Falck UK Ambulance Service Limited

Falck (Warrington)

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Falck (Warrington) is operated by Falck UK Ambulance Service Limited. Falck (Warrington) provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 6 February 2018.

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

We found the following areas of good practice:

- Staff were committed to providing the best quality care to patients. Staff displayed a caring and compassionate attitude and took pride in the service they were providing.
- Staff operated comprehensive systems to make sure that all vehicles, equipment and medicines were safely managed and fit for purpose.
- Vehicles and stations were visibly clean and tidy, with evidence of regular deep cleaning of vehicles.
- The provider had developed systems to accurately monitor whether all staff had the qualification and skills needed to provide high-quality care.
- Relevant background checks had been carried out during recruitment processes. This included, for example, a full Disclosure and Barring Service (DBS) and a driving license check.
- We observed good multidisciplinary working between crews and other NHS staff when moving patients.
- The management team worked with local NHS providers to supply services which met the needs of local people.
- Staff were well supported by the management team; they told us the management team were friendly and approachable.

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

- Staff completed a self-assessment in relation to their physical health during the recruitment process. This included a request in relation to their routine immunisation history. However, the provider did not currently check that relevant staff had been immunised with other selected vaccines, such as Hepatitis B, which may be appropriate for their role.
- There were currently no arrangements for ongoing, practical checks of driver competence beyond a periodic review of the validity of each staff member's driving license.
- The information received during the online booking procedures was not always sufficient for staff to inform themselves about the potential risks associated with transporting individual patients. Staff did not routinely keep an accurate, complete and contemporaneous record of the care and treatment provided to each patient.

Summary of findings

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 one requirement notice that affected the patient transport services. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North of England), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The only service provided was in relation patient transport.

Falck (Warrington)

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Falck (Warrington)

Falck (Warrington) is operated by Falck UK Ambulance Service Limited which is part of an international company providing ambulances services in 22 countries. Falck UK Ambulance Service Limited operates across England and Wales providing both patient transport services and emergency and urgent care services.

Falck (Warrington) is an independent ambulance service in the North West of England. They supply the local community of Rochdale, Oldham, Manchester, Liverpool and North Wales with patient transport services. The service has been operating since 2009. The provider holds contracts with five NHS trusts covering eight hospital sites. They move non-urgent patients between hospitals, homes and care facilities. The provider also supplies ambulances and staff for a specialist paediatric service, the North West and North Wales Paediatric Transport Service. They transfer critically ill children from district general hospitals to two paediatric intensive care units (PICUs) within the North West and North Wales area.

At the time of the inspection, a new registered manager had recently been registered with the CQC in September 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in patient transport services and emergency and urgent care.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Falck (Warrington) has ambulance bases in Rochdale and Warrington. Ambulances in Rochdale and Warrington are generally dispatched from a central call centre, owned by Falck Ambulances Services Limited UK, from a base in either Shropshire or London. The exception to this is when Falck (Warrington) are working with North West and North Wales Paediatric Transport Service (NWTS). Ambulances are located and co-ordinated directly from the NWTS base in Birchwood, Warrington. There are 16 vehicles across the Rochdale, Warrington and Birchwood sites.

The service employs 48 people; 3 in managerial roles and 45 providing clinical services. The employed staff are at a range of levels comprising 36 intermediate care technicians, five ambulance care assistants, two emergency care assistants and two 'vehicle make ready operatives'.

The service is registered to provide transport services, triage and medical advice provided remotely.

The service's track record on safety from November 2016 to November 2017 showed:

- No never events
- 67 incidents
- five complaints

In the same period there were 23,204 patient journeys undertaken. The service was working with both adults and children.

During the inspection on 6 February 2018, we visited the Rochdale, Warrington and Birchwood sites. We spoke with 18 staff including frontline ambulance crews and members of the management team. We spoke with four patients. During our inspection, we reviewed a sample of patient records. We checked two vehicles at Rochdale and five vehicles in Warrington.

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 April 2014. This had been a focussed inspection to check that the service had improved standards related to record keeping. The inspection found that the service was meeting all standards of quality and safety it was inspected against at that time.

Patient transport services (PTS)

Summary of findings

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- Staff operated comprehensive systems to make sure that all vehicles, equipment and medicines were safely managed and fit for purpose.
- Vehicles and stations were visibly clean and tidy, with evidence of regular deep cleaning of vehicles.
- The provider had developed systems to accurately monitor whether all staff had the qualification and skills needed to provide high-quality care.
- Relevant background checks had been carried out during recruitment processes. This included, for example, a full Disclosure and Barring Service (DBS) and a driving license check.
- We observed good multidisciplinary working between crews and other NHS staff when moving patients.
- The management team worked with local NHS providers to supply services which met the needs of local people.
- Staff were well supported by the management team; they told us the management team were friendly and approachable.

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

- Staff completed a self-assessment in relation to their physical health during the recruitment process. This included a request in relation to their routine immunisation history. However, the provider did not currently check that relevant staff had been immunised with other selected vaccines, such as Hepatitis B, which may be appropriate for their role.
- There were currently no arrangements for ongoing, practical checks of driver competence beyond a periodic review of the validity of each staff member's driving license.
- The information received during the online booking procedures was not always sufficient for staff to inform themselves about the potential risks associated with transporting individual patients. Staff did not routinely keep an accurate, complete and contemporaneous record of the care and treatment provided to each patient.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The service had an incident reporting policy that was available to all staff. Staff we spoke with were able to give examples of what constituted an incident and were aware of the incident reporting process. They were able to locate incident report forms and knew how to submit these. The service was also trialling an electronic recording system for reporting incidents at the time of the inspection.
- We reviewed incident reports that had been completed between November 2016 and November 2017. Sixty seven incidents had been recorded which covered a range of issues including vehicle faults, driving incidents, patient complaints, and patient or staff injuries.
- We reviewed three incident reporting forms. We saw evidence that the incidents had been properly investigated and the learning shared with staff. A head of health, safety, environment and quality showed us an example of a 'near miss' incident which was investigated. Following the incident, hand held metal detectors had been introduced to scan patients, where it had been identified that the patient may be at a higher risk for aggressive or violent behaviour.
- The service had reported no never events or serious incidents between November 2016 and November 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Incidents were monitored by the head of health, safety, environment and quality, who demonstrated that each incident was risk assessed and prioritised for investigation. Low risk incidents were dealt with straight away and handled within the Falck (Warrington) service. Moderate or serious incidents were also reported to a quarterly governance forum, where all of the regions were represented, so that the findings from any investigations could be shared nationally to encourage learning and prevent the possibility of a recurrence.
- The governance forum identified if any further action was needed and decided upon key learning points for frontline staff. This information was then disseminated to local station managers. The local managers then worked with individuals, or teams, to share learning and provide additional training to mitigate the risk of any incident occurring again.
- The management team told us that in the event of a joint investigation with a contracting service they received feedback, as required.We were told the service had good working relationships with NHS providers to enable this process.
- The service had reviewed its incident policy in January 2018; the policy now included reference to the duty of candour. The registered manager was responsible for ensuring compliance with the duty of candour. 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.
- The registered manager was supported by a national health, safety, environment and quality team who ensured that the duty of candour was complied with. For example, the team ensured that there was timely written and verbal communication between the service, external contractors and patients or relatives regarding incidents.
- The ambulance crew that we spoke with were aware of the duty of candour. Staff were introduced to the company's duty of candour policy during their staff induction process.
- The managers told us that there had been no incidents between November 2016 and November 2017 that had resulted in moderate, or above, patient harm that would trigger the duty of candour process.

Mandatory training

- Mandatory training for all staff comprised: safeguarding, infection prevention and control, equality and diversity, fire safety, conflict resolution, moving and handling, dementia care, mental health care, information governance, incident reporting, basic life support,

oxygen therapy and Do not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy training. Training was delivered face-to-face and through online training modules.

- Intermediate care technicians completed annual clinical refresher training courses (First Response Emergency Care; FREC) to maintain their clinical skills and knowledge. At the time of the inspection there were three members of staff who were due to complete their training in December 2017, but had not yet done so. There was a risk assessment in place for each of these members of staff which had concluded that they could remain operational providing the training course was completed by the end of February 2018.
- Falck (Warrington) also maintained a system whereby at least two of their staff had undergone additional response (blue light) training in case this was needed for their work with NWTS.
- We spoke with the head of recruitment and learning, who showed us how they kept oversight of staff training compliance. There was a training standards spreadsheet with records of compliance for each member of staff. The spreadsheet specified time frames for renewing different types of training. Administrators within the learning department sent reminder emails to individual staff members up to six months in advance to allow adequate time for staff to organise and complete training.
- At the time of the inspection, all staff were either up to date with their training or were booked on to a relevant training course within the next three months.
- We asked the head of learning about how staff, who had not completed training, were managed. They told us that completion of all training was linked to the appraisal process. Staff who were persistently non-compliant with training were not allowed to remain operationally active. The ambulance crews that we spoke with confirmed that this was the case.

Safeguarding

- The provider had a national health, safety, environment and quality department which took the lead on implementing systems and processes for protecting vulnerable adults and children. They were also responsible for investigating any safeguarding concerns. They were supported by managers who implemented policies and protocols at a local level.
- The current safeguarding policy had been implemented in February 2018 following a reorganisation of the management structures.
- The staff we spoke with gave us examples of what constituted a safeguarding concern and were able to describe the process for reporting these.
- The service had a dedicated safeguarding 'hotline' telephone number so that staff could access other members of the team who had additional safeguarding-specific training; they could then guide them about how to respond to any given situation. The telephone number was printed on staff lanyards for ease of use.
- Staff were effectively using the reporting procedures. In one example, a crew member reported that they had had concerns about a patient. They considered that is was not safe to leave the patient alone in their own home. They had reported this concern directly to the provider's safeguarding team, who in turn contacted social services. The crew remained with the patient until assurances regarding safety were sought; a care package review was instigated for the patient by social services as a result.
- Staff were aware of guidance related to specific safeguarding issues. For example, staff were able to accurately describe the legal requirement for reporting incidents of female genital mutilation. They were also aware of the PREVENT strategy for identify and preventing radicalisation.
- Safeguarding concerns were reviewed at quarterly governance meetings to ensure that any investigations were adequately supported and progressing in line with the company policy.
- Frontline ambulance staff had all completed safeguarding training in protecting vulnerable adults and children to level two. Training was renewed every three years; all staff were up to date with their training at the time of the inspection. The training incorporated issues related to protecting both children and vulnerable adults.

- The station managers had completed level three training in safeguarding children. The head of health, safety, environment and quality had also completed higher level (level four) training, as appropriate to their role.

Cleanliness, infection control and hygiene

- The service had an infection, prevention and control policy (IPC) that was available to all staff. The staff we spoke with were aware of their responsibilities related to infection, prevention and control.
- Infection, prevention and control training was delivered to all staff as part of their induction training and mandatory training updates.
- Personal protective equipment was available on all ambulances. This included, for example, disposable clinical gloves and aprons. Staff were aware of when these should be used and we observed that they were appropriately used
- All ambulances, garages, staff areas and offices were visibly clean and tidy.
- The ambulance stations that we visited had store rooms and shelves specifically for the use of the transport services. These were well organised, with all equipment and stock stored off the floor.
- Cleaning equipment was available in the ambulance stations. A coding system was used which separated equipment that was to be used in different areas. For example, in ambulances and in non-clinical areas. There were also separate mops labelled for use in each vehicle. There were posters located next to all cleaning equipment to support staff in identifying the correct equipment to use.
- There was information available to determine which cleaning agents needed to be used, as required by standards for control of substances hazardous to health.
- The service had 'vehicle make ready operative' staff who cleaned vehicles before they went out on a shift. There was a cleaning schedule which was followed by the vehicle make ready operatives.
- We reviewed daily cleaning records for the stations and vehicles. There was a schedule with a checklist for each of the vehicles, demonstrating that the correct tasks had been carried out during the previous 12 months.
- All vehicles had decontamination wipes which were within the manufacturer's expiry date. We observed ambulance cleaning down the equipment after the transfer of a patient to ensure that the vehicle was clean for the next patient.
- The ambulance crews were made aware of specific infection and hygiene risks of individual patients by information gathered at the time of the booking. The information recorded included an assessment of the patient's status in relation to infections. Crew staff confirmed they were made aware of patients who had infections so they were able to wear appropriate personal protective equipment and could ensure that adequate cleaning of the vehicle was completed after use.
- All ambulances had spill kits available which were used to clean any bodily fluids. In addition, staff used disinfectant wipes to clean equipment such as wheelchairs and stretchers after use.
- Staff explained there was a four-week "deep clean" process for internal parts of the vehicles. This process was the responsibility of the vehicle make ready operatives. We were shown documents with details of the date that this cleaning occurred; this included details regarding the extent of the "deep clean".
- The service had a uniform policy which outlined the roles and responsibilities of all staff members. Staff had an awareness of the need to wash their uniforms separately to all other clothes so that the risk of contamination was reduced.
- At the end of each shift, ambulance crews took clinical waste bags off the vehicles and these were placed in clearly identifiable, locked bins at the depot. These were emptied by a private contractor.
- There was a sharps bin available; this was rarely used due to the nature of the patients being transferred, but staff were aware of when it might be needed and how to appropriately dispose of the bin after use.
- An audit had been carried out in January 2018 against the CQC key lines of enquiry for independent ambulance providers. This had included a review of ambulance crew actions in relation to infection prevention and control. The audit had concluded that

staff were using personal protective equipment appropriately and following hand hygiene procedures, including the appropriate washing and the use of hand gel.

Environment and equipment

- The services we visited had 16 ambulances based at the Warrington and Rochdale locations that were used to transport patients. The ambulances were fitted for a range of functions including high dependency vehicles, bariatric ambulances, stretcher ambulances and multi-seat ambulances and wheelchair-carrying ambulances.
- We found the ambulance stations, including the garages and equipment storage areas, were clean and well laid out. They were well lit, tidy and fit for purpose.
- Hazardous substances were stored in a locked room, or a locked cupboard, at the different locations. There were appropriate control of substances hazardous to health assessments in place.
- We observed that staff were responsible for completing a daily vehicle check before every shift. This included checking if the vehicle was in a good state of repair and had the correct equipment available.
- The daily vehicle checks were recorded on a form. However, an audit carried out in January 2018 found signs of minor wear and tear on vehicles and equipment that had not been picked up by the daily checks. As a result of the audit, the station managers were instigating a new system to retrain staff in the use of the daily checks and carry out spot checks with staff to ensure that the system was effective at identifying any concerns with equipment.
- During our inspection we found that the equipment was in good working order. This included, for example, carry chairs, wheelchairs, strapping and valve masks. Any items that needed to be replaced periodically were labelled with a date. Relevant equipment had been serviced in line with the manufacturer's guidance.
- Consumable stock was stored on a number of shelves in store rooms or at the entrance to the vehicle garage. The level of stock was managed by the station managers. The staff we spoke with told us there was never any problem replacing used consumables.
- There was a separate area where staff could leave defective or broken items. These were clearly labelled and tied up so that staff could not use them accidentally.
- The Ministry of Transport safety test due dates, servicing schedules and insurance certificates were recorded on a computer system. Alerts were generated and sent to station managers to prompt them to renew Ministry of Transport safety test certificates or vehicle services. We checked seven vehicles on our inspection. They all had a current test certificates and the servicing was up to date.
- The vehicles used an airwave handset and a satellite navigation system in the vehicle.All essential equipment in all the vehicles had been checked. We found that all were in order and had stickers showing the next checking date. All equipment had been safety tested and appropriately calibrated, where necessary.
- The vehicles required for the paediatric service with NWTS contained relevant equipment in a design specified jointly by the provider and NWTS. Specialist paediatric medical equipment was supplied and maintained directly by NWTS and was not part of the provider's contract.

Medicines

- Falck (Warrington) provided a patient transport service and did not keep stocks of medicines on their vehicles.They did keep supplies of medical gases, including oxygen and nitrous oxide.
- The provider supplied documents which demonstrated that the premises had been inspected by the local authority and were certified to store medical gases.
- Oxygen and nitrous oxide were stored in a separate, lockable facility, with cylinders stored off the ground.All of the cylinders we checked were in date.
- Access to the medical gases was restricted to authorised personnel. A record of who the authorised personnel were was provided.
- Staff we spoke with knew about their responsibilities when administering oxygen. The amount of oxygen that patients required was requested as part of the booking procedure and the relevant information was passed to staff prior to transport.

- The ambulance crews told us that the oxygen and nitrous oxide was checked on a daily basis to ensure that it was in good working order. The station managers showed us evidence related to an external contractor inspecting and servicing oxygen equipment.
- The ambulance crew staff could administer oxygen based on a prescription recorded during the booking process for the patient journey. They could also administer oxygen that had not been prescribed, as necessary, based on their own assessment of clinical need. Staff records showed that relevant ambulance crew staff had all received training in administering oxygen and that this training was renewed every three years.

Records

- The service recorded information about the type of care required during a patient transport as part of a booking process. Staff accessed this information through electronic, hand held devices that were password protected.
- We received inconsistent evidence about the use of individual patient record forms completed during a patient transport. The management team based in Warrington confirmed that staff only completed individual patient records where treatment had occurred outside of the agreed care package received during the booking, or when an incident had occurred. We also found that the number of completed record forms indicated that they were not in use for every patient. However, we observed a patient record form being completed during a patient transfer. This was for a patient who required regular observations; crew indicated that this was a routine task as no information about the nature and type of observations required had been provided as part of the booking process and it was a task that they had instigated for themselves.
- The management team in Warrington stated that there were no routinely kept records of care provided during patient discharge transfers, even when oxygen was administered. The system for assessing and planning care relied on the information that was supplied by a third party during the online booking process. If oxygen was required, then the amount and timing would be specified as part of the booking. A patient record was only kept if oxygen was initiated during the journey that had not been specified as part of the booking. However, this process meant that, that there were occasions where oxygen was given in line with the booking requirement, but a contemporaneous record of the amount and timing of oxygen as it was actually given, together with any associated observations had not been kept. On this basis, we could not be assured that an accurate and contemporaneous record in respect of the care provided to each patient, and of any decisions taken in relation to the care provided during patient transfers, was always kept.
- Information about special notes including do not attempt cardio pulmonary resuscitation orders, dementia or mental health diagnoses, and requirements related to end-of-life care, were included as part of the booking process. Staff understood the need to review all of the booking notes and to check for the presence of do not resuscitate orders. An incident form was recorded if any special notes had not been identified during the book process so that the provider could investigate and improve the co-ordination of care with other providers.
- The provider had not historically audited patient record forms or the booking process, although the provider had identified this as an area for improvement through a prior systems review. There was a proposal in place for a new bi-annual audit system which was being implemented at the time of the inspection. The aim was to systematically identify where recording of information between providers was less than optimal with a view to improving standards.

Assessing and responding to patient risk

- Basic risk assessments were undertaken as part of the booking procedure either through an online booking form or over the phone with a centralised dispatch team. This included some screening questions to identify if the patient needed additional clinical support during the transfer. The quality of the risk assessment received through the online booking system, for example, regarding any special notes pertaining to clinical care, required the staff working for another provider to be aware of the need to provide a full range of information.

Patient transport services (PTS)

- We observed one example of a patient transfer where the booking information supplied was not adequate to ensure that staff understood the risks associated with moving the patient. Staff commented that this had been a recurring issue.
- Staff did not routinely make notes in relation to their own risk assessments for each patient. The patient record forms were not routinely used to record this information as they were primarily used for reporting exceptional circumstances or incidents. Therefore there was no consistent recording of the risks related to each patient transport and the actions taken to minimise those risks.
- The ambulance crews we spoke with had a clear understanding about what to do if a patient deteriorated during a journey. They told us they would pull over their ambulance and dial 999 for emergency assistance. Staff could also call the hospital they were working with to access clinical advice as well as dedicated clinical staff working for Falck UK Ambulance Services Limited.
- The ambulances used for patient transport services were equipped with automatic external defibrillators and oxygen that could be used in the event of an emergency. This equipment was checked daily by staff and we observed that they were in good working order on the day of the inspection.
- All staff received first aid training as part of their induction. This included providing cardiopulmonary resuscitation and the use of oxygen in an emergency situation.
- Staff had an understanding of do not attempt cardio pulmonary resuscitation orders, what the documentation looked like and the requirement to carry the relevant paperwork with patients at all times. There was a do not attempt cardio pulmonary resuscitation policy, which staff were aware of, requiring staff to complete and incident form in the event that the correct paperwork was not available for any reason.
- We noted that ambulance crew staff had been provided with conflict resolution training. Staff we spoke with were confident in their abilities to manage and de-escalate situations where patients became verbally or physically aggressive.

Staffing

- The service provided three to four ambulances per day from the Warrington main office and six to seven ambulances per day from the Rochdale base; on average there were 12 deployed crews each day. There were both substantive and casual workers available to fill the shifts.
- The ambulance operations manager and station managers reviewed staffing levels as part of their key performance indicator monitoring. We looked at examples of this monitoring information for three different hospitals over the past year. This showed that there were enough staff to meet the contracts' demands.
- We discussed staffing levels with the local operations manager. They were currently recruiting for additional ambulance crew for the Rochdale and Warrington bases, including both substantive and casual roles. They noted that they were potentially understaffed, particularly at the Rochdale base, but that the rota had been managed to ensure that all shifts were adequately filled.
- We discussed staffing levels with the ambulance crews at both Rochdale and Warrington. They confirmed that there had been sufficient staff to cover shifts by relying on staff to provide flexibility and over time; they were aware of the need for additional staff recruitment to guarantee adequate cover.
- The recruitment and learning department had reviewed concerns around staffing levels in the North West. An action plan was in place to increase staff recruitment and retention. This included recruiting staff on more flexible contracts and an increased rate of pay for the local area. The local operations manager noted that this plan had had some success, for example, they had a new ambulance crew member starting work in February 2018.
- Staff worked 12 hour shifts with a variety of different working patterns. Breaks were half an hour, or 45 minutes, depending on the length of the shift. The shift rotas were published a month in advance.
- Staff told us there had been a centralised system for managing rotas. Some ambulance crew found that this had not supported their needs adequately resulting in

unsatisfactory working patterns. The management team had been responsive to this feedback and prepared the rota at a local level for the past month. Changes had also been made to introduce a 12-week rota so that staff had adequate notice to plan their work. The ambulance crew members that we spoke with said this was a positive improvement leading to greater satisfaction with the types of shift patterns that were being worked.

- The director of patient transport services also told us a new software system was due to launch in May 2018 to further improve rota systems by matching resources to activity.

Anticipated resource and capacity risks

- The provider anticipated resource and capacity risks through the maintenance of national and local risk registers.
- For example, at the time of our inspection, the local risk register had identified issues with recruitment and changes to the types of standardised equipment used on the ambulances as areas of potential risk. We found that there were coherent action plans in place to mitigate any potential risk, through a new recruitment strategy, and staff training programmes for the use of new equipment.

Response to major incidents

- The provider had a national business continuity and major incident policy. This identified protocols and documents that needed to be in place at a local level as well as systems for managing risk to centralised services.
- There were also local business continuity plans which had been kept up to date, for example, with details of local suppliers, so that they could be operated in the event of an unexpected disruption to the service, including loss of premises, for example due to fire or flooding.
- The registered manager told us they had held discussions with their local NHS Trusts regarding supporting and assisting other services in the event of a major incident, but that there were no plans in place for the service to provide a formal response role in the event of a major incident.

Are patient transport services effective?

Evidence-based care and treatment

- Staff followed local and national protocols put in place by the provider and were aware of additional protocols for specific contracts, such as when working with the paediatric NWTS service.
- The provider had developed a new piece of software, the Global Emergency Management System. A team of staff had been charged with developing, at a national-level, flow charts and policies that described actions to complete in any given situation. The flow charts were developed through discussions with frontline and management staff, and took into account relevant, published guidance. The policies and flow charts were then added to the emergency management software which could be accessed by all staff via an individual handheld electronic device.
- The ambulance crew that we spoke with were aware of this guidance and were working to implement the processes accurately. They were aware of which policies and protocols had recently been updated and cited examples.

Assessment and planning of care

- The patient transport service provided non-emergency transport for patients who required transferring between hospitals, transfers home or to another place of care. Staff had prior information about the patients they would be requested to transfer through a booking process.
- Key information about the patient was supplied during the booking process. Staff reviewed this information to ensure a safe transfer. For example do not attempt cardio pulmonary resuscitation orders were noted, as well as other special notes, such as the requirement for oxygen therapy, or diagnoses that might affect the type of care provided, such as the presence of dementia or mental health diagnoses.
- However, some staff commented that they lacked some information about patients that could be used to improve the level of care provided. In particular, they noted that the booking information system could be improved. For example, we observed the booking

process for a patient who was referred from their GP to a hospital ward. There was no clinical information on the booking received by the ambulance crews regarding this patient. We discussed this with the ambulance crew who reported that this lack of information in the booking system was common. They therefore needed to ascertain relevant information through discussions at the handover points. The bookings were frequently made through an online system which relied on the staff working at another provider to divulge full and relevant information.

- We discussed this with the station manager who noted that there had been some communication issues around booking patients through this particular provider. They stated that they would remind the ambulance crew to record this event as an incident because they had not received enough information through the booking system to ensure that risks were minimised when moving the patient.
- Staff told us that they also held discussions with staff at the discharging service, the patient or their relatives to help plan each journey and complete the transfer safely and with minimum discomfort to the patient. For example, they would try to identify any barriers to a safe transfer of a patient at handover points so that they could consider what equipment and moving and handling techniques might be required.
- The ambulance crew were sensitive to patients' needs. For example, if a longer-distance journey was scheduled, the trip would be planned with stops to use the toilet and for refreshments. All of the ambulances held bottled water to give to patients, as required, during a journey.

Response times and patient outcomes

- The station manager in Warrington showed us how they monitored the quality of the service provided to each patient. Staff were required to record an action on their portable electronic devices to note key points in the patient journey, such as the time that they arrived at hospital to collect the patient, the time they made contact with the patient, the time they left the hospital and the time they arrived at their destination.
- There were performance targets set for each member of staff which related to the amount of time taken to assist each patient. The station manager was conscious of the need to reduce waiting times for patients and ensure prompt transport of patients, for example, to medical appointments. If any staff member dropped below a pre-determined target then they were asked to meet with their manager to discuss their performance. The provider also had a league table where staff could compare their performance against other members of staff. The information on response times was also used to inform an appraisal process.
- We also observed that information was collected and monitored by the station manager at the control room in the Rochdale base.Any member of staff could be monitored for the jobs that were assigned to them via the information available at the control room. The screen was 'live' at the local station, so the station manager was always aware of what issues were causing a delay by viewing the jobs on screen.
- The registered manager told us they held periodic meetings with their NHS Trust partners to discuss any performance issues. They showed us that they kept an up to date contract monitoring dashboard for each hospital which included information about the number of journeys made and the type of support and equipment required.

Competent staff

- There was a five-day induction training programme for all new staff. Training covered key topics including, moving and handling, safeguarding and infection prevention and control. Staff started work upon completion of the induction and mandatory training courses. Staff we spoke with had completed the induction process in line with the policy.
- All staff working on the ambulances were required to renew mandatory training in line with a specified time schedule. This included the tests required for validating clinical skills. The information provided on staff training showed that staff had either fully completed or were booked onto relevant training courses to renew their training. In cases where staff had been unable to renew training in a timely manner, there was a relevant risk assessment in place so that the provider could assure themselves that staff were safe to remain operationally active until training was complete.
- There was a process for completing driving license checks. The human resources department sent station

managers reminder emails to check driving licenses for individual staff members a year after they had joined the service, and in each subsequent year. The manager checked the driving licence validity against the Driver and Vehicle Licensing Agency system. Staff with penalty points on their driving license were risk assessed to ascertain if they were fit to continue. The provider's policy did not allow any driver with more than six penalty points on their licence to drive an ambulance.

- However, there were currently no arrangements for ongoing checks of driver competence, such as spot checks or 'ride outs' by a driving assessor. Staff told us that if they had a concern about the standard of a crew member's driving they would report this to the station manager for a review.
- The provider had recently launched a new staff supervision and appraisal system called 'my contribution'. There had been some delay in introducing the new system, meaning that staff appraisals had not been carried out in the previous year. However, the station managers and operations managers were now actively engaging staff in the new process. At the time of the inspection, we found that just under 40% of active ambulance crew had completed an appraisal process. The appraisal covered training compliance, setting of development goals and an assessment of staff wellbeing. There was a plan to complete the remaining appraisals by the end of March 2018.
- The staff we spoke with who had been involved in the 'my contribution' process commented that it had been a useful process and helped them to understand potential career progression opportunities.
- Staff requiring extra support were identified through supervision and appraisal procedures, as well as through ad hoc contact with line managers. The provider ensured staff had access to services that supported staff mental wellbeing, for example, following attendance at a traumatic patient transport event.

Coordination with other providers

- The provider had good working relationships with their NHS providers. The registered manager told us they held regular meetings with each client to monitor the provision of care.
- We discussed the service with one of the provider's clients. They told us they were satisfied with arrangements and that the provider worked hard to meet their needs.
- In one example, we saw that the NWTS service had provided a member of the ambulance crew with an 'excellence' report as they had promptly responded to the needs of a patient and been prepared to come in early for a shift to ensure the safe transfer of a patient.
- Bookings were made via a call control centre or through an online form.The ambulance crew received the information on their portable, electronic devices. We saw from the information received that a number of standard questions were asked at this stage including any special requirements. Some staff were not completely satisfied with the level on information recorded at this stage.

Multidisciplinary working

- We observed good multidisciplinary team working between crews and other NHS staff when treating patients. We saw co-ordinated care and transfer arrangements when crews were handing the care over to NHS staff.
- We spoke with staff at the NWTS paediatric service where ambulance crews were working on the day of the inspection. They commented that the Falck staff were well integrated within the service, understood the nature and boundaries of the professional working relationship, and were considered valued members of the multidisciplinary team.
- We observed that ambulance crew asked hospital staff appropriate questions to make sure that they understood the patients' needs prior to each transport.
- Staff checked that they had received the correct documentation at handover points and raised issues about the completeness of information, if necessary.

Access to information

- Staff had access to policies and standard operating procedures at each ambulance station and on hand held electronic devices.

Patient transport services (PTS)

- The ambulances were equipped with a satellite navigation system and an electronic tracker (global positioning system) to enable communication and monitoring of the vehicle whereabouts.
- Ambulance crews were provided with key information and special notes regarding care plans though the booking process. The booking information was transferred directly to their hand held devices.
- Staff were aware of the importance of do not attempt cardiopulmonary resuscitation orders, for example, in patients being transferred as part of the end-of-life care pathway. Staff had been instructed to carefully monitor the presence of the correct documentation and escalate concerns when this was not present. We reviewed one incident report where this protocol had been followed up and investigated by the registered manager.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service provided staff training on consent processes, as well as protocols for following the terms of the Mental Capacity Act (2005), through level one and level two safeguarding courses.
- Staff we spoke with had good knowledge about the importance of understanding patients' mental capacity, how they could act in line with 'best interest' decisions, and the importance of involving patients in decisions about their own care, wherever possible.
- Staff also understood the requirements of Gillick competence. Gillick is a term used to describe if a child under 16 years of age is able to consent to their own medical treatment without the need for parental permission or knowledge.

Are patient transport services caring?

Compassionate care

- All of the staff that we spoke with during the inspection showed a commitment to providing the best possible care.
- We observed care being provided on a patient journey by one ambulance crew. Staff were respectful, kind and considerate towards the patient in their care. The crew introduced themselves and explained to the patient what was happening at each stage of the journey. They explained clearly when taking the patient's heart rate and blood pressure.
- Staff showed an awareness of the importance of maintaining patients' privacy and dignity. During the patient transfers, staff ensured that patients were covered in blankets; the transfer from hospital bed to ambulance trolley was done behind a screen. There were some arrangements to support patients travelling on the vehicle. For example, some ambulances were equipped with dementia mitts (mitts provide something patients can hold and 'twiddle', helping to reduce anxiety and promote calm. The mitts are simple knitted cuffs, to which a range of items, including ribbons, buttons or beads, can be sown and which provide activity for patients) following dementia awareness training for staff at a local hospital. The ambulance crew noted that the mitts were useful for providing a distraction for patients while travelling on the ambulance.
- Staff had also been asked to read 'This is me' forms for elderly patients being discharged from wards and care homes. This provides some brief, personal history for each patient. The ambulance staff stated that this helped them to engage their patients in conversation during the journey.
- Staff were also careful about continuity of care after patients' transfers were completed. For example, they checked with patients and relatives about the availability of ongoing care and support after the transfer had been made from hospital to home.
- We spoke with NHS staff who regularly gave handovers to the ambulance crew. The nursing staff told us that the crew staff were always professional in the service they provided and they treated patients with dignity and respect.

Understanding and involvement of patients and those close to them

- Staff demonstrated an awareness of involving patients, and their relatives or carers, in any decisions that were made about their care.

- The ambulance crew we observed were supportive of patients and remained committed to involving them in their care at all times. For example, we noted they spoke with the patient by name and explained what was happening as they were being moved.
- The provider was introducing a formal, "Hello my name is" protocol to improve communication with patients. This was to ensure that it became standard practice for staff introduce themselves to patients and tell them where they were taking them.

Emotional support

- Two of the patients we spoke with told us that the staff were 'outstanding' and 'exceptional'. They stated that staff checked on their wellbeing throughout their journey and were attentive to their physical comfort and emotional wellbeing.
- Staff understood the need to support family members should a patient become unwell during a journey. Ambulance crew working on the NWTS service had been specifically tasked with supporting relatives during the patient transfers.
- We observed one example where a parent and child had been impressed by the level of support given by a member of staff; they had revisited the NWTS service to thank the member of staff personally.
- The provider had also recognised the need to support staff who had witnessed any traumatic events as a result of their work. There were posters on display at each of the ambulance bases which offered staff access to free counselling services, if necessary.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- At the time of inspection the service held contracts with five NHS providers. This was to transport patients between hospital sites, homes and care facilities. This included some end-of-life care transfers, some bariatric patient support, and a specialist paediatric transport service. The number of vehicles provided varied on a day-to-day basis depending on the needs of the service with an average of 12 crews deployed each day.
- Staffing levels, shift patterns and availability of vehicles were adjusted in line with each contract's requirements. The registered manager told us that they were also responsive to ad hoc requests for additional vehicles made by their clients and worked to provide emergency cover when it was needed.
- The management team told us they held regular meetings with representatives from the NHS Trusts that they worked with to check that they were meeting the agreed number of contracted vehicles and shifts supplied, as well as to review the number of patient journeys made.
- We noted that Falck (Warrington) had worked closely with other providers to tailor their service to their clients' needs. For example, there were three vehicles which had been fitted out specifically for use by NWTS paediatric service. Falck staff had liaised with NWTS staff to design an appropriate lay out for the vehicles and reviewed any additional items that were required for the paediatric service.

Meeting people's individual needs

- There were a range of measures to ensure staff could meet patient's needs.
- Information that had been received as part of the booking process was communicated to staff via their portable electronic devices. Additional conversations were held between staff from different services at handover points.
- A telephone interpreting service was available at all times and translation services could be arranged promptly for patients who did not speak English as a first language. Staff knew how to arrange the service.
- Staff told us, and we observed that, patient's requirements and preferences were discussed and practical adjustments were made, to meet individual needs prior to transporting patients. For example, longer journeys were planned with comfort breaks, both seated and stretcher vehicles were available, and 'same sex' crew members could be provided, where required.

- Staff understood do not attempt cardio pulmonary resuscitation orders and checked for the presence of these when working patients who were receiving end-of-life care.
- Staff were able to escalate concerns to NHS or the provider's clinical teams to access advice if a patient's health rapidly deteriorated during transfer so that an appropriate plan for management could be made. Staff told us that they followed a protocol of pulling over to the side of the road and dialling 999 for emergency services if they observed a rapid decline in a patient's health.
- All vehicles carried special communication aids, such as picture charts, to support non-verbal communication.
- Staff had completed specific training, such as in dementia care and mental health, to meet their patients' needs. This training included discussions around managing and supporting vulnerable adults.
- Staff had completed training in conflict resolution. This meant that they were aware of the need to use minimal restraint or force in response to aggressive or violent patients.
- The ambulance crew and registered manager told us they had made some special arrangements for moving bariatric patients, including the provision of additional equipment.
- The provider had worked closely with staff from NWTS paediatric service to ensure that their vehicles were specifically equipped to meet the needs of the health professionals and children who were using the service.

Access and flow

- At the time of the inspection, the average deployment per day was 12 ambulances. There were a total of 16 ambulances available for use, thus ensuring that there was adequate service cover in the event of a vehicle breakdown.
- Bookings were managed through the provider's centralised dispatch centres in either Shropshire or London. Each booking was then directed to an individual staff member's electronic portable device so that they could review the information. They logged an activity on the device to confirm that the booking had been received and reviewed.
- Staff performance was monitored by the operations manager through the use of both vehicle tracking systems and by staff logging their activity on a portable electronic device. This information was used to assess response and handover times. The information was reviewed by station managers to identify any areas for service improvement.
- The NHS providers that the service worked with requested information about performance, for example, in relation to the number of patients transported each day. The service kept an electronic log about the time taken to move each patient.

Learning from complaints and concerns

- There was a formal complaints policy. Staff were aware of this policy and acted in line with it.
- We saw that the ambulance crew members carried leaflets with them to give to patients about how to complain or provide service feedback.
- The NHS Trusts that the provider worked with forwarded information about any complaints they received in relation to Falck (Warrington) staff. If necessary, there was a process for joint investigation and learning across the different providers.
- The health, safety, environment and quality department was responsible for monitoring and investigating any complaints. The registered manager supported the process by collecting evidence and statements from staff. Complaints were reviewed at a national governance forum that was held on a quarterly basis, to monitor for any trends, or identify any opportunities for shared learning across the business.
- The head of health, safety, environment and quality noted that they risk assessed complaints as they were received to determine if there was a need for immediate action. People making a complaint were contacted within three working days to inform them of the investigating process. There was an internal target for completing an investigation, and responding to any complainant in full, within 25 working days.
- The service had received five formal complaints in the past year; we saw that these had been dealt with in line with the provider's policy.

- We asked staff how learning from complaints was shared to prevent a recurrence of the concerns raised. They were able to cite examples of actions taken, such as the provision of additional training to groups and individual members of staff.

Are patient transport services well-led?

Leadership of service

- The executive management team consisted of the chief executive, chief finance officer, director of emergency and urgent care, director of patient transport services, director of human resources, and the head of health, safety, environment and quality.
- The management team in the north west region included station managers based in Warrington and Rochdale, as well as an operations manager covering both locations.
- There had been a period of service transformation following the change in ownership to the Falck group which had occurred in July 2015. The staff we spoke with were largely positive about the changes that had occurred since the change in ownership. They told us they were aware of the leadership team and their roles and responsibilities. They noted that the local management team were approachable and responsive when they had any concerns.
- However, some staff said they had not always felt involved in the changes that had been introduced to the service and how this had impacted on their roles.
- We observed members of staff interacting well with the management team during the inspection.
- There were appropriate staff reporting procedures to escalate concerns about co-workers and colleagues through the operation of a whistleblowing policy.
- Local managers had been engaged in a leadership training course over the past three months to support the effective management of their teams.

Vision and strategy for this core service

- Falck UK Ambulance Services Limited is part of the global Falck group which operates ambulances in 22 countries.
- The UK service has a set of core values: helpful, efficient, accessible, competent, fast and reliable. We saw evidence of these values being promoted to staff, for example, through visual displays around the ambulance bases, and through the inclusion of a discussion on values during the appraisal process.
- Falck positions itself as an organisation which invests in equipment and technology to support efficient and competent care. We saw examples of how this worked in practice. There was a new Global Emergency Management System installed on all of the frontline staff's portable electronic devices. This enabled them to access relevant protocol and policies promptly. There had also been an investment in the ambulance fleet, for example, through the upgrading of equipment, including the provision of new 'banana' boards.
- We discussed the vision and strategy for the Falck (Warrington) service with the local and executive management team. They were committed to developing the business further and looking at the possibility of extending their provision into emergency and urgent care, in line with other parts of the business. They noted that this would also provide career development opportunities for their ambulance crew staff.

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

- There had been a period of service transformation following the change in ownership to the Falck group which had occurred in July 2015. It was evident that a number of new policies and protocols had recently been implemented; the implementation had been supported by investment in new computer software and training to support staff to understand and access information promptly.
- There was a governance framework in place with associated staff policies and protocols. The governance framework was actively being revised at the time of the inspection. We were told that the revised framework would be taking account of a corporate social responsibility agenda that would relate to Falck's core values.

Patient transport services (PTS)

- The governance frameworks and procedures were well understood by staff. This ensured, for example, the timely reporting and investigation of incidents and safeguarding concerns.
- We looked at the national and the regional risk registers for ambulance operations. There were national registers specific to patient transport services as well as to Falck UK Ambulance Service Limited as a whole. Risks identified at local levels were reviewed and added to the national register where risks were deemed sufficiently high or contributed to a wider, national picture. Similarly, any changes being made at a national level that would impact on operations locally were identified and monitored through the local system.
- The registers we reviewed were up to date and included actions assigned to staff members to mitigate the risks highlighted. Progress against the actions to mitigate risks was recorded and up to date. Progress against the actions to mitigate risks was recorded and up to date. The head of health, safety, environment and quality met regularly with the registered manager to review the risk registers and ensure mitigating actions remained appropriate.
- The registered manager told us that the local and national risk registers were reviewed each month by the executive management team to ensure mitigating actions remained appropriate.
- There were also quarterly governance forums where leaders met to share and resolve concerns. Content of the governance meetings was sufficient to ensure that the discussions held supported the delivery of good care.
- The service undertook some audits to identify areas for improvement. We reviewed a sample of audits completed within the past six months. These covered, for example, equipment and readiness of ambulances and vehicle defects. This also included an audit carried out in January 2018 against the CQC key lines of enquiry for independent ambulance providers.
- We found that some audits were periodically planned, and others were instigated in response to concerns raised by staff. In all cases the audits identified actions that could be taken to further improve the service. These were allocated to named members of staff with dates set for completion.
- The provider had not historically audited patient record forms or the quality of the booking process. However, this had already been identified as an area for improvement by the providers' health, safety, environment and quality department at the time of the inspection. Additional, bi-annual audits were being planned for these areas in the coming year. Our inspection found that the quality of the information received through the booking process was variable; the recording of patient information during the transfer process was not sufficient to maintain an accurate, complete and contemporaneous record of the care and treatment provided to each patient.
- The service monitored key performance indicators for each contract it held with other providers. Monthly reports were produced to aid internal monitoring and also to aid communication on performance with the relevant providers. These contained key information about performance including the number of journeys made, the type of support and equipment required, the number of aborted journeys, the overall waiting time target (less than120 minutes) for patients, the booking method and invoicing totals.
- There was a recruitment policy for employing new staff. This included proof of identity, driving licence and enhanced disclosure and barring service checks. References and qualifications were also required. We reviewed the recruitment records for two of the newest staff members and found that relevant checks had been completed.
- Staff all completed a self-assessment in relation to their physical health which included a request in relation to their routine immunisation history. However, we found that the provider did not currently check that staff who had direct patient contact as part of their role had been immunised with other selected vaccines, such as Hepatitis B, which may be appropriate for their role.
- We discussed this with the head of training and recruitment. They commented that they had received some recent advice from an occupational health provider regarding the provision of hepatitis B vaccination for all members of staff, but there was as yet no timeline for implementing a review of staff immunisation history.

Culture within the service

- There had been a period of organisational change starting in 2015 when the service had become part of the Falck group. The majority of the staff we spoke with told us that Falck had been good at keeping them informed and consulting them on changes. They found the management team to be responsive to their ideas and concerns.
- Staff described a recent example where they felt their views had been acted on. Staff had been dissatisfied with the rota system. The management of the rota had been centralised following an organisational change. Staff had been dissatisfied with the way the new system worked. They raised these concerns with the management team. The managers had taken action to resolve the concern and moved back to managing the rota at a local level. Staff commented that they had noticed an improved system within the past month.
- The executive management team and local managers we spoke with demonstrated a commitment to quality improvement and safety. For example, we noted that investment had been made to improve the overall quality of the fleet and equipment that was in use. Tailored solutions were developed for each contract held with other providers and due consideration was given to staff development and training.

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

- The service showed us examples of how they had worked with other providers to make improvements to the service. For example, they had held a review with one other provider about how to better support the needs of patients with dementia. This had led to changes in protocols for staff, including the use of dementia mitts, and guidance about ensuring accurate knowledge about patients through liaison with other staff and the use of written patient histories.
- The management team and the ambulance crew staff told us that they held informal discussions on a daily basis to ensure a flow of information about the operation of the service. We also found that the registered manager held more formal team meetings as and when they were required. For example, they had held a meeting in January 2018 to introduce a new policy related to do not attempt cardio pulmonary resuscitation forms.
- The management team told us an internal email system was due to launch within the next month so that company-wide and local staff announcements could be more effectively made.
- Ambulance crews carried feedback forms, as well as copies of the complaints procedures which could be distributed to patients, as required. There was an option to email written feedback or call a dedicated patient experience team to provide more detailed feedback.
- Staff also noted that electronic tablets were periodically taken out on the ambulances to survey patient feedback. The information received was reviewed by the registered managers and local station managers. For example, information collated for the Rochdale base in December 2017 showed that fourteen people had provided feedback.All of the patients stated that they were either 'likely' or 'extremely likely' to recommend the service to others.

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

- The service had been finalists for the North West Procurement Awards patient experience category for services to the NWTS Service. They had previously won this award in 2016 and were also the supplier of the year in 2016.
- The provider was introducing a formal, "Hello my name is" protocol to improve communication with patients. This was to ensure that it became standard practice for staff introduce themselves to patients and tell them where they were taking them.
- The provider had invested in new software, including a tailored Global emergency management systems to provide all staff with immediate access to the most up to date policies and protocols. Longer term plans for the system included using it for incident reporting. With the aim of ensure consistency throughout the company.

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Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that appropriate risk assessments and care plans are fully recorded prior to transferring patients. Steps must be taken to maintain a complete and contemporaneous record of the care and treatment provided to each patient.

Action the hospital SHOULD take to improve

- The provider should review arrangements for periodic and practical checks of driver competence.
- The provider should further mitigate the risks to staff carrying out care and treatment by checking that staff with direct patient contact had selected immunisations, such as Hepatitis B.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The provider did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients that arise from the carrying on of the regulated activity. • The provider did not maintain a complete and contemporaneous record of the care and treatment provided to each patient. This is a breach of Regulation 17 (1) (2) (b) (c).