K.F.A Medical Ltd

KFA Medical

Inspection report

Butterfield House
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

- The provider failed to ensure infection prevention and control procedures were aligned to current best practice guidelines.
- The provider failed to ensure a robust process for the safe administration, training and storage of medical gases.
- The provider failed to demonstrate that all staff employed were of good character and had the appropriate qualifications, competence, skills, experience and are fit and proper to undertake the role they were employed to perform.
- There was no assurance that mandatory training and key skills was provided to all staff. In addition, there was no assurance staff had completed it.
- Staff could not demonstrate they understood how to protect patients from abuse. There was no evidence that the service worked with other agencies to do so. There was limited evidence of training on how to recognise and report abuse nor could they articulate that they knew how to apply it.
- The design, maintenance and use of facilities, premises, vehicles and equipment did not keep people safe.
- The service did not manage patient safety incidents well. Staff did not know how to recognise or report incidents and near misses. Managers failed to investigate incidents or share lessons learned with the whole team and the wider service.
- Leaders could not demonstrate they had the skills and abilities to run the service. They could not articulate they understood and how they managed the priorities and issues the service faced.
- Leaders could not demonstrate how they operated effective governance processes, throughout the service. Not all staff were clear about their roles and accountabilities**.**
- Leaders and teams could not evidence how they used systems to manage performance effectively. They could not articulate how they identified and escalated relevant risks and issues.

Following the inspection CQC took enforcement action using our urgent powers whereby we suspended the provider's registration under section 31 as people may or will be exposed to the risk of harm until 14 June 2021. This was to immediately protect patients from the risk of harm and to give the provider the opportunity to put in place urgent actions to address our concerns.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inspected but not rated	• The provider failed to ensure that systems, procedures and practice for infection prevention and control were aligned to current best practice guidelines. • The provider failed to ensure robust processes were in place for the training, storage and safe administration of medical gases. • The provider failed to demonstrate that all staff employed were of good character and had the appropriate qualifications, competence, skills and experience to undertake the role they were employed to perform. • There was no assurance that mandatory training and key skills was provided to all staff. In addition, there was no assurance staff had completed it. • Staff could not demonstrate they understood how to protect patients from abuse. There was no evidence that the service worked with other agencies to do so. There was limited evidence of training on how to recognise and report abuse nor could they articulate that they knew how to apply it. • The design, maintenance and use of facilities, premises, vehicles and equipment did not keep people safe. • The service did not manage patient safety incidents well. Staff did not know how to recognise or report incidents and near misses. Managers failed to investigate incidents or share lessons learned with the whole team and the wider service. • Leaders could not demonstrate they had the skills and abilities to run the service. They could not articulate they understood and how they managed the priorities and issues the service faced. • Leaders could not demonstrate how they operated effective governance processes, throughout the service. Not all staff were clear about their roles and accountabilities.

Summary of findings

- Leaders and teams could not evidence how they used systems to manage performance effectively. They could not articulate how they identified and escalated relevant risks and issues.

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Summary of findings

Contents

Summary of this inspection

Background to KFA Medical

KFA Medical first registered with the CQC on 14 June 2013. The service is an independent ambulance service based in Keighley, West Yorkshire.

The company provided a range of services including; urgent and emergency paramedic and first aid medical coverage at both private and public events; blood and organ transport; first aid training, repatriation of patients all of which are not currently regulated by CQC. The company also patient transport service including patients with mental ill health which is regulated by CQC.

In January 2021 CQC received information of concern about KFA Medical Ltd. A decision was made to carry out an unannounced focussed inspection of the safe and well-led domains to investigate the concerns.

Following the January 2021 inspection, we issued the provider with a notice of decision on 15 January 2021, to urgently suspend the provider's registration to carry out regulated activity until 14 March 2021. This was due to risks identified regarding patient safety identified during the inspection. We told the provider that it must take 24 actions to comply with the regulations and should take one actions even though a regulation had not been breached, to help the service improve.

This inspection was an unannounced focussed inspection of the safe and well-led domains to gain assurance the provider had acted in response to the issues highlighted in the notice of decision to urgently suspend the provider's registration to carry out regulated activity.

How we carried out this inspection

KFA Medical Ltd are registered to carry out the following regulated activities:

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

During the inspection conducted on 10 and 11 March 2021, we visited Branwell House, Park Lane, Keighley, West Yorkshire BD21 4QX, which is the provider's operating base and undertook interviews of staff remotely.

At the time of this inspection the provider employed only one member of staff, however, there were three staff who were paid hourly who worked on an as and when required basis.

The staffing consisted of; a managing director who was also the registered manager and nominated individual, a company accountant who also was employed in a company secretary role, an operations manager and a staff trainer.

During the inspection we spoke with the registered manager, company secretary, operations manager and one staff trainer. We also reviewed four staff files and inspected one operational ambulance used for PTS.

Activity (April 2020 to January 2021);

Summary of this inspection

- In the reporting period, there were 6,477 patient transport journeys undertaken between two NHS hospitals. Five children were transported. At the time of inspection, the service was suspended, and no patient journeys had been undertaken.
- In the reporting period, there were no emergency and urgent care patient journeys undertaken.
- The provider does not store or use controlled drugs.

Track record on safety:

- No never events reported
- Clinical incidents; none with no harm, none with low harm, none with moderate harm, none with severe harm, and no deaths reported.
- No serious injuries reported
- No complaints reported.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with the legal requirements. These actions related to Patient Transport Services.

- The provider must develop systems and processes to regularly test staff for COVID-19 in line with national guidance. **Regulation 12.**
- The provider must develop a system and process to ensure all staff are subject to regular monitoring and assessment regarding their fitness to drive including health declaration and driving penalty points or motoring convictions. **Regulation 12.**
- The provider must have a job application process that covers all aspects of the role applied for. **Regulation 12.**
- The provider must have a medical gasses policy which is service specific. **Regulation 12.**
- The provider must develop a system to ensure effective sharing of learning from incidents. **Regulation 12.**
- The provider must have robust infection prevention control measures in place and those measures must follow the most current government guidance and legislation. **Regulation 12.**
- The provider must have current and appropriate disclosure and barring checks (DBS) for all staff for the role in which they are employed. **Regulation 13.**
- The provider must have a safeguarding lead that has completed safeguarding training commensurate with their role. **Regulation 13.**
- The provider must have an effective system and process to ensure all vehicles and the equipment carried on them are safe and fit for purpose. **Regulation 15.**
- The provider must have visible signage displayed at their operating base in relation to oxygen storage and accompanying fire risk assessments. **Regulation 15.**
- The provider must have the appropriate equipment for the patients transported in their vehicles with the associated systems and staff training in place for the safe operation of that equipment. **Regulation 15**.

Summary of this inspection

- The provider must have policies that are specific to the service and all cross-referenced policies within a policy must be in place. **Regulation 17.**
- The provider must have clearly defined job specifications and governance oversight of the management roles in the company. **Regulation 17.**
- The provider must develop effective systems and processes to effectively manage risk. **Regulation 17.**
- The provider must develop a systematic programme of clinical and internal audit to monitor quality, operational and financial processes. **Regulation 17.**
- The provider must have a mandatory training policy. **Regulation 17.**
- The provider must develop systems and processes to accurately record and monitor statutory and mandatory training of staff commensurate with their role. **Regulation 18.**
- The provider must recruit all staff in accordance with Schedule 3 requirements of the Health and Social Care Act 2009 (Regulations) 2014. **Regulation 19.**
- The provider must have systems and processes, including a duty of candour policy, to confirm all staff understand what their responsibilities are under duty of candour. **Regulation 20.**

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Patient transport services

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Patient transport services safe?

Inspected but not rated

Mandatory Training.

- **There was no assurance that mandatory training and key skills was provided to all staff. In addition, there was no assurance staff had completed it.**
- There was no mandatory training policy which indicated the expectations for staff in completing training. Therefore, there was no documentation of the frequency of training or role specific training requirements. The leadership team confirmed a mandatory training policy had not been developed.
- During this inspection we reviewed four staff training files and found no evidence of any completed training in one staff file. In a second staff file we found evidence of training which had not been updated as it should have been.
- We found a member of staff had been identified as the training lead but there was no evidence of any training that they had received to fulfil this role.
- We were not assured that staff providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely.

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Safeguarding

- **Staff could not demonstrate they understood how to protect patients from abuse. There was no evidence that the service worked with other agencies to do so. There was limited evidence of training on how to recognise and report abuse nor could they articulate that they knew how to apply it.**
- During the inspection we found in the four staff files that were reviewed, three members of staff had an inappropriate disclosure and barring service (DBS) checks and a fourth member of staff had an out of date standard DBS check on file, which is not the correct level of disclosure for this type service.
- The recruitment policy did not include information about what to do in the event of a DBS disclosure. During their interview the registered manager stated the applicant would not be employed however, we saw one DBS check for a staff member had returned two historical offences. There was no evidence of a risk assessment being completed and retained.
- We found evidence of continued issues with DBS checks; therefore, we were not assured the required improvements had been made to be compliant with the regulations.
- The registered manager who was the safeguarding lead for the service worked within the service on a full time basis but had completed safeguarding training below the minimum level recommended by the Royal College of Nursing intercollegiate document 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff', published in January 2019. We also noted that the training was due to be updated and no arrangements to undertake the required training had been made.
- During the interview with the registered manager, they were unable to articulate or demonstrate awareness of their duty and responsibilities under the Health and Social Care Act (HSCA) regulations to report safeguarding concerns.

Inspected but not rated

Patient transport services

Cleanliness, infection control and hygiene.

- **The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. Not all equipment, vehicles and premises were visibly clean.**
- During this inspection only one ambulance was operational as all other vehicles had been returned to the hire company.
- The provider's ambulance was visibly dirty including the floor, the track where wheelchair restrains would be secured and the wheelchair restraint cables, therefore increasing the risk of infection.
- There was conflicting information provided to the inspection team by staff whether this vehicle was cleaned and ready for use. The provider had cleaning check sheets and audits but there was no evidence how these would work in practice and it was not clear who would do this.
- The infection, prevention and control (IPC) policy did not contain evidence of the strength and dilutions of the cleaning materials in line with current best practice. The policy also did not include the training for staff in relation to IPC. Only one staff member of the four files we reviewed had current IPC training.
- When we inspected the service we found there were no cleaning materials (chemicals, mops, national colour coding awareness) at the location to clean the premises r vehicles. The registered manager also did not recognise the importance of using disposable mop heads.
- There was no robust procedure to appropriately clean vehicles following the transportation of a COVID-19 positive or suspected positive patients. The provider could not articulate, and there was no policy pertaining to, the transport of COVID-19 positive or suspected patients (single or dual patient transport). Staff told us what this process would be, however, there was no documentation in support of this and the description did not meet current best practice guidelines.
- The registered manager could not describe how the service would protect patients from asymptomatic COVID-19 staff. There was no policy or procedure regarding asymptomatic testing of staff for COVID-19 and it was not clear from the answers provided by the registered manager if this would be undertaken.
- The provider's Clinical Waste and Soiled Linen – Training information was reviewed. The document did not follow the updated NHS COVID-19 waste management standard operating procedure V4 dated 18 January 2021. This document identifies the processes providers should undertake during the segregation of COVID-19 and non COVID-19 waste, in particular, the colour coding for waste disposal.
- At this inspection we did not find evidence that the required improvements had been made therefore we were not assured that compliance with the regulations were being met.

Environment and equipment

- **The design, maintenance and use of facilities, premises, vehicles and equipment did not keep people safe.**
- There was no signage in relation to oxygen storage and no fire risk assessments in place at this location.
- The vehicle inspected had piped oxygen, however there was no patient oxygen masks available in the vehicle or at the location.
- In addition, there was no evidence staff had been trained in how to use and deliver oxygen safely to patients. There were no links in the policy as to the emergency use of oxygen and no evidence who would deliver training in administering oxygen to staff.
- There was no evidence that staff had been trained to use specialist equipment which was available for the transportation of children
- At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations.

Staffing

Inspected but not rated

Patient transport services

- **The service could not demonstrate that it had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- In the four staff files we reviewed there was limited evidence staff had been recruited in accordance with Schedule 3.
- We found that character references were not dated. One-character reference was supplied by a family member which is inappropriate, and one staff member did not have a character reference on file. The recruitment policy did not outline who would be eligible to provide a reference.
- There was no driving policy containing guidance or risk assessments in relation to staff with driving offences or penalty points. Managers confirmed driving was only included in the Staff Rota Management Policy and within this staff driving offences or penalty points were not included. This policy did not include routine driving licence checks for staff.
- The job application process did not include any requests for information about eligibility to drive including category of vehicles the applicant was qualified to drive, penalty points incurred of correct and current driving licence.
- There were no health questions in relation to fitness to drive on the provider job application form. For example, any health conditions which were identified as notifiable medical conditions or disability including but not limited to diabetes, sleep apnoea and epilepsy.
- At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations.

Medicines

- **The service could not demonstrate that it followed best practice when administering, recording and storing medicines.**
- In the medical gases policy, there were no links to emergency use of oxygen, there was no evidence staff had been trained in oxygen administration or who would deliver training in oxygen administration.
- The medical gases policy included direct statements from the BCGA code of practice 44 – The storage of gas cylinders document, without it being adapted to be service specific.
- There was no evidence of any supporting policies which were outlined in the medical gases policy.
- At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations.

Incidents

- **The service did not manage patient safety incidents well. Staff did not know how to recognise or report incidents and near misses. Managers failed to investigate incidents or share lessons learned with the whole team and the wider service.**
- There was no incident reporting system in operation and no formal process in place to share learning from incidents.
- We requested the service's duty of candour policy and staff training compliance on duty of candour, but this was not provided. In addition, the register manager could not explain what the provider's responsibilities were under duty of candour regulation.
- At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations.

Are Patient transport services well-led?

Inspected but not rated

Leadership

Inspected but not rated

Patient transport services

- **Leaders could not demonstrate they had the skills and abilities to run the service. They could not articulate they understood and how they managed the priorities and issues the service faced.**
- The registered manager could not provide detailed responses in relation to company policies stating they did not write them and didn't know what was contained within them.
- The company secretary had no previous experience in the role or ambulance sector. They were initially employed as company accountant in July 2020. However, they told us they had adopted several responsibilities in the company but there was no role specification. The registered manager confirmed that the company secretary was the clinical governance lead in the service and confirmed that they had no clinical qualifications.
- The company secretary could not describe the current management structure or how the management team would operate, however, the company secretary fulfilled roles and responsibilities that would usually be within the role of the registered manager.
- At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations.

Governance

- **Leaders could not demonstrate how they operated effective governance processes, throughout the service. Not all staff were clear about their roles and accountabilities.**
- There was no clear governance and accountability structure in place. The policies we reviewed were generic and non-service specific, which meant staff would not have the information from the provider as to what was expected from them.
- The company secretary told us they had devised new or re-written existing policies by going on the internet and copying them from other providers, therefore they were not service specific. In addition, the registered manager could not articulate the process of developing of the new policies or the content.
- At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations.

Management of risks, issues and performance

- **Leaders and teams could not evidence how they used systems to manage performance effectively. They could not articulate how they identified and escalated relevant risks and issues.**
- The registered manager confirmed the company had a risk register but was unable to articulate what was on the register or what the highest scoring risks were.
- The registered manager could not articulate the process required in the event of a positive DBS disclosure, or that a current staff member had positive disclosures on their DBS.
- The provider did not have a risk management policy or structure which meant there was little regard to the management of risk to protect staff, business assets and ensure financial sustainability.
- There was no programme of clinical and internal audit to monitor quality, operational and financial processes, or systems to identify where action should be taken.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider must develop systems and processes to accurately record and monitor statutory and mandatory training of staff commensurate with their role.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must have policies that are specific to the service and all cross-referenced policies within a policy must be in place. • The provider must have clearly defined job specifications and governance oversight of the management roles in the company. • The provider must develop effective systems and processes to effectively manage risk. • The provider must develop a systematic programme of clinical and internal audit to monitor quality, operational and financial processes. • The provider must have a mandatory training policy.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider must have an effective system and process to ensure all vehicles and the equipment carried on them are safe and fit for purpose.

This section is primarily information for the provider

Requirement notices

- The provider must have visible signage displayed at their operating base in relation to oxygen storage and accompanying fire risk assessments.
- The provider must have the appropriate equipment for the patients transported in their vehicles with the associated systems and staff training in place for the safe operation of that equipment.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The provider must have current and appropriate disclosure and barring checks (DBS) for all staff for the role in which they are employed. • The provider must have a safeguarding lead that has completed safeguarding training commensurate with their role

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must develop systems and processes to regularly test staff for COVID-19 in line with national guidance. • The provider must develop a system and process to ensure all staff are subject to regular monitoring and assessment regarding their fitness to drive including health declaration and driving penalty points or motoring convictions. • The provider must have a job application process that covers all aspects of the role applied for. • The provider must have a medical gasses policy which is service specific. • The provider must develop a system to ensure effective sharing of learning from incidents.

This section is primarily information for the provider

Requirement notices

- The provider must have robust infection prevention control measures in place and those measures must follow the most current government guidance and legislation.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour • The provider must have systems and processes, including a duty of candour policy, to confirm all staff understand what their responsibilities are under duty of candour.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed • The provider must recruit all staff in accordance with Schedule 3 requirements of the Health and Social Care Act 2009 (Regulations) 2014.