Mr. David Ogden

Unit 1

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	Inadequate
Emergency and urgent care services	**Inadequate**

Summary of findings

Letter from the Chief Inspector of Hospitals

Unit 1 is operated by Mr. David Ogden . The service provides emergency and urgent care and a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 9 January 2019.

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.

We inspected the urgent and emergency care service we did not inspect the patient transport service .

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

- Policies in relation to clinical adverse incidents, non-clinical adverse incidents and adverse incidents with a third-party provider were out of date at the time of the inspection.
- The duty of candour policy was not dated and there was not a date when the policy became live and there was no review date.
- There was no evidence the service carried out any infection prevention control audits (IPC) audits.
- The service did not formally monitor and record adherence to infection control policies and procedures.
- There was no evidence of any vehicle cleaning audits and daily vehicle cleaning and deep cleans were not recorded.
- Five automatic external defibrillators (AEDs) were checked during inspection, three had no evidence of having been portable appliance tested (PAT) tested and one of the AED`s did not have a date when the machine was operational.
- There was no risk assessment for the storage of gas cylinders.
- There was no standard moving and handling equipment on board the urgent and emergency care ambulance such as a slide sheet, transfer board or slings for stretcher/chair transfers.
- During the inspection ten patient record forms (PRF`s) were reviewed. All the records were on headed paper that was in a previous company name. All the PRF`s had omissions including times, dates, signatures and professional designations, seven records omitted a pain score, nine records omitted allergy status, there was no evidence of deteriorating patient pathways, there was no evidence of national early score (NEWS) or modified early warning score (MEWS) and there was no evidence of any pathways being utilised. Six of the ten PRF`s had no hospital handover information recorded.
- There was no system for tracking the movements of medicines obtained by the service.
- There were no recorded audits of stock management or expiry checks, no evidence of daily controlled drugs checks and there was not a record of general stock rotation or expiry checks.
- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to ensure staff received an annual appraisal and recorded these. During this inspection there was no evidence the service had a staff appraisal system.

Summary of findings

- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to develop clear guidance for staff on the transfer of children not accompanied by a responsible adult. During this inspection we found no evidence the service had developed the guidance.
- The service did not have an induction procedure for new staff.
- There was no evidence the service held regular governance meetings which had a set agenda, with minutes and actions.
- Following the last inspection in December 2017 the service was given a must do action to improve the service which was, to develop a system for identifying, reducing and controlling risk. During this inspection we saw no evidence the service had a risk register and there was not a system for identifying, reducing and controlling risk.
- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to develop some clinical quality indicators related to the safety of the service and monitor performance against these. During this inspection we saw no evidence the service had developed clinical quality indicators.

However, we found the following areas of good practice:

- All staff mandatory training and safeguarding training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was.
- All the services` vehicles were on the ministry of transport (MOT) reminder service from the Gov.uk online system which sent out an alert e mail a month then two weeks before the vehicle service was due.
- The premises including the store rooms and medicine storage were visibly clean, tidy and well laid out.
- The medicines were stored securely within a locked store room. Separate medicine stores were further secured behind a locked cupboard.
- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to ensure staff completed training updates in basic life support and the use of automated electronic defibrillators. During this inspection we saw evidence staff had received this training.
- Following the last inspection in December 2017 the service was given an action it should take to improve the service which was, to ensure staff were provided with communication aids and a translation service to aid communication with patients who have difficulty in understanding English or have communication needs. During this inspection there was evidence of a multilingual phrase book available for patient's on board both ambulances we inspected.
- The ambulance we inspected had a supply of patient information/feedback forms, which briefly detailed how to make a complaint and provide feedback regarding the service received.
- Staff had to provide their driving licence details which were checked using the government internet licence check system.

Following this inspection, we told the provider that it must take 20 actions to comply with the regulations and that it should make 15 improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two enforcement notices that affected urgent and emergency care. Details are at the end of the report.

Name of signatory

Sarah Dronsfield

Head of Hospitals Inspections North East, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Inadequate 	The company provides urgent and emergency paramedic and first aid medical coverage at both private and public events. They had transported 22 patients from events to hospital during the reporting period. The company do not have a contract with any NHS or independent provider. Policies in relation to clinical adverse incidents, non-clinical adverse incidents and adverse incidents with a third-party provider were out of date. There was no evidence the service carried out any infection prevention control (IPC) audits or formally monitored and record adherence to infection control policies and procedures. There was no guidance for staff on the management of deteriorating patients. There was no evidence the service had a risk register and there was not a system for identifying, reducing and controlling risk. There was no evidence the service held regular governance meetings which had a set agenda, with minutes and actions.

Inadequate

Unit 1

Detailed findings

Services we looked at
Emergency and urgent care.

Detailed findings

Contents

Background to Unit 1

Unit 1 is operated by Mr. David Ogden . The service opened in 2010. It is an independent ambulance service in Skipton, West Yorkshire and operates throughout the UK. The company provides urgent and emergency paramedic and first aid medical coverage at both private and public events, as well as patient transport supplying one ambulance and crew per day on an “as required basis” to another independent ambulance provider. The patient transport service was not inspected.

The service was registered to provide the following regulated activities since 12 January 2018:

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

Mr David Ogden first registered with the CQC in October 2010. The service has had a registered manager in post since 2010.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, a CQC assistant inspector, and a specialist advisor with expertise in independent health company ambulance services. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Facts and data about Unit 1

The provider is an independent ambulance service in Skipton, West Yorkshire and operates throughout the UK.

The company name is Event Fire Services Ltd and the company trade under Oak Valley Events.

The company provided urgent and emergency paramedic and first aid medical coverage at both private and public events. When required the service transported patients from events for treatment in hospital.

The CQC does not currently regulate services provided at events. This element is regulated by the Health and Safety Executive. The part of the service regulated by the CQC is the urgent and emergency care provided by the service when patients are transported to hospital and patient transport.

The service is registered to provide the following regulated activities:

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

Detailed findings

During the inspection, we visited Unit 1. We spoke with three members of staff including; the registered manager, assistant manager and administrative assistant. During our inspection, we reviewed ten sets of patient records, six staff files, eleven polices and the staff handbook. We inspected two ambulances.

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 has been inspected three times, and the most recent inspection took place in December 2017 which found that the service was not meeting all the standards of quality and safety it was inspected against. Following that 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 two requirement notices.

Activity (December 2017 to end December 2018) for Urgent Emergency Care.

- In the reporting period December 2017 to end December 2018 there were 22 emergency and urgent care patient journeys undertaken.

Seven registered paramedics, six paramedic technicians, six emergency care assistants and four patient transport drivers were registered to work for the service. The accountable officer for controlled drugs (CDs) was the registered manager.

The service had six ambulances, one was PTS only, two were dual role ambulances and three were urgent emergency care ambulances.

Track record on safety

- No never events
- Clinical incidents none with no harm, none with low harm, none with moderate harm, none with severe harm, no deaths
- No serious injuries

One complaint received the matter was investigated and not upheld.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Inadequate	Not rated	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not rated	Inadequate	Inadequate	Inadequate

Emergency and urgent care services

Safe	Inadequate
Effective	Inadequate
Caring	Not sufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

The main service provided by this ambulance service was urgent and emergency care. Where our findings on patient transport for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the urgent and emergency care section.

The company provided urgent and emergency paramedic and first aid medical coverage at both private and public events. When required the services transported patients from events for treatment in hospital.

Summary of findings

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

- Policies in relation to clinical adverse incidents, non-clinical adverse incidents and adverse incidents with a third-party provider were out of date at the time of the inspection
- The duty of candour policy was not dated and there was not a date when the policy became live and there was no review date.
- There was no evidence the service carried out any infection prevention control (IPC) audits.
- The service did not formally monitor and record adherence to infection control policies and procedures.
- There was no evidence of any vehicle cleaning audits and daily vehicle cleaning and deep cleans were not recorded.
- Five automatic external defibrillators (AEDs) were checked during inspection, three had no evidence of having been PAT tested and one of the AED`s did not have a date when the machine was operational.
- There were no risk assessments for the storage of gas cylinders.
- There was no guidance for staff on the management of deteriorating patients.

Emergency and urgent care services

- During inspection ten PRF`s were reviewed. All the records were on headed paper that was in a previous company name. All the PRF`s had omissions including times, dates, signatures and professional designations.
- There was no system for tracking the movements of medicines obtained by the service.
- There were no recorded audits of stock management or expiry checks and no evidence of daily controlled drugs checks.
- There was not a record of general stock rotation or expiry checks.
- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to ensure staff received annual appraisals and recorded these. During this inspection there was no evidence the service had a staff appraisal system.
- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to develop clear guidance for staff on the transfer of children not accompanied by a responsible adult. During this inspection we found no evidence the service had developed the guidance.
- The service did not have an induction procedure for new staff.
- There was no evidence the service held regular governance meetings which had a set agenda, with minutes and actions.
- During inspection we reviewed 11 policies nine were out of date and had no version control. The duty of candour policy had no heading identifying it as a policy. There was no date when it became effective or when the policy was due for review.
- Following the last inspection in December 2017 the service was given a must do action to improve the service which was, to develop a system for identifying, reducing and controlling risk. During this inspection we saw no evidence the service had a risk register and there was not a system for identifying, reducing and controlling risk.
- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to develop some clinical quality indicators related to the safety of the service and monitor performance against these. During this inspection we saw no evidence the service had developed clinical quality indicators or monitored performance.

However, we found the following areas of good practice:

- All staff mandatory training and safeguarding training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was.
- All the services` vehicles were on the ministry of transport (MOT) reminder service from the Gov.uk online system which sent out an alert e mail a month then two weeks before the vehicle service was due.
- The premises including the store rooms were visibly clean, tidy and well laid out.
- The medicines were stored securely within a locked store room. Separate medicine stores were further secured behind a locked cupboard within the locked store room by a lock and key.

Emergency and urgent care services

Are emergency and urgent care services safe?

Inadequate

We rated **Safe** as inadequate because;

- The duty of candour policy was not dated when it became live and there was no review date.
- The service did not have a safeguarding policy.
- The safeguarding lead was not trained to level four for children.
- The provider did not produce any evidence of having carried out any IPC audits. The audits were requested during inspection. We were told by the registered manager the service did not carry out any IPC audits.
- The provider did not produce any evidence that demonstrated they formally monitored and recorded adherence to infection control policies and procedures.
- Five automatic external defibrillators (AEDs) were checked during inspection. Three had no evidence of having been PAT tested. One of the AED`s did not have a date when the machine was operational.
- During inspection ten patient records forms (PRF`s) were reviewed. All the records were on headed paper that was in a previous company name they were not completed fully with omissions including times, dates, signatures and professional designations.

However, we did find the following good practice;

- All staff mandatory training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was due.
- All the services` vehicles were on the ministry of transport (MOT) reminder service from the Gov.uk online system
- All visible equipment within the ambulance which was inspected was visibly clean at the time of inspection

Incidents

- During the inspection we reviewed policies in relation to clinical adverse incidents, non-clinical adverse incidents and adverse incidents with a third-party provider. While each provided guidance as to how incidents were defined, reported, recorded and dealt with, the policies were out of date having been required to have been reviewed in January 2018.
- The policies outlined the method of reporting incidents or near miss which was to use the incident report form (IRF), which was available on all vehicles. Staff were advised reports should not generally have been given verbally unless the incident was serious and required immediate management action, in which case the senior member of Unit 1 staff on duty should be contacted in the first instance, and the form completed later.
- The IRF`s contained prompts for all the relevant information required for investigation of an incident. Staff were advised ideally, the forms should have been completed as accurately as possible, ideally immediately after the incident as possible.
- Due to the nature of the urgent and emergency care work no operational staff were on station or deployed that we could speak to so we were unable to review the practical application of the reporting and review policies in respect of incidents or evidence levels of staff understanding. In addition, the service had not recorded any incidents in the reporting period that could be reviewed to evidence the policies and procedures had been followed.
- The duty of candour principles ensures every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must: tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong, apologise to the patient (or, where appropriate, the patient's advocate, carer or family), offer an appropriate remedy or support to put matters right (if possible), explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long-term effects of what has happened.
- During inspection we reviewed the services` duty of candour policy. The policy was not dated and there was no date when the policy became live and there was no review date.

- The registered manager we spoke with told us the service did not carry out any training in relation to duty of candour but the principles were in the company staff handbook which was given to staff when they joined the company.
- The handbook was reviewed during the inspection and information about the duty of candour principles was not part of the document. The provider did not produce any evidence as to how the service could check which staff had read and understood the duty of candour principles.
- The service had not applied the duty of candour as there had been no incidents when this would be required.

Mandatory training

- All staff mandatory training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was due.
- The registered manager told us if a staff member was marked red on the spreadsheet which indicated their mandatory training was not up to date they would not be offered any shifts until the training was completed. Staff whose paper files that were out of date or incomplete would also not be given shifts.
- The mandatory training requirements were equality, diversity and human rights; moving and handling; safeguarding; infection prevention and control and information governance.
- The service checked the Health and Care Professions Council (HCPC) database to confirm paramedics who worked for them were trained and registered. The dates the checks were made were recorded on the database.
- All the staff mandatory training appeared to be up to date. However, what was recorded on the training spreadsheet did not tally with what was recorded in the six staff files we checked while on inspection.
- The service was reliant upon the primary employer of the staff who worked on an “as required” basis for the service to provide mandatory training. When staff registered with the service they were required to provide current mandatory training certificates which were copied and placed in the staff files and recorded on the training spreadsheet.

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Safeguarding

- The service did not have a safeguarding policy.
- During inspection we saw evidence the registered manager who was also the safeguarding lead was trained to safeguarding level three which included deprivation of liberty standards and the mental capacity act.
- At the last inspection, the designated safeguarding lead who was the managing director had not undergone any extra training to complete this role or had arrangements in place via a service level agreement for supervision and appraisal of staff by a level four trained professional. The intercollegiate document March 2014 stated that the identified safeguarding lead should be trained to level four for children.
- The registered manager told us they felt they did not require level four safeguarding training due to the low levels of patient involvement in relation to urgent and emergency care.
- There was no evidence of a suitably trained identified deputy safeguarding lead being available if the lead was on leave or sick.
- Following the last inspection carried out in December 2017 the service was given an action to take to improve which was to ensure that safeguarding training for children was provided in line with Intercollegiate Guidance (2014). This included staff providing direct care and treatment to patients as well as the safeguarding lead.
- During this inspection was saw evidence the service had confirmed staff had been trained in line with Intercollegiate Guidance (2014).
- During the inspection we discussed the safeguarding referral process with the safeguarding lead they told us if the medical practitioner attending to the patient had concerns they would either submit a safeguarding

report via the accident and emergency department of the receiving hospital or if this were not possible they would submit a report to the safeguarding team at the local council. If either of this were not possible then the report would be submitted to the service's safeguarding lead.

- Depending upon the day of submission the referral could potentially take longer than the recommended 24 hours.
- There was no evidence the service had a form available for staff to complete when making a safeguarding referral. The safeguarding lead told us staff could provide written information on paper or e mail them.
- The service had made two safeguarding referrals in the 12 months preceding this inspection.
- The service did not provide safeguarding training but was reliant upon the primary employer of the staff who worked on an "as required" basis for the service to provide safeguarding training. When staff registered with the service they were required to provide current safeguarding training certificates which were copied and placed in the staff files.
- The registered manager we spoke with told us there was information in the company staff handbook which was given to staff when they joined the company in relation to safeguarding.
- The handbook was reviewed during the inspection and information about safeguarding was not part of the document. The provider did produce any evidence as to how they could check staff understanding or if staff had read the information in relation to safeguarding.
- Managers we spoke with told us because of the nature of event work when staff met the public who may have required medical assistance it would not be known if a protection plan was in place.
- Following the inspection, the service was provided with feedback in relation to issues of concern. The service responded by submitting a spreadsheet in relation to safeguarding reporting. One tab was entitled paper the other tab electronic. It was headed EFS ambulance. It was clear the spreadsheet had been copied from another provider as both tabs stated, once completed this form should be sent to the relevant authority and a copy to the duty manager / managing director. The service did not have a duty manager. There was nothing on the form stating the timescales for submission. There were no instructions as to whether the spreadsheet should be printed or emailed.

Cleanliness, infection control and hygiene

- The service had an infection prevention and control (IPC) policy which was in date available for staff to access on the intranet site. This was supported by policies on hand hygiene, the use of personal protective equipment (PPE), equipment cleaning and a vehicle hygiene policy. These included clear guidance for staff on managing patients with infections.
- The service did not provide infection prevention and control training but was reliant upon the primary employer of the staff who worked on an "as required" basis for the service to provide this. When staff registered with the service they were required to provide IPC training certificates which were copied and placed in the staff files.
- The staff handbook was reviewed during the inspection and information about IPC was not part of the document. The provider did not produce any evidence as to how they could check staff understanding or had read the information in relation to IPC
- The provider did not produce any evidence of having carried out any IPC audits. The audits were requested during inspection. We were told by the registered manager the service did not carry out any IPC audits.
- The provider did not produce any evidence that demonstrated they formally monitored and recorded adherence to infection control policies and procedures. The registered manager told us they checked adherence to hand hygiene on site and checked that cleaning procedures were followed but did not document this.
- Staff completed cleaning schedules for each vehicle and cleaned vehicles after each event. The provider did not produce any evidence which showed which cleaning products had been used to clean each vehicle and there was no evidence produced of any cleaning audits. The audits were requested during inspection. We were told by the registered manager the service did not carry out any vehicle cleaning audits.

- Cleaning equipment was available in the ambulance garage. A colour coding system was used which separated cleaning equipment that was to be used in different areas.
- The vehicle we checked contained evidence of having been deep cleaned after their last use and the manager told us they made checks that the cleaning was up to date but did not record this. Vehicles and equipment were visibly clean.
- The service used orange bags for clinical waste which were taken from the vehicle after each shift and placed within the secured clinical waste bin outside the main ambulance station garage.
- The service utilised separate sharps boxes for the safe disposal of medicines and sharps. There does not appear to be any record of expiry dates or frequency of changing sharps boxes.
- During inspection we saw evidence of three vehicle deep cleans completed on 16 May 2018, 31 July 2018 and 3 September 2018.The provider did not have a vehicle cleaning policy in place or carried out cleaning audits. We were unable to evidence compliance or non-compliance in respect of vehicle deep cleans in relation of frequency, IPC cleaning products used, standards of cleanliness and any action plans when the levels of cleanliness had fallen below standard.

Environment and equipment

- The building from which the service operated had internal and external CCTV coverage and external lighting covering the exterior of the building and car park.
- The ground floor had a small foyer and large first aid store with racks to store general equipment used on the ambulances. There was a small laundry room adjacent to the store room which led to another locked store room. At the rear of the building was a large garage area where the vehicles used by the service were stored. The first floor of the building had a general office, a large meeting/training room with an additional smaller office, and separate kitchen and toilet facilities. There was a mezzanine floor in the garage which was used as a general storage area.
- The premises including the store rooms were visibly clean, tidy and well laid out. The room used to store medical gases and packs of equipment used by paramedics was secured with locks and alarms.
- Access codes were required to enter the storage room. A further code was required to gain entry to the controlled medicines and to the key, opening the medicines cabinet/cupboard.
- The store room had not had its lock changed which meant staff did not hold different keys which may not have allowed them access.
- The controlled medicines safe had its code changed every six months. The registered manager told us this was reflected within a policy but was unsure which policy.
- Code changes were shared with staff via a telephone call from the service lead.
- A standard mechanical keypad lock was required to enter the store room. A further small mechanical lock and key were required to gain access to the medicine cabinet/cupboard. Medicines stored within the paramedic backpacks were readily available upon entry to the store room.
- There were no temperature check recordings for the monitoring of the store rooms stocks/medicines.
- On a wall in the first aid store room was a large board with hooks for vehicle keys next to the vehicle registration number and the dates when the MOT and service was due. A ministry of transport (MOT) is a test which, by law, must be made each year on all road vehicles that are more than 3 years old, to check that they are safe to drive.
- All the services` vehicles were on the ministry of transport (MOT) reminder service from the Gov.uk online system which sent out an alert email a month then two weeks before the vehicle service was due.
- Staff we spoke with told us the vehicle servicing was done at the end of the event season and a checklist was maintained by a local garage which alerted the service when a vehicle service was due.
- During inspection we inspected four bags used at events and four first aid bags. All the consumable items contained in the bags were in date.

Emergency and urgent care services

- Portable appliance testing (PAT) is the name of a process in the United Kingdom by which electrical appliances are routinely checked for safety. We inspected five automatic external defibrillators (AEDs) during inspection. Three had no evidence of having been PAT tested. One of the AED`s did not have a date when the machine was operational. The pads in all the AED`s were in date.
- Medical gases, oxygen and Entonox, were stored within the main storeroom. The cylinders were fixed against the wall to prevent falling. The registered manager told us there was a risk assessment for the storage of gas cylinders. This was not available at the time of inspection.
- Entry to the storage room required a keycode within a locked building. The room was dry, warm and well ventilated. Empty and full gas cylinders were placed within the same shelf, separated by hand written markings on the wall.
- The service used two national providers for supplying and taking away empty cylinders.
- All the medical gas cylinders checked on station at the time of inspection were within date.
- During the inspection two vehicles, an urgent emergency care ambulance and a PTS ambulance, were inspected
- The urgent and emergency care ambulance which was a spare vehicle was inspected. The inside of the ambulance appeared clean and tidy. Any notes, signs and checklists were laminated and wipeable in line with infection control national institute of clinical excellence (NICE) standards for cleaning.
- All visible equipment within the ambulance was visibly clean at the time of inspection. The following items were inspected, suction units, splint packs, defibrillators, general Personal Protective Equipment (PPE), general infection prevention control equipment. All were in date.
- The vehicle had a large sharps container situated within the rear of the vehicle. This sharps container was not labelled and contained used sharps. It was not known when the sharps box was first installed. It was not known when the sharps box would expire.
- At the time of inspection, the sharps box was loose, with no fittings or fixtures to prevent the sharps box becoming loose in the case of a vehicle accident. The registered manager highlighted the sharps box should be contained within one of the designated cupboards.
- Both clinical and non-clinical waste bags were available for use on the vehicle.
- The trolley was visibly clean and mattress was intact. Clean linen and blankets were available at the time of inspection, stored securely within the vehicles overhead storage.
- The service had a washing machine and dryer on the ambulance station to clean the linen. At the time of inspection, these were not working. There was no contingency plan to have the linen washed elsewhere.
- There was not a process in place for the cleaning of infectious/dangerous soiled linen for example, a red bag process whereby infectious/dangerous soiled linen would be instantly identified and handled accordingly.
- Hand sanitiser gel was readily available within the rear of the ambulance. Face masks, eye protection, aprons, gloves and spillage kits were kept onboard the ambulance. There were face masks for the prevention of airborne infection. prevention. They also protected against solid and liquid aerosols.
- At the time of inspection there were two packs of cleaning wipes on the vehicle. One packet was left opened which left all the wipes dry and not fit for use. The other packet of wipes was designed for food decontamination which was displayed on the packet.
- General household anti-bacterial sprays were also available. It was not known if these were healthcare effective or advocated.
- Mobile phones were used for the purposes of communication. At the time of inspection, we were unable to locate any mobile phone(s) belonging to the vehicles we inspected.
- The vehicle had a vehicle checklist to be completed prior to the vehicle being used. This checklist was laminated and completed using a dry wipe marker. The provider could not produce any evidence of historical

records of vehicle checks at the time of inspection due to the system described. The vehicle checklist did not appear to contain all the items, equipment or vehicle status.

- During inspection we were unable to locate a service sticker on the suction machine.
- There did not appear to be any record of the service, such as a service sheet, to accompany the sticker to show the defibrillator had received a service within the last 12 months.
- We were unable to locate a service sticker for the stretcher at the time of inspection. The registered manager highlighted that each stretcher was serviced every year in line with the company's policy. The asset tag was unreadable/worn.
- The service had a paediatric harness. This harness was suitable for children being transported on the stretcher between the weights of 4.5kg to 18kg. The service did not have any other means of restraint for paediatric patient's sitting outside this weight bracket.
- During inspection a number of the consumable items were inspected, two were identified to have expired including an I-Gel (expired June 2018) and an IV Dressing Pack (expired August 2018).
- We found the suction unit tubing was left out of its protective packaging. The scoop stretcher's last service date had expired (March 2018).
- There was no standard moving and handling equipment on board the vehicle such as a slide sheet, transfer board or slings for stretcher/chair transfers.
- All the blinds were fully working ensuring privacy and dignity. The oxygen pipeline system was within its test date.
- The registered manager told us it was the routine for crews to dispose of their waste at the hospital they attended with a patient. This was in contravention of current guidelines for services managing their own commercial waste.
- The service had a contract with a local clinical waste disposal service who collected their waste once the bin got full. The outside clinical waste bin was locked and secure.
- Following the inspection, the service was provided with feedback in relation to issues of concern. The service responded by submitting a cleaning record checklist for vehicles. It would appear to have been a copy from another provider as it stated on the form, report to be completed for ancillary records and there is a document reference ODVCR.V10 3/16. The service did not have ancillary records and the document is recorded as version 10.
- Following the inspection, the service was provided with feedback in relation to issues of concern. The service responded by submitting a cleaning record checklist for vehicles. It would appear to have been copied from another service as it stated on the form, report to be completed for ancillary records and there is a document reference ODVCR.V10 3/16.

Assessing and responding to patient risk

- The provider did not produce any evidence of how they assessed and responded to patient risk.
- During inspection we reviewed the service's patient directives policy document which defined how staff should deal with patients who had an advanced order dictating restrictions on their care, including do not resuscitate orders and advanced directives. The policy was out of date being due for review in January 2018.
- Following the last inspection carried out in December 2017 the service was given an action it should take to improve which was to develop a standard operating procedure or protocol to provide guidance for staff on the management of deteriorating patients. During this inspection we found no evidence the service had developed a standard operating procedure or protocol. When we spoke to the registered manager they confirmed these were not in place.
- While the service did not carry out any planned urgent and emergency care work they did on occasions need to transport patients from event sites to local accident and emergency hospital departments dependent upon clinical need. Any assessment of patient risk was recorded on a patient report form (PRF). During inspection we checked ten PRF`s none had any evidence of deteriorating pathways, none had evidence of NEWS score which is an early warning score is a guide used by medical services to quickly identify deteriorating patients based on the vital signs or a

modified early warning score. The primary purpose is to prevent delay in intervention or transfer of critically ill patients. None had evidence of a MEWS score which is an early warning score is a guide used by medical services to quickly determine the degree of illness of a patient, seven omitted pain scores and nine omitted allergy status.

- The registered manager told us they were the first point of contact for ambulance crews seeking clinical advice and advice on escalation processes. The registered manager told us if they were unable to provide the advice they had the contact details for four doctors who would provide advice.
- There was no evidence of there being a formalised system of a point of contact being available to seek clinical advice from. The registered manager told us they would ring each of the doctors in turn to obtain advice. There were no contingency plans if each of the four were not available.
- Following the inspection, the service was provided with feedback in relation to issues of concern. The service responded by submitting a scope of patient care policy. The policy referred to other polices which were out of date. The scope of patient care policy covered duty of care and a hierarchy of care. There was no specific reference to the service provided and type of patient's staff would be dealing with or advice as to the scope of the care which should be provided.
- Following the last inspection carried out in December 2017 the service was given an action it should take to improve which was to develop a standard operating procedure or protocol to provide guidance for staff on the management of deteriorating patients. During this inspection the provider did not produce evidence they had developed a standard operating procedure or protocol. When we spoke to the registered manager they confirmed these were not in place.

Staffing

- The only employed staff were the registered manager, deputy manager and administration assistant. All operational staff were self-employed and worked for the service on an "as required" basis. None of the operational staff had employment contracts or set hours of work.
- The registered manager told us there was a pool of approximately 25 staff who were registered to work for the service. This number varied as staff left and others registered to work for them.
- Staff who wished to work for the service completed a formal registration form and references were obtained prior to commencing work for the service.
- The registered manager told us the skill mix of staff was not considered when staff registered to work for the service.
- There was no alignment of a rota or shifts to meet demand because staff worked on an as required basis. Event medical plans were completed when the service was commissioned to attend an event. These contained an assessment of the number and skill mix of staff required for the event and contained consideration of the driving skills required and capacity to allow patients to be transported off site if required.
- The registered manager told us the number of staff rostered to cover the service was sufficient to enable patients to be treated and transferred to hospital if necessary which was planned through the event medical plans.
- The provider did not produce any evidence to show they recorded the hours worked by staff or were aware of the number of hours worked by staff in their primary employment.
- The provider did not produce any evidence of how they would ensure staff were complying with the European time working directives and staff had adequate rest periods between shifts to ensure they were not fatigued and were safe to perform their role.
- The service used a closed social media page to alert staff when work was available. The registered manager told us the members of staff who volunteered first and were suitably qualified would be asked to work. In summary work was allocated on a first come first served basis.

Response to major incidents

- During the last inspection the service did not have a formal business continuity plan. During this inspection we saw evidence the service had a formal business continuity plan and a major incident plan both of which outlined roles, responsibilities and actions to take.
- There was no evidence the service had tested the plan.
- The service was not part of any other NHS or independent health provider business continuity or major incident plan.

Records

- During inspection ten patient records forms (PRF`s) were reviewed. All the records were on headed paper that was in a previous company name.
- The ten records were not completed fully with omissions including times, dates, signatures and professional designations.
- Seven records omitted a pain score, nine records omitted allergy status, there was no evidence of deteriorating patient pathways, there was no evidence of NEWS/MEWS and there was no evidence of any pathways being utilised. Six of the ten PRF`s we reviewed during inspection had no hospital handover information recorded.
- The ten records recorded consent to treatment where appropriate.
- There was not a detailed method of storing patient information relating to the transfer of patients, for example, patient infection status, mobility needs, medical needs, property and do not attempt cardiopulmonary resuscitation(DNACPR).
- In the ambulance we inspected patient records were stored within an A4 file to obscure from view the files contents. These files were not stored away within a secure container such as the glove box whilst operational.
- When we spoke to the registered manager they were not clear on how long records should be retained. They told us the medical records would be retained for six years before destruction. Medical records should be kept for longer than eight years as recommended by Records Management Code of Practice for Health and Social Care 2016.
- During inspection we reviewed six staff files. All had omissions in relation to the recording of professional qualifications and training attended.

Medicines

- The management of medicines within the service was not safe.
- The medicines were obtained by the service provider through a service level agreement and were stored securely.
- The service administered medicines listed under paramedic exemptions.
- During inspection we found medicines stored within paramedic bags were split and separated from their parent box and patient information leaflet. This presented a potential risk that out of date medicines would not be identified. In addition, if the member of staff administering the medicine did not have access to the patient information leaflet the potential risks to patients taking the medicine would not be identified.
- All the medicines we checked during inspection were in date at the time of inspection, however, there was no system for tracking the movements of medicines obtained by the service and no system to ensure medicines were within their expiry dates. This increased the risk of medicines not being fit for purpose.
- Controlled drugs were securely stored, however, there was no evidence of regular controlled drugs checks. There was therefore no way of monitoring stock levels, or administration. In addition, if a discrepancy in the stock was apparent there was no way of identifying how this could have occurred. This was not in line with guidance on the safe management of controlled medicines.
- The tagging system used by the service for checking controlled medicines did not conform with the controlled medicines guidelines and provided no reassurance the administration and stock of controlled drugs was being appropriately recorded and monitored.
- The medicine storage area was clean, tidy and appeared well organised.

Emergency and urgent care services

- The paramedic backpacks were fully stocked, clean and were made of a wipeable infection control friendly material however the backpacks were not stored off the floor which posed a risk of contamination.
- All other equipment, apart from the paramedic backpacks, was stored off the floor.
- The non-prescription medicines and controlled drugs were stored separately.
- The services had stocks of DOOP kits (Destruction of Old Pharmaceutical) waste, available for the safe destruction of controlled medicines. These were appropriately stored prior to incineration.
- A syringe of Glucagon was found stored outside of a fridge, without the standard applicable reduced expiry date when stored like this. Glucagon is used to treat severe low blood sugar (severe hypoglycaemia). Glucagon works by telling your body to release sugar (glucose) into the bloodstream to bring the blood sugar level back up. Glucagon should be stored at a temperature of 2–8°C (in a refrigerator).
- Following the inspection, the service was provided with feedback in relation to issues of concern. The service responded by submitting a drugs monthly log sheet which had additional boxes to fill in with time and date and who did the drugs audit.

Are emergency and urgent care services effective?

Inadequate

We rated **Effective** as inadequate because;

- There was no evidence the provider had a system to check staff had read, understood and adhered to company policies.
- Pain relief scores had been omitted from patient records.
- There was no evidence the provider reviewed and centrally stored response times.
- The service did not have an induction procedure for new staff.
- There was no evidence the provider carried out a training needs analysis of staff to identify training requirements, assessed the competence of staff delivering patient care and not a system to identify poor or variable staff performance and how this would be managed for staff to improve.
- In six of the ten patient record forms reviewed during inspection had no hospital handover information recorded.

However, we found the following good practice;

- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to ensure staff completed training updates in basic life support and the use of automated electronic defibrillators. During this inspection we saw evidence staff had received this training

Evidence-based care and treatment

- Best practice guidance was used in the development of the service's policies and procedures which referenced guidance from national bodies. This included guidance from both the National Institute for Health and Care Excellence (NICE) as well the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) which reflected current practice. However, of the 11 policies checked during inspection nine were out of date.
- The registered manager told us when staff joined the service they were given a staff handbook and were provided with access to JRCALC guidelines and the service's policies and procedures. During inspection we saw no evidence as to how the service checked staff had read and understood policies and procedures and adhered to them.
- The provider did not submit any evidence as to how staff were made aware of patients living with mental health needs.

Pain relief

- The service used PRF`s to assess and record how a patient's pain was managed, however, during inspection of the ten PRF`s we reviewed seven omitted a pain score and none had any evidence of NEWS/MEWS. A NEWS score is an early warning score is a guide used by medical services to quickly identify deteriorating patients based on the vital signs or a modified early

warning score. The primary purpose is to prevent delay in intervention or transfer of critically ill patients. A MEWS score which is an early warning score is a guide used by medical services to quickly determine the degree of illness of a patient

Response times

- The registered manager told us staff kept records of the time they were alerted to a casualty at events, the time they were seen, the time they left the site on transfer, the time they arrived at hospital, and the handover time. This information was recorded on the PRF`s. There was no evidence the provider reviewed and centrally stored ambulance response times.
- During inspection we reviewed ten PRF`s all were not fully completed with omissions including times, dates and signatures identified. The result of this was we could not evidence if patients had been seen promptly and that there had been no undue delays in their treatment.
- We provider did not produce any evidence to show they monitored response times. The registered manager told us they reviewed all patient records and would address any issues identified, but this was not recorded. In addition, because of the level of omissions in relation to the PRF`s we reviewed there was clearly no robust review system in place.
- During the inspection the registered manager told us the service recorded the number of transfers but did not record response times or patient outcomes. The provider did not produce any evidence which demonstrated assurance the service was provided in a timely way and patients obtained the best outcomes.

Patient outcomes

- The service did not record information about the outcomes of people's care and treatment. There was therefore no method of comparing outcomes for people in this service compared with other similar services and how they had changed over time.
- The service did not participate in any quality improvement initiatives either internally at service level, locally or nationally.
- There was no evidence of monitoring of activities to gather information to improve patient outcomes.

Competent staff

- The service did not have an induction procedure for new staff. The registered manager told us the induction procedure consisted of new staff being provided with a staff handbook and being given direction as to where to find the services` policies and procedures on the intranet site.
- There was no evidence the provider had a system in place to check if new staff had read and understood the contents of the staff handbook or had accessed the policies and procedures read, understood and adhered to them.
- During inspection we reviewed the company handbook which was provided for new staff. The handbook included the service's mission statement, the start of employment checks, absence reporting and management, health and safety, service expectations, important policies and procedures, discipline and grievance, changes in terms and conditions, changes in personal details or circumstances and leaving the service.
- The handbook did not contain any reference to key polices in relation to safeguarding, incident reporting or infection prevention and control.
- The handbook was dated 8 January 2014 and there was no evidence of it having been reviewed since then.
- During inspection we reviewed the staff conduct policy document which defined the company policy on how staff were expected to conduct themselves when performing duties for the company. The policy was out of date being due for review November 2017.
- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to ensure staff received annual appraisals and recorded these. During this inspection the provider did not produce any evidence they had a staff appraisal system. When we spoke with the registered manager they confirmed the provider did not carry out staff appraisals.
- Following the last inspection in December 2017 the service was given a should do action to improve the

service which was, to ensure staff completed training updates in basic life support and the use of automated electronic defibrillators. During this inspection we saw evidence staff had received this training.

- The registered manager told us additional training was available for staff on request and would be part funded by the service if considered appropriate. We did not see any evidence of which additional training had been made available or had been completed by staff.
- The provider did not produce any evidence to demonstrate they carried out a training needs analysis of staff to identify training requirements.
- There was no evidence managers or supervisors from the service assessed the competence of staff delivering patient care.
- The provider did not produce any evidence of a system to identify poor or variable staff performance and how this would be managed for staff to improve.

Multi-disciplinary working

- The registered manager told us staff provided a handover of information in the patient record to hospital staff on arrival and transfer, however, six of the ten PRF`s we reviewed during inspection had no hospital handover information recorded.
- During inspection the registered manager was unable to produce any PTS patient records to enable the handover process and documentation to be reviewed because these were kept by the provider who used the PTS ambulance and staff from Unit 1.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to policies about consent in adults and children and procedures to be followed when a patient refused treatment. During inspection the polices in relation to consent in adults, dealing with patients having mental health illness and refusal of treatment were reviewed all were out of date requiring to be reviewed in January 2018.
- There was evidence on the spreadsheet used to monitor staff training all staff were up to date with mental capacity act training.
- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to develop clear guidance for staff on the transfer of children not accompanied by a responsible adult.
- During this inspection provider did not produce any evidence the service had developed the guidance. When we spoke with the registered manager they confirmed the guidance had not been developed.
- Following the inspection, the service was provided with feedback in relation to issues of concern. The service responded by devising a policy in relation to dealing with mental health patients. This policy was reviewed. It did not provide members of staff with enough information to deal with patients suffering mental ill health. The policy referred to policies which were out of date. Specific reference was made to a consent in adult's policy which was out of date having been required to be reviewed in January 2018 and consent in children policy which could not be reviewed as it had not been provided.
- Following the December 2017 inspection, the service had been given a should do action to develop clear guidance for staff on the transfer of children not accompanied by a responsible adult. The provider did not produce any evidence to show this guidance had been devised.

Are emergency and urgent care services caring?

Not sufficient evidence to rate

We inspected but did not rate **Caring.**

Compassionate care

- Due to type of service provided during inspection we were unable to observe patient care.
- During the inspection of the urgent emergency care ambulance it was noted the vehicle had curtains which could be pulled across the windows to maintain patient dignity.
- During inspection we reviewed two thank you letters from people who had been at events.

Emergency and urgent care services

Emotional support

- Due to the type of service provided no patient observations were carried out therefore emotional support could not be evidenced.

Understanding and involvement of patients and those close to them

- The registered manager told us staff consulted with patients about the necessity for transfer from an event to hospital and explained the options available to them, i.e. whether they could go independently to hospital, call for an NHS ambulance or use the service, depending on the injuries or medical condition they had experienced. In this way the staff gained agreement with the patient and/or their relatives about the transfer.
- There was no evidence the provider carried out patient surveys.

Are emergency and urgent care services responsive to people's needs?

Inadequate

We rated **Responsive** as inadequate because;

- The service planning was reactive not responsive.
- There was no evidence the provider had a considered approach for tendering for the work undertaken.

However, we did see evidence of the following good practice;

- There was evidence of a multilingual phrase book available for patient's on the ambulance we inspected.

Service delivery to meet the needs of local people

- Due to the fact the service provided medical coverage at public and private events the service experienced seasonal fluctuations in activity. There was no planning until the service had tendered for and secured a contract. Resources were then planned accordingly to meet the requirements of the event plan.
- The registered manager told us because there was a pool of self-employed staff it allowed the service to respond to increases in demand, for example, if they secured an event contract at short notice.
- The service did not have any contracts for the provision of urgent and emergency care. They tendered for individual events. There was no evidence the provider had a considered approach for tendering for the work undertaken.

Meeting people's individual needs

- Following the last inspection in December 2017 the service was given an action it should take to improve the service which was, to ensure staff were provided with communication aids and a translation service to aid communication with patients who have difficulty in understanding English or have communication needs.
- During this inspection there was evidence of a multilingual phrase book available for patient's on board the ambulance we inspected.
- There was no evidence the service understood the needs of people, including individual preferences, culture or faith.
- There was no evidence the service understood the needs of patients with learning disability, mental health illness, dementia, bariatric patients, hard of hearing or deaf, partially sighted or blind or how their needs influenced the care they received.

Learning from complaints and concerns

- The service had received one complaint in the reporting period it did not relate to urgent and emergency care.
- The ambulance we inspected had a supply of patient information and feedback forms, which briefly detailed how to make a complaint and provide feedback regarding the service received.

Are emergency and urgent care services well-led?

Inadequate

We rated **Well-led** as inadequate because;

- There was no evidence of any governance systems
- There was no evidence the provider had systems and process to manage and mitigate risk.
- There was no evidence of a risk register.

- The was no evidence the provider had any key performance indicators.
- There was no evidence the service routinely collected, reviewed and acted upon patient feedback to improve the service.
- There was no evidence the provider held staff meetings or had routinely collected, reviewed and acted upon staff or patient feedback to improve the service

Leadership of service

- The service was led by a director who was the registered manager and was a registered paramedic. They took the leadership role in relation to clinical care and safeguarding. They were supported by a deputy manager and an administrative assistant who was free-lance and worked four hours on Monday and Friday and three and a half hours Tuesday, Wednesday and Thursday.
- The registered manager told us the service used two paramedics who worked on a "as required" basis at events. They were described as assistant managers who took leadership roles in the event medical plan command structure.
- The service was supported by four medical directors who were doctors. They made themselves available for clinical advice. However, there was no evidence the provider had a formal system in place which would guarantee clinical advice being available.

Vision and strategy for this service

- The service had a mission statement which was quote, "We provide high quality Ambulance and Medical services, along with Fire Safety Services to customers in the events, film and health and safety industries, all around the UK. Taking great care and pride in our work with the highest priority on transporting patients with safety, comfort and care".
- The mission statement was not displayed anywhere in the services` base or did it appear on the services` internet page.
- There was no evidence the service had a strategy for delivering the service they provided.
- There was no evidence the service had a system to check staff had read and understood the mission statement.

Culture within the service

- The registered manager described the culture as open and encouraging. Due to the nature of the service carried out we were unable to speak to any operational staff to confirm this.

Governance

- There was no evidence the service held regular governance meetings which had a set agenda, with minutes and actions. During inspection we did review the weekly meeting logs dated between 30 August and 23 November. There was no year on the logs so it could not be ascertained how current they were.
- The logs were hand written. There did not appear to be an agenda, there was no record of who was present, no record of which actions were allocated to which member of staff and no reviews of the preceding logs to confirm the actions from the previous log had been completed. None of the logs had any reference to risk.
- During inspection we saw evidence staff had to provide their driving licence details which were checked using the Government internet licence check system.
- During inspection we reviewed 11 policies nine were out of date and had no version control. The duty of candour policy had no heading identifying it as a policy. There was no date when it became effective or when the policy was due for review.

Management of risk, issues and performance

- Following the last inspection in December 2017 the service was given a must do action to improve the service which was, to develop a system for identifying, mitigating and controlling risks appropriately.
- During this inspection we saw no evidence the service had a risk register and there was a system for identifying, mitigating and controlling risks appropriately. The registered manager we spoke with confirmed the service did not have a risk register.
- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to develop some clinical quality

indicators related to the safety of the service and monitor performance against these. During this inspection we saw no evidence the service had developed clinical quality indicators related to the safety of the service and monitored performance against these. The registered manager we spoke with confirmed the service did not have key performance indicators and the service did not monitor performance.

Information Management

- The service did not have holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances.
- The service did not ensure the accuracy of key performance indicators(KPI) data as it did not collect any.

Public and staff engagement

- During inspection we saw evidence the provider had a patient feedback sheet providing an email address and telephone number should a patient wish to respond. There were contact details directing the patient to the Care Quality Commission if they felt their concerns had not been adequately dealt with. The was no reference to the Independent Sector Complaints Adjudication Service (ISCAS) which provided independent adjudication on complaints about ISCAS subscribers. ISCAS was a voluntary subscriber scheme for most of independent healthcare providers.
- The service sought feedback from event organisers they had worked for.
- There was no evidence the service routinely collected, reviewed and acted upon patient feedback to improve the service.
- The service did not hold staff meetings and had not routinely collected, reviewed and acted upon staff feedback to improve the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must develop a standard operating procedure or protocol to provide guidance for staff on the management of deteriorating patients.
- The provider must develop some clinical quality indicators related to the safety of the service and monitor performance against these.
- The provider must ensure staff receive an annual appraisal and record these.
- The provider must develop clear guidance for staff on the transfer of children not accompanied by a responsible adult.
- The provider must have systems in place to identify when policies, procedure and guidance documents are requiring a review. All polices must be in date and updated accordingly.
- The provider must carry out infection prevention control audits.
- The provider must formally monitor and record staff adherence to infection prevention control policies and procedures.
- The provider must carry out vehicle cleaning audits and maintain daily vehicle cleaning records.
- The provider must have a process in place for the cleaning of infectious or soiled linen.
- The provider must ensure all equipment is serviced and tested in accordance with manufacturers recommendations and a record is maintained of the servicing and testing.
- The provider must have a risk assessment for the storage of medical gases.
- The provider must ensure standard moving and handling equipment such as a slide sheet, transfer board or slings for stretcher or chair transfers are carried in their urgent emergency care ambulances.
- The provider must develop guidance for staff on the management of deteriorating patients.
- The provider must have a formalised system in place to ensure a single point of contact is available to provide clinical advice.
- The provider must have a system to review patient records to ensure they have been completed correctly and the information is accurate.
- The provider must have a no system for tracking the movements of medicines obtained by the service.
- The provider must carry out and record audits of stock management, expiry checks and daily controlled drugs checks.
- The provider must hold regular governance meetings which have a set agenda, with minutes and actions.
- The provider must have a risk register and a system for identifying, mitigating and controlling risks appropriately.
- The provider must develop a set of clinical quality indicators related to the safety of the service and monitor performance against these.

Action the hospital SHOULD take to improve

- The provider should review their safeguarding reporting policies so referrals are made within 24 hours upon receipt of the information leading to the referral.
- The provider should ensure the safeguarding lead is trained to safeguarding level 4.
- The provider should record temperature checks for the monitoring of the store rooms stocks and medicines.
- The provider should ensure medicines are stored in accordance with the manufactures advice.
- The provider should not split medicines from the parent box or patient information leaflet.
- The provider should ensure sharps boxes carried in their ambulances are secured.
- The provider should have PPE face masks available for staff to use which prevent airborne infection.

Outstanding practice and areas for improvement

- The provider should have a system in place to ensure consumable items are usable and to identify when they are coming to their expiry date.
- The provider should have vehicle check lists which includes all the items, equipment carried on their vehicles and the vehicle status.
- The provider should record information about the outcomes of people's care and treatment.
- The provider should have an induction procedure for new staff.
- The provider should have a system to place to check if staff had read and understood the contents of the staff handbook and had accessed the policies and procedures read, understood and adhered to them.
- The provider should have a system to assess the competence of staff delivering patient care and be able to identify poor or variable staff performance and how this would be managed for staff to improve.
- The provider should have a strategy for delivering the service they provide.
- The provider should service routinely collect, review and act upon patient feedback to improve the service.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12, (1) (2), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. a) assessing the risks to the health and safety of service users of receiving the care or treatment (b) doing all that is reasonably practicable to mitigate any such risks; The service did not have a risk register or a system in place for identifying, mitigating and controlling risks appropriately. This is an outstanding must do action from the December 2017 inspection. Risk was not discussed at the services` governance meetings. There was not a formal system in place for staff to obtain clinical advice. The incident reporting policies were out of date. There were no reviews of PRF `s to identify risk and how it mitigate against it. During inspection we checked ten PRF`s none had any evidence of deteriorating pathways, no evidence of NEWS/MEWS, seven omitted pain scores and nine omitted allergy status. The service did not have standard safeguarding forms and the referral procedure could take more than 24 hours. (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; Equipment on both ambulances inspected were out of date. Three of the five AED `s in the equipment had not been PAT tested. The sharps box in one of the ambulances inspected was not secured. There was no service sticker on the defibrillator or stretcher in one of

Enforcement actions

the ambulances inspected. During inspection the consumable items were inspected, two were identified to have expired including an I-Gel (expired June 2018) and an IV Dressing Pack (expired August 2018). We found the suction unit tubing was left out of its protective packaging. The scoop stretcher's last service date had expired (March 2018). There was no standard moving and handling equipment on board the vehicle such as a slide sheet, transfer board or slings for stretcher/chair transfers.

(g) the proper and safe management of medicines;

Medicines stored within the bag were split and separated from their parent box and patient information leaflet. There was no system for tracking the movements of medicines obtained by the service. There were no recorded audits of stock management or expiry checks. There was no evidence of daily controlled drugs checks. The service utilised a tag code system for checking controlled medicines. If the tag had changed since the last check, it would be recounted and retagged. This did not conform with the controlled medicines guidelines.

(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

There did not appear to be any FFP3 rated masks for airborne infection prevention. FFP3 dust masks protected against higher levels of dust. They also protected against solid and liquid aerosols. Both ambulances had decontamination wipes on the vehicles, both packets were left open which left all the wipes dry and ineffective for use. There did not appear to be a process in place for the cleaning of infectious/dangerous soiled linen. Hand sanitiser gel was readily available within the rear of the ambulance. It was not clear when this product expired due to it having no expiry date. There was no evidence the service carried out any IPC audits. The service did not formally monitor adherence to infection control policies and procedures. The registered manager told us they checked adherence to hand hygiene on site and checked that cleaning procedures were followed but did not document this.

This section is primarily information for the provider

Enforcement actions

Staff completed cleaning schedules for each vehicle and cleaned vehicles after each event. There was no evidence which cleaning products had been used to clean each vehicle and there was no evidence of any cleaning audits.

(i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users;

Six of the ten PRF`s we reviewed during inspection had no hospital handover information recorded. The service did not record information about the outcomes of people's care and treatment. There was therefore no method of comparing outcomes for people in this service compared with other similar services and how have they have changed over time.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17, (1) (2), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

(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);

The provider did not have a formal process to monitor and improve the safety of the service. The service had no key performance indicators therefore there was no information to act upon to improve.

This section is primarily information for the provider

Enforcement actions

(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;

There was no risk register. Risks were not discussed at governance meetings. There were no systems or processes to identify organisational risk and risk to patients. The service had a business continuity plan but there was no evidence this had been tested.

(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;

During inspection ten PRF`s were reviewed. All the records were on headed paper that was in a previous company name. The ten records were not completed fully with omissions including times, dates, signatures and professional designations. Seven records omitted a pain score, nine records omitted allergy status, there was no evidence of deteriorating patient pathways, there was no evidence of NEWS/PEWS and there was no evidence of any pathways being utilised. Six of the ten PRF`s we reviewed during inspection had no hospital handover information recorded. There was not a detailed method of storing patient information relating to the transfer of patients, for example, patient infection status, mobility needs, medical needs, property, DNACPR etc. In one ambulance patient records were stored within an A4 file to obscure from view the files contents. These files were not stored away within a secure container such as the vehicle glove box whilst operational.

(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;

During inspection we reviewed six staff files. All had omissions in relation to the recording of professional qualifications and training attended. The service did not carry out any staff appraisals. The service did not carry

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out a staff training needs analysis to identity where support and development was required. The was not a system in place for supervisors to perform and record on the job assessments of performance. The service did not have an induction procedure for new staff. Staff were provided with a company handbook, however, there was no evidence the service had a system in place to check if new staff had read and understood the handbook or had accessed the policies and procedures read, understood and adhered to them. There was no evidence of a system to identify poor or variable staff performance and how this would be managed for staff to improve.

(ii) the management of the regulated activity

When we spoke to the registered manager they were not clear on how long records should be retained. They told us the medical records would be retained for six years before destruction. Medical records should be kept for longer than the eight years as recommended by Records Management Code of Practice for Health and Social Care 2016. During inspection we reviewed eleven policies nine were out of date and the duty of candour policy had no heading identifying it as a policy, there was no date when it went live or when the review date was.

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

The service did not proactively seek patient feedback therefore there was no evaluation which would lead to an improvement of service.

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e);

There were no systems of processes in place to evaluate and improve practice.