cardiopulmonary resuscitation order in place or end of life care planning notes were recorded on the patient notes section of the electronic record. Staff could access this information through their personal digital assistant (PDA). If their PDA was not working, staff could call the control room to obtain the information. A PDA is a hand-held personal computer and a variety mobile device which functions as a personal information manager.

Medicines

The service followed best practice when administering and recording medicines. However, they did not always store them safely.

The service only stored and administered oxygen when prescribed and patients carried their own medicines. Staff confirmed that they did not carry or take responsibility for patients' own medicines.

Small oxygen cylinders were available on the ambulances to enable the transfer of oxygen dependent patients to and from the ambulance.

Staff did not always store medical gases safely and in accordance with national guidance. They stored oxygen cylinders in a well-ventilated area. This was in line with the British Compressed Gases Association guidance on the storage of gas cylinders in the workplace (2012) that states storage areas should be well defined and located in the open air where there is good natural ventilation.

However, staff did not segregate full and empty oxygen cylinders in accordance with national guidelines. We saw one empty cylinder being stored amongst the full cylinders. This meant there was a risk that staff could pick up an empty cylinder in error when required for a patient journey, which could pose a potential risk to a patient requiring oxygen therapy.

The Department of Health Technical Memorandum 02-01 guidance on medical gas pipeline systems states that stores should only be used for full cylinders, and all empty cylinders should be returned immediately to the main cylinder store. Full (including part-used) and empty cylinders should be stored separately, and the areas properly identified with signage. We raised this with managers at the time of our inspection who said they would check through all the cylinders immediately. This meant the service was in breach of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

The medicine management policy was not appropriate to the service. For example, although no medicines apart from oxygen was stored and used by staff, the medicines management policy included reference to patients group directions (PGDs) despite the provider telling us they do not use PGDs. A PGD is a written instruction for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Incidents

The service did not always manage patient safety incidents well. Staff did not consistently report incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. Managers did not always ensure that actions from patient safety alerts were implemented and monitored. However, when things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not always follow the policy and process in place to report and respond to incidents. For example, staff told us they often reported incidents verbally to their managers and the mangers would then co complete the required paperwork. This was not in line with the providers policy.

The incident reporting system was paper based. This included details of the incident facts and the immediate action taken. The base manager was required to review each form and take the required action to investigate the incident. However, staff told us they did not receive individual feedback from the incidents they reported.

Although incidents, themes and learning were shared nationwide through a variety of communication channels, such as staff bulletins, many staff were not aware of these. There were no other formal systems in place to share learning from incidents for example, there were no team meetings or one-to-one sessions.

Not all staff fully understood their responsibilities to raise concerns and record safety incidents and near misses. For example, they did not always report incidents in line with the providers policy, such as not having time to clean vehicles at the end of their shifts.

There had been seven incidents reported from August to October 2020.

No serious incidents or incidents that resulted in harm to a patient had been reported since the Worcester satellite location opened in April 2020.

The compliance manager had not received training to investigate incidents and was responsible for following the organisation's procedure when an incident was raised.

Following our inspection, the registered manager told us they reported to the Clinical Commissioning Group quality leads on a monthly basis. They said that all incident reports were passed to the E-Zec compliance team monthly and they highlighted any patterns and sent out any related bulletins/polices across the organisation.

The service did not operate an effective system for managing safety alerts and these were not always reviewed, acted upon and closed. For example, the contract manager was not aware of a recent safety alert concerning stretchers.

Inspected but not rated

Patient transport services

The provider had a policy in place, which described their responsibilities under the duty of candour legislation. Staff had an awareness of the requirements of duty of candour. There had been no serious incidents reported, therefore the registered manager had not needed to apply the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider sent us an action plan to address areas of non-compliance around incident reporting. This included actions such as, the planned recruitment of a full-time quality manager to oversee staff feedback to all staff and to reinforce the process of staff using feedback sheets that are already on site. However, there was no timeframe for the frequency of these or where issues would be escalated to. This meant we were not assured staff would report incidents in line with the providers policy. We therefore, issued a Section 29 Warning Notice.

Are Patient transport services effective?

Inspected but not rated

We did not rate this focussed inspection.

Response times

The provider told us their key performance indicators (KPI) were suspended due to the pandemic.

Patient outcomes

The service monitored compliance against its own KPIs to continue to drive improvements in patient outcomes. However, the provider told us their key performance indicators were suspended due to the pandemic.

Competent staff

The contract manager did not have any set objectives. They did not have any formal 1:1s with their managers, and their direct reporting lines were unclear, although they had been told informally who their line manager was. Following our inspection, the registered manager told us a formal probation review hearing was held with the contract manager's line manager, the operations director.

The previous line manager had recently left the business and was replaced by the operations director.

Are Patient transport services responsive?

Inspected but not rated

We did not rate this focussed inspection.

Service delivery to meet the needs of local people

Inspected but not rated

Patient transport services

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

The service provided non-emergency planned transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or requiring treatment, such as chemotherapy.

Service delivery was based on contracts held with an NHS provider, pre-bookings with private hospitals and other services. The service employed staff with different qualifications to meet the needs of people in their locality and wider community who required patient transport services.

Most of the workload was undertaken from Monday to Friday. The service provided a more limited patient transport over the weekend. Staff were flexible to extend the times if there was a need outside of these hours.

All work agreed by the control office was standard patient transfers. No higher dependency work was undertaken.

Staff contacted the hospital pharmacy department to ensure that patient medicines supplied for discharge were available at the time of discharge and therefore, reduce delays and cancelations. This was in order to improve the service provided to patients transferred from the nearby hospital after discharge.

The ambulance crew provided patients and their relatives with timely support, completing last minute bookings when requested.

Access and flow

People could not always access the service when they needed it and receive the right care in a timely way.

Staff used an electronic software system to follow ambulance routes and track journeys. This enabled the control centre to monitor the location of operational staff and turnaround times and whether the ambulance engine was switched on or off or was idling. This provided information to the service of patient time spent in the vehicle and any delays. Each hand-held device was vehicle specific to prevent any confusion and identified which member of staff was driving.

The electronic system was used to support staff. For example, if 'drop off' had not been clicked a call would be made to the crew from the control centre to check if there was an issue they could help with.

Patients did not always experience timely patient transport services. For example, between July and September 2020 the E-Zec Worcestershire satellite location site recorded a total of 57 journeys that were too late to travel due to provider error. The provider also cancelled 36 journeys during this same time period. Following our inspection, the registered manager told us this was due to reduced patient occupancy and social distancing measures put in place to address the risk of COVID-19. This led to a reduced number of patients able to travel.

Patient journeys were either booked in advance or on an ad-hoc basis. However, most work was pre-planned through the local NHS trust or GP services.

Patients' eligibility for the service was assessed at the point of booking through the internal booking system. The eligibility criteria was based on a range of circumstances including the medical need for transport, patient's physical needs, specialist equipment required, whether an escort was needed and any other patient needs.

Inspected but not rated

Patient transport services

Processes were in place to inform patients when staff were ruining late to pick them up. Staff would liaise with the hospital staff beforehand to ensure the clinic later to their original appointment time. Staff would then call the patient to explain that although they were running late, they would still be seen at their detention.

The service monitored compliance against its own key performance indicators (KPIs) to continue to drive improvements in patient outcomes.

There were KPIs set by commissioners for the patient transport service (PTS) based on national guidance. KPIs are a set of quantifiable measures used to measure or compare performance in terms of meeting agreed levels of service provision.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations. However, it was not made clear to patients how to make a complaint or raise concerns.

The service had a complaints policy in place, which stated that complaints would be acknowledged within 36 hours of receipt. This gave clear guidance to staff on how to record a complaint and how it would be investigated. The governance manager was responsible for managing and investigating complaints. Timescales for a final written response were 25 days for all complaints.

The service had received five complaints from August to October 2020. We saw evidence of investigation and response to the complainant was provided within the required timescales.

It was not made clear to patients how to make a complaint or raise concerns. Information on how to make a complaint were not visible and accessible to patients being transported on the vehicles.

Managers handled complaints were effectively. They ensured openness and transparency, confidentially, regular updates for the complainant, a timely response and explanation of the outcome, and a formal record.

Are Patient transport services well-led?

Inspected but not rated

We did not rate this focussed inspection.

Leadership

Leaders did not have all the skills and abilities needed to run the service. They did not understand and manage the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

Inspected but not rated

Patient transport services

The senior leadership team for the Worcestershire satellite site consisted of a managing director, commercial and operations director, and a human resources director. The senior management team were mostly based in the head office in Redhill.

Leaders of the E-Zec Worcester satellite location sites did not have all the skills, knowledge and experience that they needed when they were appointed and on an ongoing basis. There was a contract manager in place, who had commenced working for E-Zec in June 2020. Although they had been enrolled on a management course, this was their first time managing an ambulance contract, and they were open about their development needs. They had received an induction and had been buddied up with the more experienced registered manager at Hereford, who was available for support on an ad hoc and informal basis. They had not received any specific training around the role. A job description was provided during the first week of their employment.

Although staff received an induction, they did not always receive appropriate support, training and supervision necessary to enable them to carry out the duties they were employed to perform. For example, the contract manager had not received formal training to complete all aspects of their role, such as training in investigations, risk assessments and staff disciplinaries. However, they were able to access human resources advice by telephone. This meant that staff may not be equipped to deal with duties they were employed to perform and there was a risk staff would be unable to keep people safe from harm or abuse.

Leaders did not show a full understanding of the challenges to quality and sustainability and could not identify the actions needed to address them. The contract manager for the Worcestershire sites had applied to be a job share CQC registered manager for the E-Zec Hereford location. However, they acknowledged they did not yet fully understand what was required to become a CQC registered manager and needed support with this.

Senior leaders of E-Zec Medical Transport Ltd were not always visible and approachable. The contract manager had never met some of the senior leadership team and they had not visited the base as far as they were aware. Staff also confirmed this.

Not all staff spoke positively about the leadership of the service. Staff told us that leaders at location level were not always visible and approachable. Not all staff felt leaders had the appropriate skills and knowledge for their role and managed their aspect of the service well.

The contract manager said both sites (Hereford and Worcester) were managed separately. Staff records for Worcestershire staff were kept on site at the Worcester premise. The contract manager was line manager for supervisors and other members of staff based within Worcestershire.

There were three supervisors in post, each looking after different areas. One supervisor described their role as looking after “all things people”, This included workforce and human resources matters.

The second supervisor oversaw “all things to do with facilities” and the third was about to join the team as a fleet supervisor.

Staff at the Worcester satellite base did not have a named line manager. Staff did not know who they should report to and did not have any objectives that they were being held to account for through individual meetings, other than the general contractual key performance indicators.

Patient transport services

The service did not have clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. There was no leadership strategy, development programme or succession planning. Although supervisors had enrolled on a level 3 management course, there was no evidence of specific training for this role, and supervisors told us they were learning on the job. They felt supported by the contract manager and said the operations director was visible. All upward communications and risks were escalated to through the contract manager and head of operations.

Supervisors and managers received an induction to the organisation. Supervisors coming into the role would first attend the road based two-week training course, they would shadow road staff for a week, spend time with the appropriate mentor be it fleet, or operations control for example. They were also enrolled on a level 3 diploma course in supervision and team leading. The management induction had a specific plan.

All supervisors had attended an assessor's course in basic and advanced life skills along with a driving assessors' course and fire wardens' course. They were monitored and supported by their local and regional management.

Managers and supervisors were not maintaining a physical presence across the contract. Staff told us they rarely attended the two smaller sites.

Staff were not always supported to deal with duties they were employed to perform and there was a risk staff would be unable to keep people safe from harm or abuse. For example, there were no formal one to one supervision sessions in place for staff.

Following our inspection, we raised theses issued with the provider with a Letter of Intent and a subsequent Section 29 Warning Notice.

Vision and strategy

The service did not have a service level vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The service had developed its vision and values at provider level around the company's mission statement, which was, "To provide the very best care for each patient on every occasion". The service aimed to deliver services by ensuring patient care was at the centre of everything they did, by being accountable and honest and by treating everyone with respect and promoting good working relationships.

Some managers were unable to articulate the service strategy or values and were not consulted on the newly written strategy for the provider.

Ambulance staff and managers displayed the company's values when speaking about their work, strategy and motivations. It was clear that staff and managers wanted to do their best for patients.

The provider had a statement of purpose, which gave details of how they aimed to provide a service. This included conveying patients in a timely manner.

The service was heavily contract focused. For example, the manager had put up information on the staff board entitled 'Performance', which detailed how they were performing against their key performance indicators set within their contract. The registered manager told us they detailed how they were performing against their key performance indicators set within their contract.

Following our inspection, we raised these issues with the provider with a Letter of Intent and a subsequent Section 29 Warning Notice. In response, the provider submitted an action plan to address areas of non-compliance. This was 'to place vision strategy on base rolling screens.'

Culture

Although staff were focused on the needs of patients receiving care, not all staff felt respected, supported and valued. The service did not always promote an open culture where staff could raise concerns without fear.

There were no formal processes or tools used by leadership to gain feedback on and measure employee engagement, employee morale, and performance. Management were unable to explain how they measured this area.

Worcester was the only base where somebody had volunteered to be the staff representative. Managers told us they had recently had another volunteer come forward at Worcester base, but they not yet started.

The service had no formal process in place for documenting meetings and actions agreed between managers and the staff representative. For example, the contract manager said she 'would talk' to the operations director about them.

Managers acted to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. For example, the contract manager advised there had been 'a number of disciplinary actions taken'. They felt this was due to the newly recruited staff not being a good fit and did not believe this was a reflection on the recruitment processes.

Managers had systems in place to identify staff development needs. Staff reviewed and induction and appraisal yearly.

At location level, processes to support staff wellbeing appeared to be informal and ad-hoc. The contract manager said they made a point of ringing staff if they heard about anything. This relied on them being told about any issues. However, at organisational level E-Zec provided an employee assistant program for all staff to offer support for wellbeing.

The service had no formal forums in place for staff to meet, or have any kind of platform, outside of the staff representative at the base. Following our inspection, the registered manager told us staff could, approach their regional HR representatives if they wished escalate a concern beyond local management.

Governance

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

The governance systems and processes were not operating effectively. This meant the processes for managing risks and issues were not always clear and effective. For example, the supervisor we spoke to was unable to demonstrate an understanding of how to manage risk and their role in risk management.

The service did not have oversight of the key risks and any actions that may have been required to reduce the risk of harm to patients and, or, staff. For example, the approach to incidents was ad-hoc in terms of how incidents were

reported and addressed. Staff usually verbally reported incidents and the manager/supervisor would complete the paper forms. This was not in line with the provider policy. Following our inspection, the registered manager told us they had processes in place. For example, the head of quality and compliance held monthly review session with all contract and compliance managers. They did however, acknowledge that with the lack of experienced staff onsite to provide mentorship, the local management team were not following through with requirements.

There were insufficient processes for the dissemination of lessons learned from incidents so that such learning was shared across the whole team and wider service. Staff told us that they did not receive individual feedback from incidents reported and were not aware of the communication channels used within the organisation to share wider learning.

Responsibilities, roles and systems of accountability to support good governance and management were not clear. For example, there were no team meetings or one to one supervision sessions for operational staff. This meant that the organisation did not have an effective shared learning approach or support mechanism for staff.

Not all staff were clear about their roles, what they were accountable for, and to whom. Staff could not identify who their line manager was and what areas each supervisor was responsible for.

We could not be assured that governance arrangements supported the delivery of high-quality patient care. We did not see any evidence that meetings occurred on a regular basis and we were not assured that information was routinely cascaded to staff throughout the service.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person centred care. For example, the Clinical Commissioning Group monitored key performance indicators regarding the service's performance. This was updated each month. The registered manager told us they were held to account for any areas of poor performance.

Policies and standard operating procedures were accessible in on the company's electronic system called the hub. The service had an annual performance review process, which stated the purpose of performance review, the process, and performance ratings.

Systems were not always in place to ensure staff were accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence could flourish. We requested copies of the governance meetings following our inspection. These were dated 2018 and 2019.

There was no evidence of an effective audit plan in place. We found that checks were not always carried out correctly. For example, cleaning, infection, prevention and control, and vehicle checks. This meant that risks and concerns could not always be identified and mitigating actions would not be implemented to drive improvements.

Following our inspection, we raised these issues with the provider with a Letter of Intent and a subsequent Section 29 Warning Notice. In response, the provider submitted an action plan to address areas of non-compliance. For example, this was to place E-Zec organisational chart and senior team profiles on staff notice boards.

Management of risks, issues and performance

Inspected but not rated

Patient transport services

Leaders and teams did not consistently used systems to manage performance effectively. They did not consistently identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events.

There were no robust arrangements for identifying, recording, managing and mitigating risks, including those to keep patients safe. The Worcester premises did not have a risk register or risk management system to record the management or mitigation of local risks.

Although the contract manager was able to explain some of the risks to the service, such as staffing risks when a skill mix was not available to support a journey and attacks on staff, we were not shown any documented evidence as to how these risks were assessed, mitigated and managed by the service at the time of our inspection. Following our inspection, the provider submitted a risk register for the Worcester premises.

Managers showed a lack of understanding in relation to keeping staff and patients safe through the COVID-19 pandemic. They were unaware of a COVID-19 plan in place and staff were not managing clinical waste and cleaning in line with policies.

There was no systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. We found no evidence of an effective audit plan in place. Some checks were not carried out correctly, such as cleaning rotas. Repairs required on vehicles were not carried out in a timely way and there were no risk assessments to mitigate ongoing risk to patients.

Following our inspection, we raised these issues with the provider with a Letter of Intent and a subsequent Section 29 Warning Notice. In response, the provider submitted an action plan to address areas of non-compliance. This was to produce a contract risk assessment.

Information management

Not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

A supervisor used an electronic system to assist with managing the number of hours staff worked and to book their annual leave.

Staff could access the intranet for staff training and access to E-Zec policies and procedures.

However, managers could not produce an exception report from the staff training system. Managers would need to investigate individual records to determine which staff members had not completed mandatory training. Following our inspection, the registered manager told us training records were monitored on a constant basis along with Disclosure and Barring Service status and driving licenses and that all information was kept in a simple to use central repository.

Public and staff engagement

Leaders and staff did not actively and openly engage with staff to plan and manage services.

Inspected but not rated

Patient transport services

Staff were able to raise issues through a 'representative' approach. Staff were able to raise issues face-to-face or alternatively they could put them anonymously into a dedicated communication box. Staff did not feel this role was effective.

Staff did not always feel safe to raise concerns and leaders did not show the value of staff raising concerns. Staff did not feel engaged with their employer in planning and delivery of their service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	S29 Warning Notice The provider did not always ensure infection, prevention and control systems, processes and practices were developed, implemented and communicated to staff effectively. Including protecting patients at risk of harm from cross infection. (Regulation 12 (1) (2)). The provider did not a ensure staff had the knowledge to improve the hygiene standards within the organisation. (Regulation 12 (1) (2)). The provider did not ensure medical gases were stored safely and in accordance with national guidance. (Regulation 12 (1) (2)). The provider did not ensure the maintenance and use of equipment kept people safe. (Regulation 15 (1) (2)). The provider did not always ensure governance systems and processes operated effectively. Including the organisation having oversight of key risks and implementing mitigating actions to reduce the risk of harm to patients and/or staff. (Regulation 17 (1) (2)). The provider did not always ensure that all incidents were reported and dealt with appropriately. Including effective dissemination of lessons learned from incidents. (Regulation 17 (1) (2)