Devon & Cornwall Ambulance Service Ltd

Devon & Cornwall Ambulance Service

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

Devon & Cornwall Ambulance Service is operated by Devon & Cornwall Ambulance Service Ltd. The service offers ambulance transport under the regulated activities of:

Transport services, triage and medical advice provided remotely.

Treatment of disease, disorder or injury.

The service also provides outside of CQC scope event cover and medical repatriation. In England, the law makes event organisers responsible for ensuring safety at the event is maintained, which means that event medical cover comes under the remit of the Health & Safety Executive. The activities at Devon & Cornwall Ambulance Service regulated by the CQC are transport services, triage and medical advice provided remotely and the treatment of disease, disorder or injury.

The non-event service at Devon & Cornwall Ambulance service is small. The service had been registered with CQC on 14 April 2018 and the management told us they had undertaken approximately four journeys since then. These had all been transfers of patients to their homes, from a variety of locations. We requested information from the provider regarding the scale of the service, but this was not provided. The provider does not have any commissioning agreements and no formal written service level agreements with other providers.

Following concerns raised with us we carried out a focussed unannounced visit on 14 May 2018 and looked specifically at the areas of safe and well led. We inspected this service using our focused inspection methodology.

Throughout the inspection, we took account of 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 issues that the service provider needs to improve:

- There were no systems to record and receive feedback from incidents. Learning from incidents was not evident. There was no evident track record for patient safety.
- There was no evidence that mandatory training was completed to keep patients safe.
- There were no systems, processes or practices available to allow frontline staff to report adult and children safeguarding incidents.
- An adequate standard of cleanliness and hygiene was not maintained and so placed patients and those involved in the service at risk of cross infection.
- We found the provider did not have a safe management and administration system for ensuring all clinical equipment was working properly.
- There was no audit or checks to establish consumable items and sterile supplies were in date and safe for use.
- There was no audit trail of where the above equipment had come from and stock numbers would indicate they had all come from different batch sources.
- The management of medicines was inadequate and unsafe. This included the records of how and when medicines were obtained, records of administration and disposal, stock checks and security.
- The storage of medical gas cylinders was not safe and secure and placed staff and patients at risk.
- Patient records were not stored securely and risked a breach of patient confidentiality.
- The assessment of patient risk was not completed and so patient safety could not be assured. There were no assessments and safety checks for monitoring and managing risks to patient and staff safety.

Summary of findings

- Skill mix and how competencies were maintained were not available and so patient safety could not be assured.
- Recruitment procedures to ensure the safety of service users were not recorded.
- The director of operations was unclear about how auditing at the company took place and so quality measurement and assessment of the service was not undertaken.
- There was a lack of processes to assess, monitor and mitigate the risks relating to the health and safety and welfare of patients and others.
- The leadership team did not have the capability to run the service effectively due to the lack of understanding of responsibilities, scope and use of governance.
- There was no evidence that culture of the service was part of the director's focus or direction.
- There were no systems to seek the views of the public and staff about the service available. There was no evidence or assurances Devon & Cornwall Ambulance was engaging with the public or its staff.

As a result of the above, CQC urgently suspended registration of the following regulated activities until 15 August 2018 to allow the provider to address the issues identified at the inspection:

Transport services, triage and medical advice provided remotely.

Treatment of disease, disorder or injury.

This means the provider cannot carry out these regulated activities. We will re-inspect the service before this date to gain assurance that sufficient progress has been made to ensure the service meet standards of quality and safety, before lifting the suspension of registration.

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. Details are at the end of the report.

Amanda Stanford
Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Devon & Cornwall Ambulance Service is operated by Devon & Cornwall Ambulance Service Ltd and has one ambulance. The service provides a patient transport service to a range of places including hospitals, clinic appointments and their homes. The service provides a repatriation service from air ambulance flights to hospitals. The service has been registered with CQC since 14 April 2018 and had undertaken approximately four journeys.

Devon & Cornwall Ambulance Service

Detailed findings

Services we looked at
Patient transport services (PTS);

Detailed findings

Contents

Background to Devon & Cornwall Ambulance Service

Devon & Cornwall Ambulance Service is operated by Devon & Cornwall Ambulance Service Ltd and undertakes the following regulated activities:

Transport services, triage and medical advice provided remotely.

Treatment of disease, disorder or injury.

The service was registered with CQC in April 2018 and so has not been inspected previously by CQC. It is a small independent ambulance service located in Bude,Cornwall. The service has one ambulance and a small staff team with the only permanent staff being the management team. The service covers the south west and wider country with patient transport and from air ambulance locations to hospital or home. The service provides events cover, which is not within the scope of this inspection.

The service has had a registered manager Mr Jamie Sprake, in post since April 2018.

Our inspection team

The team that inspected the service comprised two CQC managers,a CQC inspector, and a specialist advisor with expertise in ambulance services. The inspection team was overseen by Julie Foster, Inspection Manager and Mary Cridge Head of Hospital Inspection.

Facts and data about Devon & Cornwall Ambulance Service

During the inspection, we visited the base location which was the home address of the registered manager. There was no specific administration office, equipment store, staff facilities or cleaning store. On street parking was used for the one vehicle.

We spoke with one member of management, the director of operations, as no other staff were available. We did not have the opportunity to speak with any patients or relatives.

We looked at the one ambulance in use and we reviewed four patient records.

During our inspection, we reviewed five sets of staff records and interviewed the director of operations. Activity from April 2018 to May 2018 was approximately four patient transport journeys. We requested specific information regarding those patient journeys; we were told that detail was not available for our review. The four patient journey records available in paper form showed only one was within CQC scope of review.

We also requested information about safety performance, complaints, and other performance and governance arrangements; however none of this

information was available. The provider's track record on safety and complaints was not available. No incidents or complaints had been reported to the provider, this also included serious incidents and never events.

Patient Transport Services were arranged by on the spot purchase basis. There were no commissioned or contracted arrangements with any other provider. At the time of inspection, the main types of transfers the company was completing were long distance journeys.

The service employed a registered manager, a director of operations and three temporary staff. None of the temporarily staff were permanently employed or employed on a full time basis.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Patient transport services (PTS)

Safe	
Well-led	
Overall	

Information about the service

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The service employed a registered manager, a director of operations and three temporary staff. None of the temporarily staff were permanently employed or employed on a full time basis.

Patient transport services (PTS)

Summary of findings

We found the following issues that the service provider needs to improve:

- There were no systems to record and receive feedback from incidents. Learning from incidents was not evident. There was no evident track record for patient safety.
- There was no evidence that mandatory training was completed to keep patients safe.
- There were no systems, processes or practices available to allow frontline staff to report adult and children safeguarding incidents.
- The ambulance was not stored securely which allowed unobserved and unsupervised access from the public.
- An adequate standard of cleanliness and hygiene was not maintained and so placed patients and those involved in the service at risk of cross infection.
- We found the provider did not have a safe management and administration system for ensuring all clinical equipment was working properly.
- There was no audit or checks to establish consumable items and sterile supplies were in date and safe for use.
- There was no audit trail of where the above equipment had come from and stock numbers would indicate they had all come from different batch sources.
- The management of medicines was inadequate and unsafe. This included the records of how and when medicines were obtained, records of administration and disposal, stock checks and security.
- The storage of medical gas cylinders was not safe and secure and placed staff and patients at risk.
- Patient records were not stored securely and risked a breach of patient confidentiality.
- The assessment of patient risk was not completed and so patient safety could not be assured. There were no assessments and safety checks for monitoring and managing risks to patient and staff safety.
- Skill mix and how competencies were maintained were not available and so patient safety could not be assured.
- Recruitment procedures to ensure the safety of service users were not recorded.
- The director of operations was unclear about how auditing at the company took place and so quality measurement and assessment of the service was not undertaken.
- There was a lack of processes to assess, monitor and mitigate the risks relating to the health and safety and welfare of patients and others.
- The leadership team did not have the capability to run the service effectively due to the lack of understanding of responsibilities, scope and use of governance.
- There was no evidence that culture of the service was part of the director's focus or direction.
- There were no systems to seek the views of the public and staff about the service available. There was no evidence or assurances Devon & Cornwall Ambulance was engaging with the public or its staff.

Patient transport services (PTS)

Are patient transport services safe?

- There were no systems to record and receive feedback from incidents. Learning from incidents was not evident. There was no evident track record for patient safety.
- There was no evidence that mandatory training was to keep patients safe.
- There were no systems, processes or practices available to allow frontline staff to report adult and children safeguarding incidents.
- An adequate standard of cleanliness and hygiene were not maintained and so placed patients and those involved in the service at risk of cross infection.
- We found the provider did not have a safe management and administration system for ensuring all clinical equipment was that it was working properly.
- There was no audit or checks to establish consumable items and sterile supplies were in date and safe for use.
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- Recruitment procedures to ensure the safety of service users were not completed.

Incidents

- Systems were not available to record incidents and to review for learning to improve practice. Providers of care must ensure robust systems are available for recognising, reporting, investigating and responding to serious incidents and for arranging and resourcing investigations. We saw no evidence of any reliable systems, processes and practices to keep people safe. There was no policy or procedure for staff to follow for the reporting of incidents. We saw no evidence of how the provider would work with other organisations to review incidents and assess for wider learning.
- The management of the service did not demonstrate a clear understanding of their responsibilities for the safe management of incidents. There were no systems for staff to report incidents or to receive feedback from any incidents. Staff were not present at the time of our inspection, so we could not determine if staff understood their responsibilities to raise concerns, record safety incidents and report near misses.
- At inspection we requested information on safety performance but this was not available. This meant we were unable to look at the organisation's track record on safety, or establish what lessons were learned and improvements made if things went wrong.
- The employee handbook 2017/2018 noted that notice boards were a way to access news and information, the document states ' This is where you'll find up to date information so it's a good idea to keep an eye on your local notice board which are at head office and any fixed company treatment room'. On inspection we noted there to be no notice board, head office, treatment room or staff room available.
- We also noted that the handbook states 'We have quarterly business newsletters that is emailed to all staff and posted on the team Facebook page, it contains the latest headline news as well as interesting updates about the company'. No business letters were available for our review.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 duty of candour was introduced in November 2014. This Regulation requires organisations to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm that falls into defined thresholds. The director of operations could not describe the process within the service of duty of candour.

Mandatory training

- The management did not have assurance that staff were completing mandatory training to keep patients safe. Mandatory training records were not available and so it

could not be evidenced that staff were appropriately and safely trained to provide the service. We requested information on mandatory training during our visit, but this was not supplied.

- Staff training was not available as planned in the supporting workers policy. The policy stated that in house training and discussions are held every second month. There was no evidence that these events had taken place.
- The company policy for development and training noted that each member of staff has a personal development plan in which their training needs area identified and planned to be met. The provider did not meet their own policy as no such plans were available.
- There were no systems to check staff compliance with mandatory training or check completion rates. The employee guide and standard operating procedure 2017/2018 stated, 'We recognize it's our duty of care in providing statutory and mandatory training, and all employees must be aware that if any statutory or mandatory training topics are out of date, it may mean they cannot be rostered to work until they have completed the training'. The training records did not identify which areas of staff training were incomplete or out of date and as such the provider could not safely establish who had the current skills to be working or not working.
- There was no evidence that any staff had completed an induction to ensure their safety to work. The company policy for supporting workers stated all new members of staff receive an induction training programme. These records were not available and there was no evidence that the company met its own policy. The policy identified a person responsible for organising the induction process. This person did not work for Devon and Cornwall Ambulance Service.
- The employee guide and standard operating procedure 2017/2018 stated, 'At your induction you'll learn all the basics about working for Devon & Cornwall, such as health and safety and legal requirements'. No records were available and we were made aware of a staff member who had worked the previous day to our inspection who had not undertaken a recorded induction.
- Driver training records were not available and so we could not evidence that safety assessments and training had been provided to any staff.
- There was no evidence of specific training. For example, there were no assurances that staff transferring a patient with dementia had appropriate dementia training. We asked the manager if he kept records detailing any specialist training his employees had in order for him to allocate jobs accordingly. He advised us he did not.
- There were no staff available to talk to at the inspection, and so we were unable to ask staff if they thought the training they received was effective in relation to systems, processes and practices.

Safeguarding

- There was a policy to guide frontline staff to report adult and child safeguarding incidents. In line with the 'Statutory Guidance Care Act' and 'Working together to safeguard children 2015', the safeguarding policy stated procedures for recognising abuse.
- There were no protocols for safeguarding referrals in the event of work that maybe sub-contracted to or from other providers. This meant that there were no guidelines for staff to follow when working with other providers to ensure all patients were safe from harm.
- Staff training records for safeguarding adults and children were not available to ensure staff had the skills to keep patients safe. The inspection team requested evidence of staff safeguarding training, including details regarding the level of training and expiration dates, this information was not available. The safeguarding children and young people: roles and competences for health care staff Intercollegiate document 2014', states all clinical staff working with children, young people and their parents and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person must be trained to safeguarding children level 3, with non-clinical staff trained to level 2. However, there were no systems to check what level staff were trained to or whether training was out of date.
- We were told by the director of operations that staff worked for other ambulance companies and therefore received safeguarding training from their main employer. Records that would have confirmed the training and the level were not available to ensure staff were suitably trained.

Cleanliness, infection control and hygiene

- An adequate standard of cleanliness and hygiene were not maintained and so placed patients and those

involved in the service at risk of cross infection. We found that Devon & Cornwall Ambulance Service failed to meet the standards set out in 'The Health and Social Care Act 2008 Code of Practice of the prevention and control of infections and related guidance (2015)'.

- The standard of cleanliness in the ambulance was not acceptable and did not protect the public from the risk of cross infection. We saw a folder containing equipment checklists and cleaning logs. These were designed for use by crews at the start of each shift to record the completion of equipment checks and cleaning. We saw that only three had been attempted. None were fully completed to establish full cleaning had been undertaken.
- The condition of the ambulance indicated that Devon & Cornwall Ambulance Service was non-compliant with legislative requirements. We inspected the vehicle in use and noted a number of issues of concern. On the day of inspection we found the ambulance had not been cleaned since use on the previous day. It was visibly dirty; we found areas of thick dust on surfaces. Debris such as dirt, dust and discarded medical packaging was on the floor of the vehicle. We also found splatters of brown matter of unidentifiable origin, on the floor, door, walls and medical equipment. Seating and the trolley within the vehicle were visibly dirty and sticky. Reusable equipment such as splints and slide sheets were visibly dirty. Equipment including patient trolleys and chairs did not have cleaning labels.
- Management of hygiene and cross infection was not adequate. Records of compliance with cleaning schedules were not available. The company infection control policy stated that the operations manager was responsible for implementing infection control procedures. The policy also stated that the ambulance must be cleaned between each patient journey and have a comprehensive weekly clean. The director of operation was named as the person who provides leadership and supervision of infection control procedures and ensures good housekeeping standards are applied. The director of operations told us the vehicle was cleaned daily, however, due to the unclean state of the vehicle; it was evident that cleaning had not taken place.
- The company's infection control policy was not adequate to identify actions to ensure infection control. The Health and Safety Executive (HSE) states health and safety policies, such as infection control, should be reviewed "At least once a year". The review process should, examine whether the health and safety policy reflects the organisation's current priorities, plans and targets. The policy 'infection control' dated November 2017 was incomplete and did not demonstrate that reliable systems were available to prevent and protect people from healthcare-associated infections. There was no infection control cleaning schedule and no evidence of when the vehicle and equipment had last been cleaned, or when it was next due.
- The infection control policy also detailed procedures that the service was not qualified to undertake, for example insertion of a urinary catheter or use of commodes. This inclusion in the policy would misinform staff of the scope of their role.
- The inspection team requested details of waste transfer notes, these were not available. Therefore, there were no assurances that waste management was being handled safely, audited and reviewed.
- Storage and management of cleaning materials was not suitable or adequate. During the inspection, we asked to see where the cleaning materials were stored. We were initially told they were locked in a cupboard, and the director of operations did not have access to them; however he also told us it was his responsibility to clean the vehicle that day. It was not clear how he was to do this without access to the cleaning cupboard. We found the cupboard was open; this was the same cupboard as where the provider kept all paperwork, along with other household items, including dog toys and non-related household items such as the vacuum cleaner. Cleaning materials consisted of one bottle of lemon disinfectant.
- There was no evidence of how the provider was managing waste segregation. We were taken to a shed at the back of the property and told this was where the other cleaning equipment was stored; this consisted of a mop bucket in very poor condition, which contained snails and cobwebs, and its condition would indicate it had not been used for some considerable time. The mop handle was broken and the mop head was visibly contaminated.
- We saw no segregation of cleaning mops or cloths and buckets. There were no cleaning schedules or advisory signs. This was not compliant with the Department of Health, 'Health Building Note 00-09: Infection control in

the built environment', which states that storage areas should be separate from clinical areas, that waste, laundry and cleaning equipment should be stored separately to protect form damage and contamination.
- The company infection control policy noted plastic aprons or gowns were outlined as a standard precaution. The provider was not meeting its own policy. Personal protective equipment (PPE) such as gloves were available but aprons were not seen, which meant there was no assurance staff were protecting themselves and patients from transfer of infection.
- We saw clean linen in one vehicle. We were told by the director of operations that dirty linen was washed in the family washing machine. This did not ensure that risks of cross infection had been considered.

Environment and equipment

- The ambulance was not stored securely which allowed unobserved and unsupervised access from the public.
- When we arrived for the unannounced visit we found the vehicle had been parked outside the registered address, which was on a residential street. The vehicle had been left unlocked and the inspection team were able to gain access to all areas of the vehicle, including medicines and equipment, for twenty minutes before being noticed. The director of operations told us the vehicle was usually stored on a locked compound with CCTV cameras and secure access. However, we were later told that they no longer had a lease for the secure compound.
- The base for the delivery of the service was the provider's own home and did not have a designated space for administration, equipment, management or crew. There was no separate office or storage space and no facilities such as a staff toilet or shower facilities available.
- The provider advertises the service as a patient transport service, however they were using an emergency designed ambulance, and therefore there was no provision to carry anyone in a wheelchair, as there were no means of securing it.
- The employee handbook 2017/2018 states 'It is the duty of Devon & Cornwall Ambulance Service to provide and maintain safe systems of work and equipment'. Stock equipment for the ambulance was in various cupboards with other belongings of the family residing at the home, there was no segregation to ensure cleanliness or identification for staff of which cupboards were for ambulance service use.
- There were no records available to evidence that the service monitored and manages faulty equipment or vehicles. We requested to see copies of any audits for equipment and service and maintenance records but these were not provided. Therefore, there were no assurances that equipment was being audited and maintained to ensure safety.
- There was no safe management and administration system for ensuring all clinical equipment was working properly. There was no record of a list of clinical equipment maintained by the provider, equipment location, when calibration was due or that this had been completed. We found medical equipment which had no evidence of any safety checks being undertaken. For example, the Automated External Defibrillator (AED) and suction unit. The ambulance had a defibrillator in the ambulance cabin, this had no battery and so was not suitable for use. Equipment was not all suitable for purpose, moving and handling equipment, trolleys and seats were seen to be available for adults but we did not see any relevant equipment available for children.
- There was no audit or checks to establish consumable items and sterile supplies were in date and safe for use. Consumable items and sterile supplies were stored in the vehicle, not all the items were in date and some of the packaging looked visibly soiled. There were needles, suture and cannula equipment available (a small tube used to deliver fluid or medicine directly into a patients arm), some of which were out of date with an expiry date as far back as 2014. There was no clear identification of who had the skills and competence to use this equipment. We saw biohazard equipment available but it was all out of date and so no longer suitable for use.
- There was no audit trail of where the above equipment had come from and stock numbers would indicate they had all come from different batch sources.
- There was no documented evidence available that vehicle checks and servicing scheduling was planned and recorded. We saw evidence that the vehicle had been serviced in January and May 2018. However, no schedule of servicing was planned.
- There were no records of daily oil checks, tyre temperatures of observational checks of the ambulance

to ensure its safety for use. We saw three vehicle check records. None of the forms were fully completed and the mileage records did not follow a consecutive number to ensure correct records were being maintained. One of the three records seen noted that the blue light siren was not working, consecutive records did not note this and there was no record of repair. It was also noted that no staff had emergency driving training for the use of blue lights and sirens.

- Maintenance of the ambulance was not recorded. The safety and suitability of premises policy stated that 'we pride ourselves on the ongoing attention to detail with regards to maintenance of the fleet'. We were told the only incident the service had encountered since inception related to a breakdown on the motorway, caused by a lack of fuel, which according to the director of operations was caused by a faulty fuel gauge. We requested evidence of the investigation into this, and evidence that the fuel gauge had been repaired. We were not provided with any evidence of either of these as requested. The director of operations said their policy had been changed to ensure vehicles fuel supply did not drop below half full, however we did not see this in the policy.
- On the vehicle during inspection, we found a fuel can stored next to oxygen and nitrous oxide cylinders. The fuel can had evidently been used to carry fuel, however was currently empty. The storage next to medical gases was not risk assessed or considered for its safe storage.

Medicines

- The management of medicines was inadequate and unsafe. The management of medicines policy (Revision 01/2017) was available for staff. The policy identified a list of medicines covered by the policy. Only seven of the medicines were available in the ambulance and of those there was no evidence that any of the permanent or temporary staff had the training and skills to administer them. There were no clear records or policy to identify who was trained and competent to administer the drugs accessible in the ambulance. The director of operations told us that no medicines had been administered.
- Security of medicines was not safe. We found adrenaline, a prescription only medicine (POM) and other frontline drugs in an unsealed paramedic pack left in the rear of a response vehicle. The vehicle was seen to be unlocked and accessible in a residential area. It was observed that children playing in the area could have accessed the ambulance without any restriction and had immediate access to these medicines.
- The record of how medicines were obtained was not available and so not identified if the route was safe or legal. The director of operations told us they had no record of how the medicines had been supplied as they had been acquired from a previous employer. The medicines were prescription only medicines and so needed to be correctly prescribed and authorised, these were not. The named staff member lead for medicines was not employed permanently or full time by the service and no references or current police check was available for them.
- The systems identified for the procurement of medicines were not managed by an appropriate member of staff. The director of operations and the management of medicines policy identified a trained nurse, not yet permanently employed with the service as the medical director. The role of medical director must be undertaken by a person with a medical degree and so this person did not have the right qualifications or authority for this role. The management of medicines policy noted that this person was responsible for the procurement of medicines. The policy also identifies that a standard operating procedure will document the method of supply from the pharmaceutical supplier to the authorised staff. This standard operating procedure was not available.
- The managements understanding of the administration of prescription only medicines was not safe or within the companies own policy. Two adrenaline pre filled syringes were stocked in the ambulance, we were told these were the director of operations own medicines, prescribed for him but he was using them as stock for the ambulance, this is not what the medicines were prescribed for.
- The rotation of medicine stock did not ensure medicines were in date. The management of medicines policy states that stock medicines must be rotated monthly to ensure medicines had not expired. Of the ten ampules of medicines seen, five of the ampules had expired. Medicines administered after their expiry date may be ineffective.

- The management of medicines policy noted that out of date medicines should be stored in a locked cupboard, separated from medicines available for use. The provider was therefore not meeting their own policy.
- There was no record of when and how medicines were checked for expiry and logged as stored. We asked the director of operations how often they were checked and he said they were checked each time the ambulance was used. This was not recorded as checked. We asked how many ampules the ambulance had of a medicine called Naloxone; he thought there were two when in fact there were seven. This identified a lack of awareness of how many medicines were available and that checks were not undertaken.
- Practices for medicines for children were not clear or safe. There were purchased over the counter medicines for children. There was no medicines policy available for children's medicines; this meant that there was no clear policy for staff to follow. Not all of these medicines were in their original boxes and so we could not establish if they were within their expiry period and so safe and effective for use.
- The storage of medical gas cylinders was not safe and secure and placed staff and patients at risk. The vehicle had two cylinders of medical gas and one cylinder of oxygen; all were visibly dirty and stored insecurely. This indicated that the provider had failed to follow nationally recognised guidance such as 'the code of practice 44: the storage of gas cylinders (2016)' and 'Technical information sheet 36 (2017)' from the British Compressed Gases Association. There was no audit or record of where the oxygen or medical gases had been obtained from, this meant that any recall or audit was not possible. There were no records of when they had been used; this did not provide a clear audit trail to ensure any usage was recorded.
- One unsecured medical gas cylinder was found in an ambulance cupboard alongside a fuel can which had evidently contained motor fuel. This was an unsafe practice.
- There were no training records available to confirm which staff could or could not administer the medical gases.
- The management of medicines policy did not reflect the equipment available. The policy directs staff to measure oxygen saturation to calculate the level of oxygen to be given using equipment that the ambulance did not have. This would be misinformation for staff and not enable the staff follow the company policy.
- We saw that the disposal of medicines was not safe. The disposal box was open and the previously used and unopened ampules of a controlled medicine were evident and accessible. There were no records of how medicines were disposed of when no longer suitable for use. The director of operations told us they would put them down the sink which was not in line with their own policy.

Records

- Patient records were not stored securely and risked a breach of patient confidentiality. The provider's record policy said that Devon and Cornwall Ambulance Service adhered fully to the Data Protection Act 1998 where records should be kept in a confidential and secure fashion. The provider did not adhere to their own policy.
- The ambulance was left on a public road and was unlocked, discussion with the director of operations indicated that the vehicle had been unlocked all night. The presence of patient data indicated that the vehicle had not been checked properly at the end of a shift and leaving confidential medical information in a vehicle in this manner constituted a breach of regulations. This was brought to the attention of the director of operations during our inspection.
- The provider did not meet their own records policy and procedure. The employee handbook stated 'All employees within the Devon & Cornwall Ambulance Service are responsible for personal data to be kept secure, relative to the security level of the data e.g., keeping the data locked in a filing cabinet or room'. This was not seen to be the case and the provider did not adhere to their own instructions.
- The management and security of patient records within the location was not maintained. We were told by the director of operations that there was no access to the cupboard containing the patient's records. We then found the cupboard was unlocked, and the box containing the provider's paperwork did not contain any patient information. The director of operations was not able to locate where patients records were held and so could not ensure its security.
- Records were poorly completed and did not identify risk and record risk management. One of the vehicle folders

held four patient transfer records which included names, addresses and some health details. We looked at the four journey records for patients of which only one was within CQC scope of review. None of the forms were fully completed and two of the forms were not signed. We saw that details of patient care were minimal and did not identify risks and how risks were assessed and managed. We saw that when medicines were administered, details of the medicine, dose and any associated management were not fully recorded.

Assessing and responding to patient risk

- The assessment of patient risk was not implemented and so patient safety could not be assured. There were no assessments and safety checks for monitoring and managing risks to patient and staff safety.
- There were no systems or processes for detecting deteriorating patients during transfer. The provider did not have any clinical guidelines to recognise and manage patients whose condition deteriorated. The director of operations told us that staff would either have an escort who would deal with the deterioration or dial 999 for urgent assistance.
- The 'non-emergency patient transport request form' in use stated that the record should be used for each patient transfer; this record included key risk assessment questions such as the fitness, mobility, sensory/mental function and general health issues for each referral. We asked to see completed risk assessments for each transfer undertaken; the director of operations was unable to provide these, and said he did not know where they were. The records found in the ambulance for patient transfer did not include any risk assessments or detailed plans to manage risks.
- There was no available service criterion for accepting patients for transfer; this meant that patients may be accepted for transfer when they were not appropriate for the service provided. The director of operations was unable to demonstrate which types of patient transfers the service would or would not accept. We asked to see evidence of the transfer logs for this service, but the director of operations advised us this would be a laborious task as he would have to search through each one manually on the computer. We requested a review this information but it has not been provided.
- There is no mechanism for staff to seek senior support in the event of medical or other emergencies. There was no policy to support staff make decisions and seek advice in the case of medical emergencies.

Staffing

- Evidence of how skill mix and competencies were maintained was not available and so patient safety could not be assured. Training records were not overseen to ensure staff had the correct qualifications, training and updates to operate safely. This meant that appropriate skills could not be evidenced for each patient transport undertaken.
- The service had a policy relating to staffing but this did not set out the minimum standards of training expected, or the frequency of updates for that training to ensure patient safety. The director of operations told us that many of the staff worked for other providers, and therefore had access to training via that route; the service did not request or retain any evidence of this and therefore could not be assured that the training was in date or appropriate.
- The training evidence seen was not satisfactory or complete enough to evidence staff have been sufficiently trained to ensure patient safety. Training information for three staff in the form of certificates of completion were seen. These had all been completed by staff in previous employment and some were out of date, for example the safe driving certificate for the registered manager expired in 2014.
- Recruitment procedures to ensure the safety of service users were not followed. During the inspection, we were told by the director of operations there were two substantive post holders; one being the registered manager and the other the director of operations. Additional employees were bank staff, of which there were approximately four. We were not able to ascertain the exact numbers as the director of operations was unsure. We were told recruitment was 'ad hoc', with staff often recruited via social media for specific jobs. This method of recruitment did not enable the appropriate checks, or induction to be completed to ensure patient safety.
- The provider recruitment policy included a form titled 'Pre-Employment Checklist'. Of the eight staff employed only three had completed pre-employment checklists. None of these had been completed in full, with gaps and

omissions of references, qualifications and police checks. No staff members held a contract of employment or a job description to identify and confirm the scope of their role.

- There was no information about the remaining five members of staff and there was no evidence of relevant employment checks or screening having been undertaken. The director of operations told us that he had worked with some of the bank staff, and had personally seen their records and qualifications; however, he confirmed that the service held no written information about these staff.
- Police safety checks and references were not available and so patient safety could not be assured. We requested to see Disclosure and Barring Service (DBS) and employment checks, contractual and training information for all staff working for the provider. These were not available at inspection. Additional files were not available and the director of operations told us some staff recruitment checks had not yet been completed. One member of staff in the process of being recruited had worked the day before, and ahead of satisfactory employment checks having been completed. This did not ensure patient safety.
- The details included in the company insurance policy were not met. This meant that patients may be at risk if injured during transfer and may be unable to obtain compensation for this. The company's public liability insurance policy sets out that all new and existing employees and subcontractors are Disclosure Barring Service (DBS) checked or equivalent and have the appropriate qualifications and experience to undertake the business activity. No evidence of these checks and appropriate qualifications were available.
- Record management including storage and security was not implemented and staff data was at risk of inappropriate access. Information was stored in an open cupboard and contained the recruitment paperwork for only three staff members. The contents of the cupboard were disorganised, buried under household items, loose-leaf and not in any structured order. Staffing records were found accessible for one staff on the unlocked ambulance.
- We do not have any assurance that systems or processes to ensure the correctly qualified staff are driving the correct vehicles. This information was not available at the time of our inspection. For the size and wheel base of the ambulance a category C1 drivers licence would be required. The director of operations did not have category C1 status which would enable him to drive the ambulance. He told us he never drove the vehicle but was not able to provide details of the staff that were qualified to drive.
- Training records were not clear of the qualifications being stated. We reviewed the training record of a staff member who told us they had qualified as an Emergency Medical Technician (EMT); this was because they had attended a First Person on Scene course, which doesn't qualify them as an EMT. We saw an Immediate Life support (ILS) course certificate which included the prefix EMT (Emergency Medical Technician) with the persons name. The staff member used this title without evidence that training had been completed.

Anticipated resource and capacity risks

- There was no planning to manage any anticipated resource or capacity risks. The work undertaken was on a spot purchase basis and no commissioned contracts were held.
- There were no plans to manage staff skills to meet demand and so therefore there were no plans to manage foreseeable risk to ensure patient safety.

Response to major incidents

- No training or guidance was provided for staff of their actions in response to any major incident. We requested information on major incident training and business continuity preparedness prior, but this was not available.

Are patient transport services well-led?

- The director of operations was unclear about how auditing at the company took place and so quality measurement and assessment of the service was not available or provided.
- There were a lack of processes to assess, monitor and mitigate the risks relating to the health and safety and welfare of patients and others.
- The leadership team did not have the capability to run the service effectively due to the lack of understanding of responsibilities, scope and use of governance.
- There was no evidence that culture of the service was part of the director's focus or direction.

- There were no systems to seek the views of the public and staff about the service available. There was no evidence or assurances Devon & Cornwall Ambulance was engaging with the public or its staff.[

Vision and strategy for this this core service

- Staff could access the company values through the employee's handbook. We were not able to talk with any staff to identify if they had been involved with the development of the values or how they were upheld.
- The three core values were, every one of us makes a difference, customers are at the heart of everything we do and together we make things better. During our inspection, we did not see any evidence of promoting the company values, for example posters.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The director of operations was unclear about how auditing at the company took place and so quality measurement and assessment of the service was not completed. There were no key performance indicators used to measure the service being provided. We were informed the operations manager performed spot checks on the service, however the scope of these checks were not available and we were not shown evidence of findings or any resulting actions. Therefore, there was no auditing of patient transport services that could be described or produced.
- The environment at the base was disorganised and not suitable to successfully manage an ambulance service. There was no consistent system for checking the cleanliness and readiness of the vehicle by crew at the start and end of each assignment. We saw incomplete checklists and the state of the vehicle did not demonstrate the checklist had been used to ensure the quality and consistency of cleaning.
- There was a lack of processes to assess, monitor and mitigate the risks relating to the health and safety and welfare of patients and others. The company did not maintain a risk register or have access to a health and safety assurance. The operations manager was unable to provide explanations of how risks to staff and patients were identified assessed or detail any mitigating actions.
- There were no risk assessments for equipment, staff or patients. We saw no risk assessments for equipment such as ramps and chairs.

Leadership of service

- The leadership team did not have the capability to run the service effectively due to the lack of understanding of their responsibilities, safety management and use of governance to monitor and develop the service.
- The registered manager had started work in a full time position with another ambulance provider which meant his time to manage and lead the service would be limited.
- The provider does not recognise or ensure compliance with current regulation. The policies of the service refer to previous regulations and do not refer to the current legislation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Policies were recorded as being a first revision in 2017. The policy for assessing and monitoring the quality of the service notes staff must read the policy as part of their induction. This means that staff will be guided by the wrong legislation.
- The leadership of the service does not ensure that appropriate overview of social media is maintained. The employee handbook states 'There is a clear professional and reputable risk if company information, both comments and or photographs, if used inappropriately or without due consideration of the risks involved. The risks associated with any confidential information being disclosed or anything which identifies Devon & Cornwall Ambulance Service working environment can lead to a number of outcomes'. We saw social media site evidence of inappropriate pictures and comments made by staff whilst on duty for this service. There was no system to ensure this did not happen and action was not taken when this had happened. The employee handbook states that acts of gross misconduct included 'Inappropriate use of social networking sites that may include posting statements or personal opinion about the company, its business, customers, patients, service users all employees'. No action was seen in reference to the pictures made available on the social media site.
- The reputational risks for the company were not managed by the registered manager. The employee handbook noted as an act of gross misconduct included 'Convictions of a criminal offence that in the company's opinion may affect the reputation for its relationship

with its employees, service users or public, or otherwise affects the employees suitability to continue working for the company'. We were made aware of relevant criminal convictions of a staff member which would impact on the creditability and reputation of the service. No risk assessments had been completed or scope of work for that person to ensure the safe management of the service.

- The provider did not ensure the security of the ambulance and left the vehicle unlocked with medicines, equipment and records available. The safety and suitability of premises policy stated that the vehicle must be securely locked at all times that it is unattended. Therefore, the provider did not meet its own policy.

Culture within the service

- There was no evidence that culture of the service was monitored or included in how the service was developed. No staff were available to speak to on the day of inspection to ask about the culture of the service. There were no staff meetings to discuss the organisation and any changes or developments. There were no management meetings to establish a cultural focus or direction.

Public and staff engagement (local and service level if this is the main core service)

- There were no systems to seek the views of the public and staff about the service available. There was no evidence or assurances Devon & Cornwall Ambulance was engaging with the public or its staff.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- At the time of inspection there were no plans evident regarding the innovation, improvement and sustainability of the business.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Systems need to be implemented to identify, record and receive feedback from incidents. Learning from incidents must be undertaken and monitored to develop a track record for patient safety.
- Mandatory training must be implemented and recorded to keep patients safe.
- Systems, processes or practices must be implemented to allow frontline staff to report adult and children safeguarding incidents.
- Ensure an adequate standard of cleanliness and hygiene are maintained to reduce any risk of cross infection.
- Safe management and administration systems must be implemented for ensuring all clinical equipment works properly.
- Implement audits or checks to establish consumable items and sterile supplies are in date and safe for use.
- Ensure secure storage of the vehicle and its contents at all times.
- Put in place an asset register and database for scheduling repairs/safety checks
- Systems must be implemented to ensure management of medicines is safe. This included the records of how and when medicines were obtained, records of administration and disposal, stock checks and security.
- Ensure storage of medical gas cylinders are safe and secure and do not place staff and patients at risk.
- Patient records must be stored securely to ensure no breach of patient confidentiality.
- There must be an assessment of patient risk so patient safety can be assured. There must be assessments and safety checks for monitoring and managing risks to patient and staff safety.
- Ensure that skill mix and competencies must be maintained to ensure patient safety.
- Recruitment procedures must be completed to ensure the safety of patients.
- Auditing must be implemented so quality measurement and assessment of the service is available.
- Processes to assess monitor and mitigate the risks relating to the health and safety and welfare of patients and others must be implemented.
- The leadership team must have insight into how to manage services effectively to include understanding their responsibilities, scope and use of governance.
- There must be a consideration of culture of the service to improve director's focus or direction.
- Systems must be started to seek the views of the public and staff about the service available.

This section is primarily information for the provider

Enforcement actions

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **12**(1) Care and treatment must be provided in a safe way for service users. **12**(2)(a) assessing the risks to the health and safety of service users **12**(2)(b) doing all that is reasonably practicable to mitigate any such risks **12(**2**)** (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. **12**(2) (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. **12**(2)(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; **12**(2)(g) the proper and safe management of medicines **12**(2)(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated How the regulation was not being met • There were no systems, processes or practices available to allow frontline staff to report adult and children safeguarding incidents. • There were no systems to record and receive feedback from incidents. Learning from incidents was not evident. There was no evident track record for patient safety. • The assessment of patient risk was not competed and so patient safety could not be assured. There were no assessments and safety checks for monitoring and managing risks to patient and staff safety.

This section is primarily information for the provider

Enforcement actions

- There was no audit trail of where the above equipment had come from and stock numbers would indicate they had all come from different batch sources.
- The management of medicines was inadequate and unsafe. This included the records of how and when medicines were obtained, records of administration and disposal, stock checks and security.
- The storage of medical gas cylinders was not safe and secure and placed staff and patients at risk.
- We found the provider did not have a safe management and administration system for ensuring all clinical equipment was that it was working properly.
- There was no audit or checks to establish consumable items and sterile supplies were in date and safe for use
- Skill mix and how competencies were maintained were not available and so patient safety could not be assured.
- Recruitment procedures to ensure the safety of service users were not completed.
- There was no evidence that mandatory training was completed to keep patients safe.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1)** Systems or processes must be established and operated effectively to ensure compliance with the requirements. **17(2)(a)** assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) **17(2)(b)** 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

Enforcement actions

17(2)(c)maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

17 (2) (d) maintain securely such other records as are necessary to be kept in relation to— i. persons employed in the carrying on of the regulated activity, and

ii. the management of the regulated activity;

17 (2) (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

How the regulation was not being met

- The director of operations was unclear about how auditing at the company to place and so quality measurement and assessment of the service were not undertaken.
- There was a lack of processes to assess, monitor and mitigate the risks relating to the health and safety and welfare of patients and others.
- The leadership team did not have the capability to run the service effectively due to the lack of understanding of responsibilities, scope and use of governance.
- There was no evidence that culture of the service was part of the director's focus or direction.
- There were no systems to seek the views of the public and staff about the service available. There was no evidence or assurances Devon & Cornwall Ambulance was engaging with the public or its staff.
- An adequate standard of cleanliness and hygiene were not maintained and so placed patients and those involved in the service at risk of cross infection.
- Patient records were not stored securely and risked a breach of patient confidentiality.