Care Quality Commission

Medic 1 Direct Ltd

Medic 1 Direct ltd

Quality Report

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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 known to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location	
Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Medic 1 Direct Ltd is a private ambulance service operated by Medic 1 Direct Ltd. The service provides first aid services for the public and staff at events across England including transporting patients to emergency departments.

This service is registered with the CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC, which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medic 1 Direct Ltd provides services to patients taking part in or attending a sport or cultural event. These types of arrangements are exempt by law from CQC regulation. Therefore, at Medic 1 Direct Ltd, we did not inspect the services provided to patients taking part in or attending a sport or cultural event. However, providers are required to register with CQC if they transport patients off the event site to the local hospital. Medic 1 Direct Ltd had transported 10 patients to hospital from an event site within 12 months prior to inspection.

We inspected this service using our comprehensive inspection methodology. The Care Quality Commission does not have any regulatory powers in Wales; therefore, this was a partial inspection of the service. The provider's headquarters is in Wales but the regulated activity is carried out within England.

We inspected the provider's only location in Canterbury, Kent, which is a non-operational administrative base. We carried out the announced part of the inspection on 9 January 2018. There were two members of staff present at the inspection, the registered manager and the senior administrator.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Staff followed infection prevention and control procedures to reduce the spread of infection to patients.
- Staff completed extensive training in a range of clinical skills and theory to enable them to undertake their roles.
- The service carried out comprehensive risk assessments prior to each event and liaised with local services.
- Staff within the service had completed training to assist with meeting the needs of individuals including patients living with dementia and learning disabilities.
- The service encouraged feedback from patients.
- Staff felt supported by the managers of the service and said the managers were always available to discuss concerns.
- The recruitment procedure ensured patients were safeguarded against unsuitable staff.

However, we also found the following issues that the service provider needs to improve:

- There was a lack of incident reporting which suggested staff were not able to identify incidents.
- Senior management lacked understanding of the duty of candour and there was no policy for the duty of candour.
- The service did not record informal training, observations or spot checks.
- The wording in the adult safeguarding policy required amending to make it easier to read.
- The service had a patient feedback form, but there was a lack of information available to patients and their families regarding raising a formal complaint.

Summary of findings

- Patient record forms were not always fully completed.
- Staff did not have access to translation services.
- Audits were not undertaken and therefore learning did not take place from review of procedures and practice.
- The organisational risk register was incomplete as it did not rate the risks or contain any actions taken to mitigate the identified risks.

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, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected urgent and emergency services. Details are at the end of the report.

Amanda Stanford
Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Medic 1 Direct Ltd is a private ambulance service operated by Medic 1 Direct Ltd. The service provides first aid for the public and staff at events across England including transporting patients to emergency departments.

Care Quality Commission

Medic 1 Direct ltd

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

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Detailed findings from this inspection

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Background to Medic 1 Direct ltd

Medic 1 Direct Ltd is operated by Medic 1 Direct Ltd. Medic 1 Direct Ltd provides first aid for the public and staff at events across the country including transporting patients to emergency departments.

The service opened in 2010. Between 2010 and 2016, the service employed four family members. In 2017, it employed another three members of staff.

The service has had a registered manager in post since the service started. The registered manager was also the Clinical Director of the organisation.

It is an independent ambulance service with its headquarters in Wales. It has a non-operational base in Canterbury, Kent. There were no staff, vehicles, equipment or records at this base.

This was the first CQC inspection for Medic 1 Direct Ltd. The inspection took place on 9 January 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in the ambulance service.

The inspection team was overseen by Catherine Campbell, Head of Hospital Inspections.

Facts and data about Medic 1 Direct ltd

Activity (October 2016 to October 2017)

- The service covered 89 events and conveyed 10 patients from the event site to the local hospital.
- There were seven employed staff within the service consisting of the clinical director (registered manager), administrators, the fleet manager, the head of operations, procurement and accounts.
- The seven employed staff were clinically trained and undertook event work as either emergency medical technicians or emergency care assistants.
- The clinical director was a registered paramedic.
- The service had 55 contractors (temporary staff) that it could use. Of these, 24% worked regularly within the NHS.
- The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No never events
- No clinical or non-clinical incidents
- No serious injuries
- No complaints

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the non-operational base in Canterbury, Kent. We were unable to inspect the headquarters, as the Care Quality Commission (CQC) has no regulatory power in Wales.

The registered manager and the senior administrator travelled from Wales to Canterbury for the inspection. Both members of staff undertook clinical roles at events.

As there were no staff based at the location we inspected, we invited them to provide feedback by telephone, email or via the CQC webpage prior to the inspection. Six contractors (temporary staff) including emergency care assistants and emergency medical technicians provided written feedback.

We were unable to speak with patients during our inspection, as there were no local events taking place. We reviewed the patient records for the 10 patients the service conveyed to hospital within the past 12 months. The provider has a fleet of eight vehicles. The registered manager and senior administrator brought one ambulance, one kit bag and one medicines bag to the inspection from Wales. We reviewed the records for ten members of staff including contractors.

The provider used the same processes, policies and systems for both regulated and the non-regulated activities. Therefore, we have reviewed the dual processes, policies and systems, and used this information to inform our judgement, as we did not observe any regulated activity during the inspection.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with the CQC.

Patient transport services (PTS)

Summary of findings

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Staff followed infection prevention and control procedures to reduce the spread of infection to patients.
- Staff completed extensive training in a range of clinical skills and theory to enable them to undertake their roles.
- The service carried out comprehensive risk assessments prior to each event and liaised with local services.
- Staff within the service had completed training to assist with meeting the needs of individuals including patients living with dementia and learning disabilities.
- The service encouraged feedback from patients.
- Staff felt supported by the managers of the service and said the managers were always available to discuss concerns.
- The recruitment procedure ensured patients were safeguarded against unsuitable staff.

However, we also found the following issues that the service provider needs to improve:

- There was a lack of incident reporting which suggested staff were not able to identify incidents.
- Senior management lacked understanding of the duty of candour and there was no policy for the duty of candour.
- The service did not record informal training, observations or spot checks.
- The wording in the adult safeguarding policy required amending to make it easier to read.
- The service had a patient feedback form, but there was a lack of information available to patients and their families regarding raising a formal complaint.
- Patient record forms were not always fully completed.
- Staff did not have access to translation services.
- Audits were not undertaken and therefore learning did not take place from review of procedures and practice.
- The organisational risk register was incomplete as it did not rate the risks or contain any actions taken to mitigate the identified risks.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The incident reporting policies and processes did not give assurance that all staff understood how and when to report an incident.
- The service had an 'Incident Reporting Policy' due for review in May 2018. The provider used this policy for both the regulated and the non-regulated activities. The policy was not comprehensive as it only covered the procedure for staff to follow for information governance incidents and did not reference national legislation. The service did not have policies for clinical incidents including near misses. This meant staff did not have clear reporting procedures to follow when these types of incidents occurred.
- Staff had reported no incidents between October 2016 and October 2017. Low reporting rates may represent under reporting which could be because of a lack of awareness of safety issues amongst staff. High reporting rates often reflect a more open and transparent culture across the organisation.
- The two staff at inspection told us in the event of an incident staff would complete the incident reporting form and notify their line manager. The incident reporting form would be kept with the patient record.
- The registered manager reported one broken down vehicle at an event site within the past 12 months. The service did not record this as an incident, which might mean the service had missed opportunities for learning and potentially preventing the same incident from occurring.
- The two staff at inspection told us the service was developing an electronic incident reporting system, which could enable management to identify themes more easily. The service aimed to use this information to plan events and ensure mitigation of identified risks.
- The service reported no never events.Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The registered manager was not familiar with the term 'duty of candour' but thought there was a policy on this. However, there was no duty of candour policy in the list of policies the provider sent us. There was no reference to the duty of candour within the incident reporting policy. This meant there was no assurance the service knew how to identify and manage incidents, which trigger the duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The registered manager told us staff were always open and honest with patients.

Mandatory training

- All staff had undertaken a comprehensive induction programme and mandatory training to equip them with the skills required to perform their role. All staff who worked at events may convey patients to hospital, therefore we looked at mandatory training for all staff.
- The service had a 'Staff Training' policy due for review in May 2018, which outlined the purpose of training and the responsibilities of Medic 1 Direct Ltd in delivering training.
- Staff undertook mandatory trainingexception of
- The two staff at inspection told us all staff, including contractors, undertook mandatory training modules including mental health, patient handling, basic life support, patient records and de-escalation skills. There were also mandatory driving and giving patient medicines training for the relevant staff. This demonstrated staff had access to a range of training to prepare them for undertaking assessment and conveyance of patients from the event site.
- At the time of inspection, the service reported 100% compliance with mandatory training. Mandatory training included seven modules: mental health awareness, manual handling, de-escalation, driver training, patient handover, basic life support and infection control.
- The records for 10 members of staff showed they had completed all mandatory training relevant for their role except for AED. The training records showed staff completed this
- Although the staff training policy stated staff should complete yearly driving assessments, the training records showed staff exceeded this requirement and

undertook six monthly assessments on both cars and ambulances. This meant the service monitored the driving performance of staff closely and would be able to identify poor performance more easily.

- The registered manager told us the head of operations carried out spot checks on the driving performance of staff but did not document the observations. This meant the service had no assurance these spot checks were completed and actions taken when poor performance was identified.
- The registered manager told us if staff did not attend mandatory training or this had expired, their duties were restricted to reflect the missed training. For example, if an emergency medical technician let their training lapse, they would practice as a first aider and their manager would oversee their clinical duties during an event. This provided assurance staff did not work out of their current scope of practice.
- Staff accessed an online learning system to complete theory modules and competency tests using personal logins. This meant staff could access training remotely which is important when the majority of staff were not located on-site.

Safeguarding

- The service had a safeguarding policy for children and young people (CYP) due for review in May 2018 and a safeguarding policy for adults due for review in October 2020. These policies were used for both the regulated and the non-regulated activities. Both policies referred to current national legislation, which meant staff, worked in line with best practice.
- However, only the adult safeguarding policy identified the safeguarding lead for the organisation and their contact telephone number. This meant staff who used the safeguarding policy for CYP might not know who to contact for advice.
- The adults safeguarding policy was not fully completed and had phrases such as ‘name of organisation’ and ‘name of place/file/log’ where the service was meant to amend prior to publishing the policy. This meant the policy might not be easy for staff to read.
- The service had reported no safeguarding concerns to the CQC in the 12 months prior to inspection.
- The two staff at inspection told us they would report safeguarding concerns to the event manager for the service that escalated this to the duty officer or the safeguarding lead for
- advice. The registered manager stated if the safeguarding concerns were urgent, the event manager would call the police or social services.
- The two staff at inspection told us they would complete a paper safeguarding alert form, which they would store in the patient record form. Staff would discuss safeguarding concerns with the safeguarding lead that would refer to the local authority, although staff could refer directly. This is in line with the service’s safeguarding policies.
- The registered manager told us staff did not have contact with patients until they have completed their induction, which included adult and level two CYP safeguarding training. This ensured only staff who knew how to identify and report abuse worked with patients.
- NHS paramedics received their level three safeguarding CYP training through their Local Health Board. We saw the record for one paramedic, which showed level three CYP safeguarding training. This is in line with national guidance.
- The service reported 100% compliance to all safeguarding training.
- The service had arranged for a national charity to provide training on domestic abuse to its staff. This meant staff had a better awareness of identifying domestic abuse.

Cleanliness, infection control and hygiene

- The provider had comprehensive infection control policies but we identified a lack of clinical audit. This meant the provider did not have assurance if the policies were effective, and if staff followed them.
- The service had an infection control and prevention policy (review date May 2020). The provider used this policy for both the regulated and the non-regulated activities. The policy outlined effective handwashing, clinical waste, protective clothing, spillages and sharps. There were also separate policies for personal protective equipment and the management of sharps (review date May 2018). However, none of the infection control policies referenced national legislation. This meant the service did not have assurance staff were following best practice guidelines.
- All staff wore uniforms, but there was no guidance on how staff should clean their uniform or how to manage soiled uniforms. This meant there was no standard procedure for staff to follow.

- The two staff at inspection wore their uniforms, which appeared clean.
- There were service level agreements in place for the collection and destruction of clinical waste and sharps bins.We saw staff had assembled the sharp bin on the ambulance correctly.
- As we did not see patient contact, we were not able to observe compliance with the infection control policy during the inspection.
- We saw that staff had hand gels and personal protective equipment available in the vehicle and kit bags for use prior to and following any patient contact. This meant staff had access to equipment to prevent the spread of infection.
- All of the 10 training records we reviewed showed staff completed infection control training. The registered manager told us it included sepsis training and assessing handwashing
- techniques. The registered manager and a registered nurse from the local NHS Trust delivered this training.
- We saw one kit bag contained a fabric tourniquet. The World Healthcare Organisation (WHO) states best practice is to use clean elastic tourniquets when reused between patients. We escalated our concern to the registered manager who reported she cleaned the fabric tourniquet between every patient use; however, this was not sufficient to prevent the spread of infection such as blood borne viruses.
- The service had instructions for cleaning the interior of an ambulance. It outlined when, what and who should clean areas of the ambulance such as the floor, cupboards and stretchers. This meant staff had a standardised approach to cleaning vehicles.
- The two staff at inspection told us all vehicles received a deep clean at least weekly or more often if indicated. The fleet manager undertook training in clinical disinfection and deep cleaned the vehicles in house.
- We asked the service to bring evidence of vehicle cleaning such as vehicle spot checks and cleaning checklists to the inspection for review. However, we did not receive this information so we could not gain assurance the service cleaned vehicles in line with their policy.
- The service did not conduct any clinical audits for infection control. This meant the service did not have assurance staff complied with the infection control policies and standard operating procedures.

Environment and equipment

- We are unable to comment on the design and maintenance of the ambulance station in Wales.
- The service had a ‘Vehicle Equipment and Inventory Check Procedure’ (review date May 2018). It outlined the responsibilities of staff to undertake inspections of the vehicle and equipment prior to its use. We asked the service to bring evidence of vehicle checklists to the inspection for review. However, we received a blank ‘Ambulance Equipment Checklist’. This did not provide assurance that staff followed procedures for checking equipment, prior to its use in line with their policy.
- The service had a monthly equipment maintenance checklist to ensure the ambulance contained enough supplies of equipment that was clean and in working order. We saw the completed checklist for one vehicle dated January 2018, which showed three missing items: vacuum mattress, aprons and pelvic sling. The service did not have assurance the ambulance now contained the correct level of supplies, as staff did not document actions taken such as restock of the missing items. If aprons were missing for up to a month, this meant staff did not have sufficient personal protective equipment available to prevent the spread of infection.
- All equipment on the vehicle we inspected was clean and stored appropriately. This meant the equipment was ready for use.
- We saw the equipment on the ambulance we inspected had received servicing and maintenance within the last 12 months. This included the suction unit, carry chair and stretchers. This meant the equipment was fit for purpose and safe to use.
- The two staff at the inspection told us a third party calibrated the resuscitation medical devices annually. We saw receipts dated July 2017 to confirm this. This ensured emergency equipment was fit for purpose and safe to use.
- The registered manager told us if staff had not received equipment training or their training had lapsed, the team leader removed this bit of equipment from that member of staff’s kit bag. This prevented staff from working out of their scope of practice.
- The two staff at inspection told us if they discovered faulty equipment during an event, they would inform

the team leader who would escalate this to head office. Staff would remove the faulty piece of equipment from the vehicle. This prevented staff from using faulty equipment and helped to protect patients.

- Head office would courier replacement equipment to the vehicle at the event site. However, if the faulty equipment was emergency equipment such as a defibrillator, staff could get a replacement from the local NHS ambulance resilience officer but this had not happened in practice. A resilience officer works as part of a team to assess, anticipate, prevent, prepare, respond and recover from threats to public safety such as extreme weather and outbreaks of disease.
- The service had a kit bag checklist, which the stores person used to stock the kit bags according to staff grade prior to each event. The registered manager explained once a kit bag was ready, the stores person attached a dated label to the outside of the kit bag. This helped staff identify kit bags that were and were not ready for use.
- If a member of staff wanted to use their own kit bag, the service ensured this underwent the same checks. We asked the provider for evidence of kit bag checks prior to use but received a blank checklist. Therefore, we were unable to gain assurance staff completed these checks.
- The service brought a kit bag to the inspection as an example. We found some out of date items including hand gel, bandages and paediatric airways. We brought this to the attention of the registered manager who told us she last used the bag in October 2017 and there had been no event work since. This kit bag would undergo further checks as detailed above before use.
- The kit bag we reviewed contained appropriate equipment for both adults and children. This showed staff were equipped to care for patients of all ages.
- Staff explained the service took additional stock to event sites so staff could replenish their kit bags when necessary. This ensured staff did not use kit bags that had a large volume of missing items.
- The service had eight vehicles including ambulances, a rapid response vehicle and an unmarked car. We checked the government website and found all the vehicles had up to date tax and MOT. This demonstrated all vehicles were roadworthy at the time of the inspection.
- Each vehicle had its own folder, which contained details of its previous ownership, road tax, MOT and registration. At the inspection, we reviewed the folder for the vehicle we inspected and found no omissions in documentation.
- There was a general risk assessment form for each ambulance. It highlighted potential hazards such as moving and handling and the current control measures. This enabled staff awareness of risks and what to do to mitigate the risk to the patient and/or themselves.
- We saw an in date certificate for motor insurance which covered the service's fleet of vehicles. This meant the service had legal protection if their vehicles were involved in an accident.
- The registered manager told us the service had a contract in place with a vehicle mechanic company for yearly servicing of vehicles. This ensured all vehicles were fit for purpose.
- There was no formal replacement plan for vehicles, for example replacing all vehicles with newer models after five years of service. The registered manager told us the mechanic made an assessment and recommendations if a vehicle was not repairable and needed to be taken off the road.
- The service had a service level agreement with a garage that provided 24 hour, seven days a week breakdown cover. Staff told us if they had a vehicle breakdown at an event, they would call the garage, who would arrange a replacement vehicle. This ensured business continuity.

Medicines

- The provider had clear processes in place for the receipt, storage and administration of medicines. However, the medicines management policy did not outline the procedures to take for controlled drugs. Record forms for the 10 patient conveyed to hospital, showed staff did not consistently document medicine administration in line with best practice.
- The service had a 'Medicines Management Policy' (review date January 2019). The provider used this policy for both the regulated and the non-regulated activities. It outlined standing operating procedures, protocols and responsibilities of staff about medicines including the management of medicine errors. It also clearly identified which medicines different grades of staff could administer using t.
- The service reported no medicine errors between October 2016 and October 2017.

- There was a service level agreement with a pharmacy to supply and dispose of medicines.
- The two staff at inspection explained that a qualified healthcare professional under a patient specific direction (PSD) administered medicines. This enabled qualified staff to treat patients on the way to the hospital.
- The service received Medicines and Healthcare products Regulatory Agency () alerts through the contracted doctor or pharmacist who contacted the registered manager. The registered manager told us she would share any such alerts through email to the relevant teams.
- We saw the service had applied to the Home Office for a controlled drugs licence in September 2017. Companies and individuals in England, Wales or Scotland need to apply for Home Office
- licenses if they wish to produce, supply, possess, import or export controlled drugs. The service did not currently store controlled drugs on site but had plans to in the future.
- The service stored medicines within a locked cabinet inside a locked room at the headquarters in Wales. This was in line with the National Institute for Health and Care Excellence (NICE) guideline NG46. The room had surveillance cameras so all activity within this room was captured.The service provided photographs of the locked room and cabinet where they kept medicines. This was in line with best practice guidelines.
- The registered manager told us she undertook a medicines stock audit once a month and recorded this electronically. When stocks were low or medicine expired, she would complete an order form and return expired medicine to the pharmacy for destruction. We asked the service to bring evidence of medicine audits to the inspection for review. However, we did not receive this information so we could not gain assurance the registered manager undertook this audit.
- The registered manager explained she collected the medicines from the pharmacy in person. Then at the base, the registered manager and another competent member of staff recorded the receipt of the medicines within a logbook and locked these in a cabinet. We saw the data entries in the medicines logbook from October 2016 to January 2018 and found no omissions.
- Each drug bag had a code for identification. The two staff at inspection told us if staff used a medicine from a drug bag, the staff member would inform the event manager who ensured its replenishment.
- During an event, staff locked the additional stock of medicines within the vehicles. We were unable to observe this, as there were no local events taking place.
- The two staff at inspection told us, before an event, they signed out the medicines from the medicines cabinet and recorded this. The same process happened when medicines returned after an event. We saw completed checks of medicines for five events with no omissions.
- The registered manager cross-referenced any discrepancies in stock levels with the patient record forms (PRFs), which evidenced all administrations of medicine during an event. This meant the registered manager could easily identify any errors and the staff members responsible for the errors.
- The Medicines Management Policy stated management would audit 10% of PRFs following a large event to evaluate compliance with the policy and identify learning needs. We asked the service to bring evidence of medicine audits to the inspection for review. However, we did not receive this information so we could not gain assurance management undertook this audit.
- The service brought one drug bag to the inspection as an example. We inspected the contents of the drug bag against the service's drug bag checklist. We found all medicines were within date and kept within their original boxes.
- We reviewed the PRFs for the 10 patients who the service conveyed to hospital and found staff administered medicine to seven of these patients. Staff administered controlled drugs to two of these patients. We found the following, which showed PRFs were not consistently being completed fully in line with the provider's medicines management policy:
  - All PRFs stated the medicine name
  - All of PRFs stated the dose
  - Four PRFs stated the administration route
  - No PRFs stated the batch number of the medicine
  - Six PRFs stated the time of administration
  - Six PRFs were signed against the administration
- The registered manager was the accountable officer for controlled drugs. The service did not store controlled

drugs at the base. Controlled drugs were couriered direct from the pharmacy to the event site and back again. A risk assessment of the event indicated the quantities of medicine required.

- The medicines management policy did not contain any guidance for staff on the management of controlled drugs. The two staff at inspection reported the event manager and a paramedic would receive the controlled drugs at the event site. They would complete an entry into the record book upon receipt. Staff told us they recorded administered controlled drugs within this logbook, detailing the date, time, batch number, patient record number and two members of staff signed this. Staff told us they witnessed and recorded the disposal of any unused but opened controlled drugs. We requested copies of the medicine record book but we did not receive this information. Therefore, we were unable to gain assurance around this process.
- The registered manager reported staff disposed of partially used and open controlled drugs into sharps bins. This was in line with the National Institute for Health and Care Excellence (NICE) guideline NG46.
- Staff told us any unused controlled drugs were couriered back to the pharmacy at the end of the event. We requested copies of the medicine record book but we did not receive this information. Therefore, we were unable to gain assurance around this process.

Records

- The service had a ‘Management of Health Records Procedure’ policy (review date May 2018). It outlined the responsibility of staff in relation to record keeping, storage, handling and security of patient record forms (PRFs) in relation to the Data Protection Act (1998). The provider used this policy for both the regulated and the non-regulated activities.
- The two staff at inspection told us the service stored PRFs in a locked filing cabinet within a locked room. We were unable to observe this as the service kept PRFs at the headquarters in Wales. It kept PRFs for a minimum of 10 years. This is in line with national guidance.
- The registered manager explained the management of PRFs at an event site. Staff carried PRFs in a locked carry case during event work. Staff handed these to the team leader at the end of each day and they placed these into a locked cabinet. This ensured confidential patient information was stored securely.
- The senior administrator told us she manually inputted PRFs into an electronic database. During the process, if there was any missing information she escalated this to the registered manager who discussed this with the relevant member of staff. This process was informal and did not form part of a wider audit. However, the service identified a theme of incomplete documentation for first aiders so the service organised a training day, which used real PRF examples to aid learning.
- We saw the PRFs were comprehensive and consisted of 13 sections including medical history, observations, a body map and administration of drugs.
- We reviewed the PRFs for the 10 patients who the service conveyed to hospital, we looked at pain assessment, levels of consciousness, past medical history, allergies and clinical observations. We found the following which showed staff completed PRFs to a reasonable standard:
  - Nine out of 10 patients had their past medical history, allergies and consciousness level recorded.
  - Nine out of 10 patients had their level of clinical observations recorded.
  - Seven out of 10 patients had their pain scores documented.
- The service did not undertake any record keeping audits, therefore it missed opportunities to assess staff compliance to the management of health records procedure and identify improvements.
- Due to the nature of event work, staff were unlikely to see ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) orders. The PRFs we reviewed did not have any documentation to indicate any of these patients had end of life care planning or DNACPR orders.

Assessing and responding to patient risk

- We reviewed 10 patient record forms (PRFs) for patient conveyed to hospital from the event site and found staff conveyed patients to hospital due to the following reasons: chest pain, high blood pressure, loss of consciousness, fractured bones, seizure, head injury and urinary problems.
- The two staff at inspection told us they had access to electronic and paper Joint Royal Colleges Ambulance Liaison Committee guidelines. This meant staff had access to best practice guidelines during their work.

- In the 10 PRFs we reviewed, we found staff had recorded frequent observations in all but one PRF. This patient only had their temperature recorded. This meant staff might not have been able to identify deterioration in this patient's condition.
- At the time of inspection, the service reported all staff had completed de-escalation training. Staff also completed a nationally recognised two-day course in control and restraint, which related to a non-regulated activity provided within Wales. This meant staff were equipped with the necessary skills to manage an aggressive or violent patient.
- There were no specific policies for how to identify or manage a deteriorating patient at events. This meant there were no clear escalation processes for staff to follow if a patient's condition deteriorated.

Staffing

- The service employed seven permanent members of staff and had 55 contractors (temporary staff) who undertook event work. Of these, 24% worked for the NHS and/or the Welsh ambulance service.
- The service reported no sickness or turnover of permanent staff in the 12 months prior to inspection.
- The service had a 'Lone Worker Policy' (review date August 2020) which referenced the Health and Safety at Work Act 1974. It stated a risk assessment would be undertaken to establish if lone working was safe and outlined the responsibilities of the lone worker. However, the registered manager told us staff never worked alone at events due to the risk of emergency treatment and conveyance to hospital.
- The skill mix and staffing levels for an event were established following the planning meeting with the event organiser. The registered manager explained the service assigned contractors to events based on their grade and availability to work. The service allocated staff on a rotational basis if there were more staff than available shifts. This ensured all staff had exposure to different events.
- Some events ran into the early hours of the morning. In these circumstances, the service split the shifts amongst staff to maintain safety. The registered manager stated staff worked a maximum of 10 hours. This is in line with the Working Time Regulations 1998.
- One staff member told us the service planned their journey to an event and organised set rest breaks along the way. This ensured staff did not drive for extended periods, which can cause tiredness.
- The senior management team covered an out of hours rota to provide 24 hours, seven days a week support to staff. The service informed staff of who was on duty at the start of each day. The telephone number for out of hours remained the same regardless of the event, which meant staff were familiar with the number.
- One member of staff reported the service took into account skill mix when pairing staff together for an event. This enabled the service to provide safe care and treatment at all times.

Anticipated resource and capacity risks

- The registered manager told us the service knew themes and trends for frequent events because they completed post event reports. For example, the service was more likely to convey spectators at golfing events for slips, trips and falls than festivals, where they were more likely to treat spectators with intoxication.
- We reviewed a post event medical report dated January 2018. It outlined the staffing levels, the total number of patient incidents categorised by patient condition, such as cuts and head injury, patient outcome, such as advice only or refused treatment, and a request from the event organiser for feedback. This report enabled the service to reflect on the service it provided and plan for future events taking into account the risks identified.
- The registered manager told us the service held regular scenario training regarding major incidents. The lead clinician assessed staff on their actions and carried out a hot debrief afterwards. The training officer received details of any identified training needs for staff.
- We received the training reports for March 2017 and June 2017, when staff of all grades undertook a training scenario. One example of a training scenario used was casualties of differing medical needs at an event site following a collision of a car with the crowd due to loss of consciousness of the driver. However, information received from the service on both occasions did not state if they identified any areas for improvement or details of actions taken by the service following the training.

Patient transport services (PTS)

Response to major incidents

- The registered manager told us the service held regular scenario training regarding major incidents. The lead clinician assessed staff on their actions and carried out a hot debrief afterwards. The training officer received details of any identified training needs for staff.
- We received the training reports for March 2017 and June 2017, when staff of all grades undertook a training scenario. One example of a training scenario used was casualties of differing medical needs at an event site following a collision of a car with the crowd due to loss of consciousness of the driver. However, information received from the service on both occasions did not state if they identified any areas for improvement or details of actions taken by the service following the training.

Are patient transport services effective?

Evidence-based care and treatment

- We saw from patient records that staff delivered evidence based care in line with the National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee guidelines.
- Staff followed NICE quality standards for Stroke in Adults. Patient records showed ambulance staff used a validated tool to screen a patient that had a sudden onset of neurological symptoms in line with best practice.
- Staff followed NICE quality standards for Head Injury: assessment and early management. Patient records showed ambulance staff changed their initial advice, to discharge a patient, after the patient developed blurred vision following a head injury. They conveyed the patient to hospital in line with best practice.
- The service consulted external professionals such as medical consultants, patient safety officers and advanced nurse practitioners to develop and review policies. The service reviewed all policies every three years or sooner if there were changes to national guidance.
- The service held sign off meetings with its professional advisors if appropriate, to review policies. We saw the meeting minutes dated August 2017 for the review and saw discussion of the lone worker policy for sign off.
- The governance meeting minutes dated October 2017 demonstrated the service reviewed the current provision of emergency medical technician training and updated the contents in line
- with new clinical guidelines. This ensured staff received training that reflected current best practice.
- The provider did not complete clinical performance audits on patient record forms. This meant the provider did not have assurance staff delivered care and treatment in line with national guidance or best practice.

Assessment and planning of care

- Staff at the event control room relayed information about the patient's condition over the radio to event staff. This ensured frontline staff could attend to the patient's needs efficiently.
- As part of the patient assessment, crews asked patients about their past medical conditions including mental health disorders. We saw completed patient record forms, which showed staff identified and documented when patients had mental health disorders.
- The service undertook a physical assessment of the event site prior to the event. This included timing the drive to the local accident and emergency department and to key points around the event site. This enabled staff to inform local departments of their estimated time of arrival.
- Before an event, the service developed a plan with the local NHS ambulance resilience officer. It consisted of the address and contact numbers of local services such as the local stroke unit. This ensured the service took patients to the most appropriate hospital for treatment.
- The registered manager explained ambulance crews could call the duty officer or the local NHS ambulance resilience officer (if agreed at the event organiser meeting) for clinical advice during an event. This ensured staff had access to enhanced clinical advice and support if required. We did not see any evidence of this in the 10 patient record forms we reviewed.
- The service had a handover policy and process document (review date May 2018). The provider used this policy for the regulated activity. However, this did not contain a standard operating procedure for staff to follow. This meant staff might not understand how to conduct a comprehensive handover with the hospital staff.

Patient transport services (PTS)

Response times and patient outcomes

- The service provided first aid services for the public and staff at events. During an event, staff positioned themselves within the spectator areas and within the medical centre. This enabled the staff to respond quickly to any incident.
- The service had an arrival on scene target of three minutes. The service did not carry out audits to monitor their response times. This meant the service was unable to evaluate its compliance to the target and identify downward trends.
- The service did not carry out audits to monitor patient outcomes for the regulated activity. This meant the service missed opportunities to benchmark its performance against other providers and identify areas for improvement.
- Kit bags and vehicles were fitted with Global Positioning System (GPS) tracking devices. A member of staff told us this enabled the service to get the closest team along with the most suitable skill mix to be on route to the patient quickly.
- The service used the patient feedback form and feedback from event organisers to monitor the quality of care they provided. On one occasion, the registered manager received video footage as feedback to show how staff responded to a medical emergency within their target response time, which meant the patient received the appropriate care at the right time.

Competent staff

- The registered manager reported all staff received a five-day induction to equip them with the basic skills to undertake their role. It included mental health awareness, risk assessment, handover, communication skills, infection control and basic life support.
- Staff told us before having any patient contact they attended the induction and completed some of the mandatory training modules. This ensured staff had the right skills and knowledge to commence their employment.
- The 'staff induction time plan' showed within six months of the induction, staff had to complete first person on site, patient handling and driving assessment training. The registered manager reported only when staff had completed this training would they be able to undertake that specific role. For example, staff could only drive once they had completed their driving training and assessment. This ensured staff did not work outside of their scope of practice.
- Training records showed all staff had completed mandatory patient handling and driver assessment training. Only 40% of staff had training records showing completion of first person on-site training. The training plan showed staff should complete this training within six months of joining the service. This suggested the provider did not have accurate records for this training.
- Documentation we reviewed showed the service offered emergency care assistant (ECA) training to all patient transport staff. We saw all ECAs had undertaken this training. Medic 1 Direct Ltd was an approved training centre, so staff could achieve a diploma in emergency care assistance. This demonstrated the service provided staff with opportunities to develop.
- The 'Staff Training Policy' (review date May 2018) stated patient transport staff had a probationary period of six months in which they had a mentor who undertook monthly reviews. We requested evidence of the monthly reviews from the service after the inspection; however, the service informed us the reviews were not in place. This suggested there was a lack of on-going support and management of staff.
- The registered manager explained training sessions ran in groups and took the form of lectures, role-play, case studies, scenarios and practical sessions. Assessment was undertaken formally and informally. However, the service did not record all informal training, which staff attended. This meant the service was unable to gain assurance staff had relevant training. We escalated this to the registered manager who stated the service would review its use of the word informal and the recording of such training and assessment.
- The service provided additional training based on staff learning needs, staff requests or in response to service need. Training records showed staff undertook additional training, such as a cardiac study day, ambulance equipment, team leader and a teacher-training course.
- The service circulated emails to staff informing them of the availability of training. Staff signed a register at the start of training and all attendees received a certificate. Certificates were kept in staff files, which were at the headquarters in Wales. We asked the service to bring 10

staff files including certificates to the inspection for review. However, we did not receive any certificates to review but we saw lists of additional training each staff member had undertaken within their training record.

- At the time of the inspection, the service had no formal process in place for carrying out staff appraisals.Therefore, we did not gain assurance that the service had a system for identifying and managing variable or poor staff performance.
- The service had plans to introduce yearly appraisals for its employed staff and four members of staff had this scheduled. Previously, informal appraisals occurred at the request of staff or an open door policy meant staff could raise concerns directly to management. The service reported staff had not reported any issues.
- The service was developing an IT system, which would enable the electronic recording of staff training to improve managerial oversight and access to information.
- Staff were able to complete external training courses with prior agreement from the registered manager. For example, one administrator had completed a Level Three Award in Education and Training, paid for by the organisation. This meant staff had opportunities to enhance their skillset and gain new skills such as teaching.

Coordination with other providers

- Senior management visited each new location prior to an event to risk assess and plan the requirements for staffing and vehicles. The visit consisted of a planning meeting involving the organiser, local council, the NHS local ambulance resilience officer and other public services. This ensured care was delivered in a co-ordinated way and responsibilities of each public service identified prior to the event.

Multi-disciplinary working

- The registered manager explained when staff transferred a patient to hospital, they handed over using the patient record form. In the 10 patient record forms we reviewed, 60% did not contain details of the handover such as time of handover or signature of the accepting clinician. This meant the service had no assurance staff carried out handovers efficiently and effectively.
- The service worked closely with local councils, the local NHS ambulance resilience officer and the event organisers. The clinical director attended medical planning meetings with the event organisers. This ensured the registered manager was aware of any anticipated risks and planned pathways of care.

Access to information

- For each event, the service provided staff with documentation, which included the address of the event, contact details and addresses of local NHS services and event site maps. This ensured staff had the information they needed to deliver effective care and treatment.
- Policies and procedures were available for staff at the head office at all times. If they required information from these whilst at events, the staff would contact the duty officer. This meant information was always made accessible to staff who may need it.
- Satellite navigation systems were available for all vehicles when required.
- Due to the nature of event work, staff were unlikely to see ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) orders.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a ‘Capacity and Consent Policy’ due for review October 2020.The provider used this policy for both the regulated and the non-regulated activities. The policy reflected best practice in relation to adults, children and young people. It provided clear and comprehensive guidance to staff on assessing a patient’s mental capacity, gaining consent, deprivation of liberty and record keeping.
- The records for 10 members of staff showed all staff had attended the mental health awareness, mental capacity act and Mental Health Act mandatory training.
- Staff understood their responsibility to gain patient consent. We saw staff documented when a patient did not consent to treatment such as administration of medicine.

Patient transport services (PTS)

Are patient transport services caring?

Compassionate care

- We did not see any examples of patient care during the inspection. However, we reviewed feedback provided by patients and relatives, which was very positive about the service.
- We saw cards and feedback forms from four patients. One card read, “They were true professionals and are a credit to their profession and company.”
- One thank you note said, “Thank you all for your prompt attention and care.”
- We saw five comments on the service’s social media page included, “Everyone is so focused on patient care.” All comments we reviewed were positive.
- We received six feedback comments from staff which demonstrated the service provided compassionate care:
- “The team always make everyone they meet feel comfortable including the person accompanying the patient”.
- “Staff are very caring and understanding of patients from all backgrounds and walks of life, staff will go out of the way to help those whom are under our care”.
- “All staff understand the importance of patient confidentiality and patient dignity”.

Understanding and involvement of patients and those close to them

- Feedback provided by a relative included an example where staff ensured the patient was safe by escorting the patient and their relative back to their car in the car park at an event after deciding not to take the patient to hospital.

Emotional support

- We did not observe any direct care during the inspection.

Are patient transport services responsive to people’s needs?

Service planning and delivery to meet the needs of local people

- The provider planned and delivered the service to meet the needs of local people. Administrators completed a standard booking form when receiving a referral for an event. It compriseda number of questions such as the number of spectators, whether the event has happened before and fire risks such as barbeques or open fires. The service used this information to risk assess the event and identify service needs such as staffing, number of vehicles and staff skill mix.

Meeting people’s individual needs

- The service had vehicles, which could accommodate wheelchair users.
- The service had enrolled on the dementia friend’s scheme, which aims to increase people’s knowledge about dementia and how they can help to create dementia friendly communities. Staff completed online modules on dementia and obtained a certificate at the end of the course. This meant staff were equipped with the knowledge to enable them to identify the needs of a person living with dementia.
- Staff received training in the area of learning disability within the mandatory mental health training.
- Due to the type of service provided, it was difficult to arrange translation services for patients whose first language was not English. Staff did not have access to telephone translation service and instead used an English-speaking friend or relative to translate where the patient required immediate treatment. The use of relatives for interpreting is strongly discouraged in national guidance and is not good practice.
- Vehicles enabled the patient to have a relative or friend accompany them to the local hospital.

Access and flow

- All first aiders had portable radios and automated external defibrillators with them during an event so they were equipped to receive live information and respond to any medical emergency quickly.

Learning from complaints and concerns

- The service had a ‘Complaint Resolution Policy’ (review date October 2019). The provider used this policy for both the regulated and the non-regulated activities. The policy was clear and outlined timeframes for dealing with complaints, such as acknowledgement of a complaint within four working days.
- The service had not received any complaints in the 12 months prior to inspection.

- Although feedback forms were available, there were no complaint posters or specific complaint leaflets kept within the vehicles, therefore patients would not know how to make a formal complaint or where to send a written complaint to.

Are patient transport services well-led?

Leadership of service

- Staff feedback was very positive about the management of the organisation. They felt the senior management team valued their opinions and were readily available to listen to staff.
- The senior management team consisted of the clinical director, the senior administrator, head of operations, head of procurement and head of accounts.
- The senior management team reported to the clinical director.
- The fleet manager and the event staff reported directly to the head of operations.
- The service employed a qualified trainer who was also an advanced ambulance technician. He undertook a five-day residential course every year to maintain his trainer status. This ensured staff received training that reflected best practice.
- At the end of each event day, the team leader held a hot debrief. The team discussed the health and wellbeing of staff, calls and patient treatment and reflected on how the event had gone. This showed teams worked to resolve issues to improve the delivery of good quality care as the event continued.

Vision and strategy for this this core service

- The service had a mission statement, which was 'to give excellent care'.
- The registered manager told us the future strategy of the business was to grow whilst continuing to be patient focused.

Governance, risk management and quality measurement

- The registered manager told us the service reviewed the applicant's training records, details of references and the Health Care Professional Council (HCPC) register if applicable, during their interviews. This demonstrated the service had an effective recruitment process.
- The service had a 'Disclosure and Barring Policy' (review date May 2019). The provider applied this policy to staff that provided both regulated and non-regulated activities. It outlined responsibilities, storage, usage, retention and disposal of disclosure and barring service (DBS) documentation. However, the registered manager acknowledged it lacked detail and did not demonstrate how to manage declarations or disclosed information.
- There was a service level agreement with a third party who managed the DBS checks. Once processed, the third party sent an email to the service who requested the employee to bring the physical document into the head office for review. We saw the DBS reference numbers
- The service had identified risks to the organisation such as patient experience, finance and staffing. However, the risk register did not identify the current level of risk, the current control measures and actions for each of the domains. Therefore, the senior management team might not have had a clear understanding of the risks to the organisation.
- The provider did not carry out clinical audits or monitor its performance. This meant the provider did not have assurance about whether patients received safe care in a timely manner.

Culture within the service

- The registered manager reported there was a no blame culture within the service. If there were any concerns about the competency of a member of staff, they would carry out a reflective recorded in the 10 staff records we reviewed. This meant the provider had assurance DBS checks were processed and the outcomes checked in line with their policy.
- The registered manager told us the service risk assessed any concerns raised in the DBS certificate, although there was no standard operating procedure for this.
- The service undertook a yearly check of DBS certificates and the Health and Care Professions Council registers. This ensured staff were suitable and qualified to carry out their duties.
- The registered manager told us prior to the start of an event all registered healthcare professionals had their registration checked. This provided the service with assurance that staff were legally fit to practice.
- All vehicles were tracked which allowed the service to monitor the standard of driving for all staff. If staff drove

a vehicle above the speed limit, the duty officer received an email alert. The registered manager reported this allowed the service to notice themes for repeat offenders.

- The Head of Operations undertook a yearly check of driving licences for all drivers. We saw evidence to show yearly driving licence checks took place, which included the driving licence number and the date of the check. This ensured all staff were legally allowed to drive.
- All staff wore name badges, which had a barcode. The event manager scanned this barcode at the beginning of an event to check the staff member worked for the service. This ensured unauthorised staff did not assess or treat patients.
- If staff had treated a person during an event, the event manager and team leader would review the patient record form and discuss this with the member of staff involved to allow staff to reflect and provide feedback.
- The registered manager and the senior administrator took responsibility to submit notifications to the Care Quality Commission. There were no notifications submitted in the 12 months prior to inspection, as there had been no incidents meeting this threshold.
- The senior management team attended monthly governance meetings. We saw the meeting minutes for August, September and October 2017, which showed the standing agenda included finance, recruitment, workload and training. It did not include incidents, risk register, audit or complaints, which meant the organisation might not have had complete oversight of these.
- session, identifying areas for improvement and schedule the correct training. We asked the service to bring 10 staff files to the inspection for review. However, we did not receive this information and therefore did not see evidence of reflective sessions.
- The service had a 'Whistleblowing' policy due for review in May 2018. It outlined the process for staff to follow if they wanted to raise serious concerns. However, the policy failed to clearly signpost employees to the correct organisations if they did not wish to raise their concern internally.
- The registered manager reported staff regularly visited the station informally to catch up with other members of staff. This showed staff actively engaged with the service.
- The service had an 'Equality and Diversity' policy due for review in May 2018. The provider used this policy for both the regulated and the non-regulated activities. It outlined the responsibilities of the organisation and staff to ensure no direct or indirect discrimination occurred within the business.

Public and staff engagement

- The service kept patient feedback forms within the vehicles. The forms allowed patients to provide feedback following receipt of care at events. These forms were available in the vehicle we inspected and asked patients or their relative to rate Medic 1 Direct Ltd on key aspects of care such as listening and response time.
- The registered manager told us the service received thank you cards and postcards from patients who had received treatment. The service displayed cards on the noticeboard within the staff room and the managers provided feedback to named individuals.
- The service contacted contractors by telephone, emails, face to face at training and social activities. This ensured the service kept staff from remote locations engaged.
- The service received feedback and comments from event organisers who they had worked with which was shared with staff.
- All employed staff attended monthly team meetings. The meeting minutes for August, September and October 2017 showed the standing agenda included vehicles, development and training. This meant the service could disseminate updates and changes to practice to large numbers of staff at once.

Innovation, improvement and sustainability

- The service was developing an internal electronic system, which would improve the accessibility of records and enable further analysis and oversight.
- The service had an Environmental policy due for review May 2018. It outlined the organisation's commitment to minimise the environmental impact of their work by using a number of initiatives such as recycling materials and purchasing environmentally responsible items.

Outstanding practice and areas for improvement

Outstanding practice

We saw one area of outstanding practice during the inspection, which affected the regulated activity. The service used advance technology to track kit bags and vehicles. It enabled the event control room to deploy the nearest team to the patient. This meant staff with the correct equipment and skill could deliver emergency treatment to the patient without delay.

Areas for improvement

Action the hospital MUST take to improve

- The provider MUST ensure all staff understand their responsibilities in relation to the duty of candour.
- The provider MUST review the completeness of its organisational risk register.
- The provider MUST ensure staff use appropriate translation services for patients.

Action the hospital SHOULD take to improve

Outstanding practice and areas for improvement

- The provider SHOULD review the knowledge of staff to identify and report incidents.
- The provider SHOULD review the recording of informal staff training, observations and spot checks.
- The provider SHOULD ensure the generic text in the adult safeguarding policy is updated to be relevant to the service.
- The provider SHOULD ensure patients and their families are aware of how to raise a complaint.
- The provider SHOULD establish an audit programme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users must- (a) be appropriate, (b) meet their needs and (c) reflect their preferences. Staff did not have access to translation services.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Senior management lacked understanding of the duty of candour and there was no organisational policy for the duty of candour.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to- (a)assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

This section is primarily information for the provider

Requirement notices

The provider's risk register did not reflect a full assessment of organisational risks and actions taken to mitigate these risks.