Hearts First Aid Training Limited

Hearts First Aid Training 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 know 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

Hearts First Aid Training Limited, trading as Hearts First Ambulance Service provides repatriation services and patient transport services on an ad hoc basis.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on the 5 July 2017, along with a further unannounced visit to the service on the 17 July 2017.

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:

- All vehicles were of a high standard and maintained regularly by a reputable company. They were designed specifically in mind for the specifications of the services work.
- The compliance manager had commenced new processes and procedures since being in post from May 2017.
- Policies that were in place gave clear instructions for staff on their roles and responsibilities. Most of these were largely based on national guidance and recommendations.
- We saw that each member of staff completed local induction training on commencing employment within the service. The compliance manager or director would supervise the induction process.
- Staff completed training appropriate to their roles, responsibilities and the needs of the service.
- Staff had completed Mental Capacity Act training and were aware of their roles and responsibilities in ensuring consent and escalating concerns.
- Staff had received safeguarding training for children, level 2 and 3. There was a lead for safeguarding, who had completed level 4. We were given an example of a safeguarding referral they were currently referring and were assured of their processes.
- Facilities were appropriate to the needs of the service. Ambulances were secure.
- There was a clear vehicle maintenance log, which included MOTs and required vehicle services.

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

- Recruitment processes need to be more robust to ensure that legal compliance and consistency is maintained for all candidates.
- There was no framework in place for the service to describe its governance arrangements. We found that reporting arrangements to ensure effective information sharing were weak.
- There were no formal arrangements for clinical staff to receive annual appraisals.
- There was no formal risk register or similar tool used.

Summary of findings

- There was not an accompanying policy to inform staff what type of incident to report or what would be done once a report was received.
- The service had no formal policy or guidelines for the transfer of patients living with dementia or a learning disability.
- There were new policies in place, however, these were not clearly dated when created or when they were for review.
- There was no formal audit process or audit calendar in place, although we saw some evidence of audits that had commenced from June 2017.
- The service did not have a patient group direction for all necessary medicines used within the service. Staff had not all received competency checks for medicines administration.
- There was no process to monitor temperatures in the vehicles where medications were permanently stored.
- Mental Capacity Act training compliance for staff was at 66%.
- The service did not formally record any details of one to one discussions with staff or clinical supervision.
- There were no formal team meetings.
- The service did not have a formal vision or strategy.

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 four requirement notices that affected the patient transport service. Details are at the end of the report.

Edward Baker

Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Hearts First Ambulance Service is a medium sized independent ambulance provider. It runs from the town of Radlett, in Hertfordshire. The service had eight ambulances. These were all under 18 months old. They also had a specific ambulance designed for the transfer of bariatric patients. There were also two patient transfer ambulances with no monitoring equipment, two medical transfer cars, two 4x4 vehicles with stretchers and one response vehicle. The service employed seven registered paramedics, six technicians and one emergency care assistant full time. Bank staff were also used within the service. Cleaning regimes, mandatory training and appropriate vehicle and equipment maintenance were in place. However, the governance systems, relating to recruitment and managing risks were weak.

Hearts First Aid Training Ltd

Detailed findings

Services we looked at
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Detailed findings

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Background to Hearts First Aid Training Ltd

Hearts First Ambulance Service is an independent ambulance provider based in Hertfordshire and is operated by Hearts First Aid Training Limited. The service has been open since January 2008 and operates from one location. Hearts First Ambulance Service primarily completes repatriation of insured patients from European countries back to the UK. A smaller proportion of this work is private and NHS funded patients who need to be repatriated back to their home address or a receiving hospital. The service did not provide and emergency response service.

There are eight ambulances, classed as high dependency/A&E ambulances, two patient transfer ambulances with no monitoring equipment, two medical transfer cars, two 4x4 vehicles with stretchers and one response vehicle.

The service was in the process of changing their registered manager. At the time of our inspection the registered manager had been absent for over 28 days and the role was being carried out by the compliance manager who was completing their application to take over the role full time. The company director had a shared responsibility in the day-to-day running of the service.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and two further CQC inspectors. Julie Fraser, Inspection Manager, oversaw the inspection team.

Facts and data about Hearts First Aid Training Ltd

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.
- Treatment, Disease, Disorder or Injury.

During the inspection, we visited the ambulance base. We spoke with five staff including; registered paramedics and management. During our inspection, we reviewed five sets of patient records.

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

The service had been previously inspected in May 2013. The findings from the previous inspection were; they met the standards for care and welfare of people, assessing and monitoring the quality of service provision and records.

Activity (June 2016 to June 2017):

Detailed findings

- There were 1,739 patient transport journeys undertaken. From this number of total patient transfers, only a small number of patient transfers came under the CQC scope of registration. Sixty three per cent of these within scope, including one child, were transfers funded by the NHS.. The remainder were privately funded repatriations including one child.

There were seven registered paramedics, technicians, and one emergency care assistant employed full time by the service. There was also a bank of part-time staff. All the staff employed at the service had a minimum of five years' experience as a paramedic or technician within the NHS.

The service carried no controlled drugs on the premises or vehicles.

Track record on safety

- Zero Never events reported in the last 12 months
- The service had recorded three incidents since June 2017.
- Zero serious injuries reported in the previous 12 months
- Zero complaints from June 2016 to July 2017.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The service had introduced an incident reporting system in June 2017. This system was paper based and staff were required to complete the details on a designated form which would then be reviewed by managers. There was not an accompanying policy to inform staff what type of incident to report or what would be done once a report was received.
- We did not see evidence that managers within the service had received the appropriate training to investigate incidents.
- From June 2017 to July 2017 there had been 3 incidents reported: all of these related to vehicle faults. Incidents were not assigned with a severity.
- Incidents were not discussed within the management team and there were no mechanisms in place to allow feedback to staff if learning was identified.
- From March 2015, all independent healthcare providers were required to comply with the duty of candour regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The 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. Managers were aware of the duty of candour regulation but advised there had not been any incidents where this needed to be followed. The service had a policy in place that defined when the principles of duty of candour should be followed.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were well maintained within the service. We observed the premises and vehicles to be visibly clean on the day of our inspection.
- The service had an infection control policy in place and this contained details of staff responsibilities, guidance, and training requirements.
- We reviewed five vehicles during our inspection and found them all to be visibly clean throughout. Equipment contained within vehicles was also clean and stored to ensure it remained free from dirt or dust.
- The staff using the vehicles carried out daily cleaning. These included ensuring surfaces of trolleys and equipment were cleaned following use. We found that all vehicles had the appropriate cleaning equipment stored for staff use.
- Deep clean schedules were in place to ensure regular thorough cleaning of all vehicles. This involved equipment being removed and all internal and external areas being fully cleaned. We observed that these schedules were up to date and all vehicles had received a deep clean within the necessary time frame assigned by the service. If a vehicle became contaminated or very dirty during the course of its use, the vehicle would be returned for a full deep clean.
- Chemicals were stored securely and were appropriate for the service. Information relating to the control of substances hazardous to health regulations (COSHH) was available within the service and contained relevant details to ensure those using chemicals were able to do so safely.
- Mops for different areas of the service were not always segregated in line with guidance and we found mops were not stored out of buckets. Guidance on the areas which each coloured mop should be used in was visible within the service.
- The service provided appropriate waste disposal systems, which included domestic waste, clinical waste and sharps. The appropriate containers were in place during our inspection; however, some sharps bins did not always have the date of commencement of use recorded on them. This was not in line with national guidance for the safe management of sharps: Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- There were coloured bags in place for both general and clinical waste. Clinical waste storage bins were secure and were collected regularly by an external provider. We observed on two out of five vehicles that domestic waste bags had clinical waste within them.

Patient transport services (PTS)

- Alcohol hand gel was available on all five vehicles we reviewed.
- Staff were required to complete infection control training within the service. At the time of our inspection 73% of staff had completed the training.

Environment and equipment

- The service was located within a small shared business site. Ambulances were located onsite, with an equipment store attached to the address. The address had a designated office area with secure cupboard for records and business related files. The gate to the car park was open during office hours, outside of these hours the car park was secured. All vehicles within the car park were kept locked.
- Operations managers completed daily checks of vehicles to ensure they were suitable for use; this was recorded on a specific form and retained by the service. Staff were responsible for checking oil and water levels of vehicles prior to the commencement of a journey.
- We observed that all equipment was stored safely within vehicles, and that equipment had received a safety check within the previous 12 months. Stickers were visible on equipment that had been safety checked to advise staff when the next check was due.
- Records of services and electrical equipment test histories were kept electronically. The electronic record contained details of when each item of equipment required its next service. An external provider carried out services and electrical equipment tests. We saw evidence that equipment had been subject to electrical appliance equipment testing and had been calibrated.
- Equipment stores within the premises were organised and well maintained. However, some equipment was stored on top of cupboard, which was a safety risk.
- On all of the vehicles we reviewed, fire extinguishers were available and had received the appropriate check to ensure they were safe and suitable for use.
- All vehicles that were used for transporting wheelchairs had the appropriate mechanisms to secure them during transport. All vehicles has suitable seatbelts/lapbelts for use when transporting patients.
- Vehicles were maintained by an external provider or the vehicle manufacturer depending on the warranty status. We observed that all service histories, MOTs and insurances for vehicles at the location were up to date. The service kept electronics records of when vehicles were next due services and MOTs. Vehicles would go back to manufacturers as necessary for larger scale work. All five vehicles we reviewed were in working order and had no visible external damage or faults.
- The service occasionally transported children. Vehicles did not contain the necessary seat belts/restraints to ensure children could be transported safely. The service did have a baby car seat that was used to transport small children, however there was no record of how old the seat was or that it had ever received a safety check to ensure it was suitable for multiple patient use. We escalated concerns relating to transportation of children with the managers during our inspection. On our unannounced inspection, managers told us they had ordered an appropriate child harness and were waiting for its delivery. We requested confirmation of the delivery of the harness once this had occurred. A 'transfer of children' policy had been implemented, which included guidance of the use of seat belts and car seats.
- At the time of our inspection, the service did not have a complete fire safety risk assessment or procedure in place. An external company had been contracted to cover health and safety aspects of the service and were due to carry out a visit within the months following our inspection. We requested to view these once they had been completed. The landlord of the premises was responsible for the electrical wiring and building control certificates.
- Fire alarms were present in all areas of the service, however a record was not kept of how often these were tested and fire drills were not carried out. Managers advised us this would be reviewed following our inspection to improve fire safety within the service.
- Staff received fire safety training as part of their mandatory training, 85% of staff had completed this training.
- Fire safety signage was displayed throughout the premises and fire exits were easy to identify. Fire extinguishers were available within offices and storerooms.

Medicines

Patient transport services (PTS)

- There were appropriate systems in place regarding the safe handling of medicines; however, storage facilities of medicines did not always ensure their safety or suitability for use.
- All medicines were stored permanently on vehicles. Whilst these vehicles remained locked, they were located within a large shared area and medicines were not always stored in a secure way on vehicles, for example, the cupboard for storing medicines was not always locked. This was raised immediately to the director of the service.
- We also noted that during our inspection the vehicles were parked in direct sunlight resulting in increased internal temperatures. This meant that medicines maybe stored above the maximum level of 25 degrees Celsius, which may reduce their efficacy and safety for use.
- We escalated concerns relating to medicines storage with the service who advised us they would review this process. This was checked on the unannounced inspection, the medicines were locked on board the vehicles, however, they were still stored in the vehicle when not in use. This meant they could still be stored above the maximum temperature of 25 degrees Celsius during the summer months.
- Thermometers were in the process of being fitted within ambulances, however the service had not created a guideline to suggest maximum or minimum temperatures or what they would do if temperatures were found to be out of range.
- The service had a policy in place for medicines management, which reflected national guidance. This policy documented the steps necessary to ensure medicines were kept, administered and disposed of in a safe way.
- Medicines were ordered safely. This was carried out by the medical director.
- All medicines within the service were in date and this was monitored by operations managers.
- Staff had not received the necessary training in relation to managing and administering medicines according to their skill level. The service could not provide evidence that ambulance technicians had received competency checks for administering prescription only medicines (POMs). Following the inspection the service developed a medicines competency sign off sheet, 88% of staff had completed this. An email was sent to the remaining staff to sign during their next shift once they had received the training.
- The service used one medicine, used for pain relief, that was not part of the Joint Royal Colleges Ambulance Liaison Committee. The service did not have a patient group direction for this medication or any competency checks to demonstrate staff understanding of this medicine. Patient group directions (PGDs) are documents permitting the supply of prescription-only medicines to groups of patients, without an individual prescription. Healthcare workers using PGDs should be sufficiently trained to be able to supply and administer prescription-only medicines.
- Compressed gas cylinders, such as oxygen and Entonox, were stored securely and compliant with guidelines throughout the service and on vehicles.
- Medical gases were stored in appropriate fittings within all vehicles to ensure they were secure.
- The service carried a range of POMs, which were separated on vehicles into bags for paramedics and technicians to ensure only medicines that staff were permitted to administer were used. We reviewed order forms and disposal records for medicines within the service and observed these correlated with what the service had stored.
- There were two replacement medicine bags stored within the manager's office. We observed these were locked and only accessible by managers.
- The service did not utilise or store any controlled drugs.

Records

- A patient journey form was completed at booking and then transferred to the ambulance crew prior to the patient collection. If a patient was administered any medicines or deteriorated during transfer this was documented within the patient journey form.
- We looked at five patient record forms. These were all accurate, legible and contained appropriate information.
- Patient records were not stored securely within the service. We observed box files of historic patient records

were not kept within a locked cupboard and were kept on shelves located in an office that was accessible to any staff. We raised this with the manager who advised us this would be rectified immediately. On the unannounced inspection, patient records were found to be in a locked cupboard, which was only accessible to the director and compliance manager.

Safeguarding

- Policies were in place for safeguarding children, young people and vulnerable adults. We reviewed these policies and found that they did not contain the most up to date national guidance and some sections were unclear about how they related to the subject of safeguarding. We escalated this to senior managers during the inspection and were informed that a review of these policies was in progress and these concerns would be addressed.
- Safeguarding policies contained clear guidance for staff on how to report safeguarding concerns. If a concern was identified, this was reported directly to the provider's control room supervisor, who would then make a referral to the relevant local safeguarding authority. Flow charts were present throughout the premises to demonstrate the correct procedure to staff.
- Paramedics were required to complete level three safeguarding children training, with all other clinical staff requiring level two safeguarding training. This was in line with the Royal College of Paediatrics and Child Health (RCPCH) Intercollegiate document 2014. We saw evidence that 90% of staff had completed level two safeguarding children training and 88% of paramedics had completed level three safeguarding children training. The director of the company assured us that by the end of July 2017, 100% of staff will have completed the appropriate level of training for their role.
- All staff we spoke with understood their responsibilities to raise, record and report safeguarding concerns. Staff we spoke with provided an example of where they had identified a safeguarding concern and how they had reported it following the service procedure.
- **Mandatory training**
- Mandatory training was carried out by the service on topics including manual handling, equality and diversity, infection control and information governance.
- An external company who specialised in healthcare training provided the mandatory training. This was computer based and could be accessed from home. This was helpful for staff to complete who were working remotely.
- Compliance ranged from 66% to 85%. Since the inspection, mandatory training rates had improved.
- **Assessing and responding to patient risk**
- Risk assessments were carried out for patients at the point of booking. The operation managers who took bookings were aware of the individual risks associated with the patients they saw. The service did not have documented criteria in place to outline which patients would be suitable for the service or who would not be accepted. Managers told us that the operations managers received bookings so that each request could be dealt with on a case by case basis. If during a booking the operations manager was unsure if a patient was suitable then this would be discussed with the company director.
- Patient information, including their acuity, was provided to operations managers during the booking process. The appropriate crew level and experience was discussed with those booking the transport. We observed that the crews' experience level met the contractual requirements.
- Managers told us that the service usually transported clinically stable patients who were low risk. If a patient was deemed high risk this would be assessed and the journey refused if the service felt it was unsuitable for them to transport. The service did carry out high dependency transfers which were assessed clinically on a case by case basis to ensure the correct staff could be provided.
- If a patient deteriorated during transportation, the crew would either call 999 or transfer the patient to the nearest A&E department. There was not a supporting policy in place to advise staff what to do if a patient deteriorated.
- The service did not transfer patients detained under the Mental Health Act. Staff received training on reducing the need for restraint in health and social care, 66% of staff had completed this. The director told us that staff would not restrain patients or relatives.

Patient transport services (PTS)

- **Staffing**
- The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of safe care and treatment on the day of our inspection.
- The service employed 14 members of full-time staff. This included the director, who was the owner of the service, with a compliance manager and four operation managers. The remaining staff were paramedics, technicians and one emergency care assistant.
- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. We saw that rotas and shift patterns were aligned to demand. The service could not provide timesheets or evidence to show that staff working hours adhered to the Working Time Directive, allowing adequate breaks between shifts. This was discussed with the director and compliance manager during our inspection. During our unannounced inspection, we found a new timesheet for staff had been implemented and the policy had been updated outlining that staff needed to complete timesheets accurately.
- The service utilised bank staff, these members of staff were still employed at a NHS ambulance service or retired and would work on an ad-hoc basis.
- The staff were supported out of hours by the operation managers. Staff also had the director's phone number if any issues or concerns needed to be raised through the night.
- **Response to major incidents**
- Due to the nature of the service, they did not have a major incident plan or would not take part in any response to a local major incident.
- The service did not have a business continuity plan in place at the time of our inspection.
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- The service did not keep a record of completion of advanced life support training. Therefore we could not be assured that all paramedics had completed this training necessary for their role.
- An electronic record was maintained by the service of when staff would be due training, with reminders flagging to managers if a staff member was coming up to the expiration of a module. The majority of training was completed via an e-learning system.

Are patient transport services effective?

Evidence-based care and treatment

- We saw that most local policies the service had were largely in line with national evidence based guidance; however, none of the policies were dated or contained detailed dates for next review. The safeguarding policy was undated and did not contain complete current national guidance. On the unannounced inspection, we found that all policies had a review date and the compliance manager was in the process of including policy creation dates.
- The service did not complete formal audits. However, we saw evidence that cleanliness and the patient report forms (PRFs) had started to be audited daily since June 2017.
- Patients were assessed, their care planned and delivered in line with guidance and policy.
- We saw copies of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines, which staff could refer to when needed.

Assessment and planning of care

- The director of the service was informed of each patient's clinical condition at the time of booking. This enabled the service to provide the necessary equipment and staffing numbers/level.
- There was no formal patient criteria or guidelines used when booking a patient transfer. The management team told us that if they arrived to transfer a patient that was too unwell to travel and needed more support than they could provide, they would not carry out the transfer. Staff told us that this had happened previously, due to at time of booking the medical history of the patient not being given correctly.

Patient transport services (PTS)

- Bookings were usually carried out several days or weeks in advance, however the service did complete short notice transfers. They were always able to fulfil a short notice transfer.
- On the day of the patient journey, a PRF was started; these were kept in the vehicles and in the crew's staff room. These included relevant patient information and alerts to any necessary medical information, such as if the patient had diabetes or any requirements relating to their mobility. We reviewed five PRFs and saw that they were fully completed.
- Planning for the patient journey started with the booking call. Staff would make sure that the crews would have access to the patient's property and that the relevant equipment was available to take if needed, for example a wheelchair, which were available on all vehicles.
- Staff would make sure enough water was available for the patient's journey before they left the base. They did not use any formal nutritional assessment for patients.

Response times and patient outcomes

- As the majority of work completed by the service was the transfer of patients between locations, there were no defined patient outcome measures to record.
- Response times were not routinely recorded, as all transfers were pre-planned. However, we were told that adequate time was allowed for handovers, traffic problems, vehicle preparation and cleaning. The service told us there were never delays in transfers, but as the service did not record this data we could not be assured that journeys were always on time.
- The service did not undertake audits, which would allow it to assess if they were meeting the needs of the patient groups it served. We asked the provider for an audit policy and schedule, the provider informed us the service did not have these in place.
- The service did not benchmark itself against other providers. This meant that the service had been unable to measure its performance and determine outcomes for patients.

Competent staff

- We were told thatall staff had the appropriate qualifications for their role within the service.
- We reviewed 13 staff files and found references had not been requested. This meant the service could not be assured staff were suitable for their role. The main reason given was that the staff employed were known by the director from previous work within the NHS. However, since the inspection, all staff references have been requested, 33% had been returned by 19 July 2017.
- We observed that all seven paramedics had up to date details of their professional registration within staff files.
- All staff had the relevant driver training for driving ambulances safely.
- We saw that each member of staff completed local induction training on commencing employment within the service. The compliance manager or director would supervise the induction process.
- Two of the staff were registered trainers, so could complete training as required at the base, this would include refresher training on equipment, for example, bariatric stretcher and equipment.
- There was no appraisal system in place for staff that had direct contact with patients. Appraisals were only completed with administrative staff. Managers told us that training needs would be identified through informal discussions, although we saw no written records relating to these discussions. Since the inspection, the director told us they had put processes in place for yearly appraisals of permanent and bank staff.
- Driving licence checks were completed prior to commencement of employment and reviewed annually. We saw some staff had received 'blue light' training when they had worked previously within the NHS. The director was looking for a registered company who provided refresher courses in enhanced driving skills; this had not started at the time of the inspection. However, this is not a legal requirement.

Coordination with other providers and multi-disciplinary working

- Due to the majority of the services work being for large insurance companies for repatriation, there was minimal communication needed with other providers.

Patient transport services (PTS)

- The director told us that he was trying to promote the service to NHS trusts. This had resulted in an acute trust funding a transfer of a bariatric patient from their hospital back to the patient's home in another part of the country.
- One stakeholder told us that the service was always open about their ability to confirm the booking and their capacity to complete it when requested. Staff told us 'they always tell us whether something is out of their capacity, which enable them to find the right service from the start'.

Access to information

- The patient transfer crews had access to patient details such as, name, date of birth, address, pick up, and drop off locations. The service received a record of the medical condition of the patient and the reason for their transport.
- This information was present on the crews daily patient report forms (PRFs). We reviewed five PRFs that included all the relevant information needed for a safe transfer.
- Patient's vital signs were recorded on the PRF. Depending on the clinical presentation of the patient, staff had a full observation chart to use, or a small area on the PRF to document just one or two sets of observations. The chart included blood pressure, heart rate, temperature and respiration rate.
- Staff told us they were given clear reasons for the transfers they responded to and access to information on patient information.
- The service used satellite navigation systems. Vehicles were equipped with tracking devices to enable the manager and operation team to be aware of the location of all resources. Staff had mobile phones and radios for communication if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had an understanding of the Mental Capacity Act 2005. They understood that a capacity assessment might be needed for a person who was thought to lack capacity and stated that if they came across a situation where they had concerns the staff would seek advice from a manager or operation team.
- Mental Capacity Act training compliance for staff was at 66%.
- Staff understood their roles and responsibilities for gaining consent and told us that consent was obtained from patients prior to all interventions, treatments and journeys. This would be documented on the PRF. Consent was part of their Mental Capacity policy.
- Patients signed the PRFs to confirm consent for the planned journey.
- For young children, consent was sought from the parent or guardian in line with national guidance.
- If patients were travelling with a do not attempt cardio-pulmonary resuscitation (DNACPR) order, they would ensure that it had been signed within 48 hours with the patient, family and/or carer's involvement.

Are patient transport services caring?

Compassionate care

- We were unable to speak with patients or observe any patient journeys during our inspection. However, staff told us that they always treated all patients and their families with respect and dignity, the director of the service always told staff during their induction to 'treat patients as if they were your own family'.
- The service did not formally collect patient feedback. However, on the patient report forms there was a tick box to say if their care had been poor, good or excellent. Staff would ask the patient and then ticked the box. The service informed us they had not received any rating lower than "good" in the previous six months.
- We were told that staff did everything they could to make the patients journey as comfortable as possible and would always stop a journey for comfort breaks if needed.
- Staff told us that they maintained patient's dignity at all times during transfers. Staff would ensure the patient had their own clothes to wear, if not they had blankets available to use to conserve patients privacy and dignity.

Understanding and involvement of patients and those close to them

Patient transport services (PTS)

- Staff were able to demonstrate an understanding of patients' needs, giving examples of when care and journey details could be changed to provide a safe and comfortable journey. Due to the nature of the service's work, they would always ensure that a patient or relative was included in communication regarding journey times, airport pickups and travel across European country boarders.
- Staff told us that family were always welcome to accompany the patient if it was safe to do so.

Emotional support

- Due to the long distance journeys the service provided, the crews sometimes spent a lot of time with the patients. They were able to talk and provide support if this was needed.

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

Service planning and delivery to meet the needs of local people

- The service provided non-emergency transport for patients who needed to be repatriated from another country back to the UK; this was funded either by insurance companies or privately by the patient. The service also carried out ad hoc patient transport services for care homes or hospitals.
- The service would allocate the right number of staff based on the length of the journey and the reason the patient was being transferred. For example, if they were driving to Poland, then they would ensure there was four staff for the journey to be carried out safely, to enable breaks for the crew. The service used the European Union Driving Regulations guidance to ensure driver safety.

Meeting people's individual needs

- Services were planned according to the patients' needs during the booking process. A variety of equipment was available and additional staffing could be sourced according to the needs of the booking.
- All staff were provided with a user friendly multi-lingual pocket translation phrase book to help communicate with patients who spoke little English. This book contained pictures for common words and medical problems, such as level of pain and part of the body affected.
- The service had a specific vehicle to transfer bariatric patients, with a second vehicle on order. This ensured safe handling and transportation in comfort. If the staff had not used the vehicle or equipment recently, then they would have a 'refresher' session before they commenced the journey.
- All ambulances were accessible by wheelchair users via ramps and each vehicle carried its own wheelchair or carry chair.
- The vehicles had tea and coffee making facilities, water bottles and a DVD player on board each ambulance. The crews would also stop regularly for comfort breaks when needed. We were told that staff would also ask patients if they needed any shopping essentials before they got home, like bread and milk, due to patients returning home after a number of weeks abroad, then they would stop before they reached the destination to buy the essentials. This was outlined in the service's meeting nutritional needs policy.
- The service had no formal policy or guidelines for the transfer of patients living with dementia or a learning disability. However, staff would find out as much as possible from the patient and their family and/or carers. They would always ensure they had access to the patient's property and it would be safe once they had returned home.

Access and flow

- Emergency treatment or transfers were not provided by the service.
- Bookings were taken from the operations team and discussed with the director. There was no formal patient eligibility criteria. The director would decide whether the medical condition of the patient was suitable for their service to carry out.
- The only reason for not accepting bookings would be a patient's clinical condition. Otherwise, all patient journey requests would be accepted, even at short notice.

Patient transport services (PTS)

- Due to the specific type of pre-booked service provided, it was not necessary to record or monitor response times, on the scene times and turnaround times..

Learning from complaints and concerns

- The service had a complaints policy and a set procedure; named 'how to make a complaint, comment or compliment about us'. These documents outlined the process for recording complaints, escalating them and details of who patients can directly contact. The complaints manager was the director for the service.
- The document was in all vehicles for patients to have access to and on completion of their journey, they would be given a card detailing how to contact the service if they had any concerns or comments about the service.
- The service told us that they had no reported complaints from June 2016 to July 2017. The patient report forms contained a small feedback section for patients to complete and sign after a planned journey. We saw that feedback had been positive.
- We were told that patients being transferred by the service were informed of their right to raise concerns and were signposted to the Care Quality Commission and the Government Ombudsman. We saw evidence of these details in the 'how to make a complaint' document.
- The service provided no formal shared learning from complaints or feedback however we were told that they would be discussed informally at weekly handovers or via email if there was anything of concern to share with staff. We saw no evidence of this as we were told the service had not received any complaints.

Are patient transport services well-led?

Leadership / culture of service

- The service was currently going through a change of registered manager during the inspection. We found that the current registered manager had been away for more than 28 days. Providers must inform the Care Quality Commission of any absence by the registered manager which they had not done at the time of inspection, this was a breach of the Health and Social Care Act 2008 (Registration) Regulations 2009: Notification of absence 14 (1) (b). This had been completed since the inspection. The service compliance manager had submitted the relevant forms needed to be compliant and to apply to become the registered manager of the service as soon as we notified them of this. We were unable to speak to the current registered manager of the service.
- There was a director of the service and a compliance manager who had been in post since May 2017. When asked to see the director's personal file, we were told he did not have a formal staff file. The compliance manager did have a staff file, however it was missing the appropriate paperwork. We advised that a director needs to be compliant with the Health and Social Care Act 2008 (regulated Activities) Regulation 5, Fit and proper persons: directors. The director told us that this would be completed. On the unannounced inspection, we reviewed the director's and the compliance manager's staff file and found them to be complete with all the relevant information.
- The director and the compliance manager told us that they worked with an open and informal culture with their staff. All staff had the director's phone number and were told to contact him any time during the day if needed. There were also operational managers who covered the service over a 24-hour period, providing ongoing support and advice to staff who were out on patient transfers. Due to the time away from the base, this was important for staff to always have a point of contact if any issues or concerns were raised during the patients transfer.
- The service had access to a medical director who assisted with medicine supervision and procurement. The medical director had a substantive post in an NHS trust and maintained competence, training and appraisals through that provider.
- Both the compliance manager and the director were aware of the scope and limitations of the service, based on the size, numbers and type of work booked for.

Vision and strategy for this this core service

- The service did not have a formal vision or strategy. However, their mission was 'to provide the very best level of care together with a cost effective transport service to all patients from, or wherever they need to be transferred to'.

- Whilst there were plans to purchase two more vehicles to increase their fleet from eight vehicles to 10, there was no clear strategy for the service and no formal plan outlining their strategic growth.

Governance, risk management and quality measurement

- There was no governance framework in place within the service. We found that reporting arrangements to ensure effective information sharing were weak.
- The compliance manager was in charge of compliance, audits, incident reporting and medicines management. However, the review of these procedures and processes had only commenced when they were appointed in May 2017. We also saw no evidence of an incident policy, staff training in reporting incidents and no evidence of sharing lessons learnt with staff.
- Reporting of incidents were only formally recorded and reported since June 2017. The service did not have a system or process in place to identify and assess risks to the health, safety or welfare of people who use the service. There was no process for risks to be formally recorded or monitored. A risk register or similar tool was not used. We saw no evidence of a risk register, or similar, in place on the unannounced inspection.
- There was no audit strategy or plan in place for the service. This meant that at the time of inspection there was limited opportunity for the service to measure its quality.
- The new compliance manager had completed a policy on assessing and measuring the quality of the service, which all staff had to read on induction. It outlined a quality audit to be completed on an annual basis. However, this was not completed yet, as only started June 2017.
- All policies were new; however, they did not have a created or review date. This meant that no audit trail could be available for any updates so staff could be assured that they were reading the most up to date document. Policies were available for the staff to read, however, there was no process to evidence that staff had read them. This was reviewed on the unannounced visit and we found that policies had review dates. The compliance manager was in the process of including creation dates on each policy.
- The service did not hold any formal minuted staff meetings. The director told us this was done informally when he 'caught up' with staff at the base. On the unannounced inspection we were told that the service had held a staff meeting. We were provided with minutes of this meeting which showed topics discussed included; breaks on long distance transfers, uniforms and documentation on patient records. Meetings were then scheduled every two months, with all staff invited.
- There was a weekly handover meeting. This was attended by the director, compliance manager and operation mangers. The agenda included items such as, vehicle updates, staff updates, cleaning and general communication from the director to the team. These were minuted.
- There was a staff communication folder in the staff room outlining any necessary information or concerns from the management team. Staff were always reminded to keep their vehicles clean in each update.

Public and staff engagement

- There were no engagement mechanisms in place to allow staff to share their ideas or thoughts about the service.
- The service did not routinely engage with the public or its patient's to assess the level of service it provided. However, the short feedback on the patient report forms was positive and the service had received three letters complimenting the service and staff.

Innovation, improvement and sustainability

- The service planned to expand in the future although this was not supported with a strategic plan. It was envisaged that they would increase their ambulance fleet from eight to 10 ambulances. Managers told us they had the finance and staffing in place to progress this plan.
- The management restructure was underway regarding the new compliance manager. It was envisaged that this new structure would strengthen lines of accountability and compliance with regulations.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to the governance of the service. Such as the lack of incident management policy, no risk assessments or risk register, inadequate information in staff files, lack of participation in audits and lack of policies such as patients living with dementia.
- The provider must ensure that they inform the Care Quality Commission of the registered manager being absent for longer than 28 days.
- The provider must ensure the safe storage, management and temperature control of medicines.
- The provider must ensure all equipment used by the service is suitable for the purpose for which they are used, properly used and properly maintained.
- The provider must ensure all employed staff have a personnel files which contain the relevant recruitment and qualification information and are maintained and kept up to date.

Action the hospital SHOULD take to improve

- The provider should carry our annual appraisals on all clinical staff.
- The provider should ensure that patient group directives are in place for medicines not covered under JRCALC guidance.
- The provider should hold formal team meetings for staff to attend that are minuted.

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 14 CQC (Registration) Regulations 2009 Notifications – notice of absence The provider did not inform the CQC that the previous registered manager was absent from their duties for 28 days or more.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have an incident management policy, there were no risk assessments or risk register, there were inadequate information in staff files, there was no participation in audits and lack of policies such as consent and patient living with dementia .

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment There were not appropriate child safety harnesses to transport patients under the age of 16. A baby car seat was used for small children the provider was unable to provide evidence of safety check to ensure its suitability for use.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure the safe storage, management and temperature control of all medicines

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not ensure all staff have a personnel files which contain the relevant information, or were maintained and kept up to date.