IMT Medical Transport Headquarters

Quality Report

Link Road Depot
Link Road Huyton
Liverpool
Merseyside
L36 6AP
Tel:0151 4493710
Website:www.imtmedical.co.uk

Date of inspection visit: 13 August and 4 September 2020
Date of publication: 28/10/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

IMT Medical Transport Headquarters is operated by IMT Medical Transport Limited. It is an independent ambulance service which was first registered in January 2018. The service is located in Liverpool and serves several NHS hospital trusts and local authorities. The service provides a patient transport service specialising in the transfer of mental health patients, including those detained under the Mental Health Act 1983, across the country.

We inspected this service using our inspection methodology. We carried out a focused unannounced visit to the service on 13 August 2020 and interviewed staff remotely on 4 September 2020 to follow up on enforcement action issued from the previous comprehensive inspection on 2 and 3 October 2019. We did not rate the service as this was a focused inspection.

Our previous inspection identified improvement was required as there was no effective systems in place to ensure risk assessments for patients were completed in line with policy and safeguarding concerns/referrals were made by operational staff. The policies did not identify all patient risks, the number of staff required for patient transport, how to manage a deteriorating patient, patient restraint, the Mental Health Act 1983 or the Mental Capacity Act 2005. Patient records were not completed to include all the necessary information, such as the, dynamic risk assessment on arrival, patient journey observations during transportation and the H4 authority form. (The H4 authority form is a legal document under the Mental Health Act 1983, to transfer a patient from one hospital to another under different managers).

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

- The service had reviewed and amended policies, but not all the information was clear and detailed for staff to follow. The policies did not always include best practice guidance or legislation.
- There was no clear process for regular audits of the service provided.
- It was unclear who the clinical and mental health support for the service was.

However, we found the following areas of good practice:

Summary of findings

- The service had made improvements in relation to the safeguarding processes and procedures for referrals by operational staff. Support for the service safeguarding lead was in place until face to face training could be arranged due to external influences.
- The service had made improvements to documentation and procedures to make sure incidents, including restraint were reported and investigated.
- The service had identified exclusion criteria for patient transport
- The service had made improvements to documentation to identify and record patient risk and assessments so the risks to the health and safety of the service users were assessed and risks were mitigated.

Following this inspection, we told the provider that it must take some actions to comply with the regulations. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals North, on behalf of the Chief Inspector of Hospitals

Summary of findings

Contents

Summary of this inspection

Background to IMT Medical Transport Headquarters

IMT Medical Transport Headquarters is operated by IMT Medical Transport Limited. The service registered with the care quality commission in January 2018. The service is available 24 hours a day, every day of the year.

The service is an independent ambulance provider specialising in the secure transport of mental health patients and those detained under the Mental Health Act 1983. The different types of transfers included from secure mental health units, inpatient units and acute settings; for example, accident and emergency departments to receiving mental health facilities or courts of law.

The service has had a registered manager in post since January 2018. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in January 2020.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Judith Connor, Head of Hospital Inspection (North West).

How we carried out this inspection

We inspected this service using our inspection methodology. We carried out a focused unannounced visit to the service on 13 August 2020 and interviewed staff remotely on 4 September 2020 to follow up on enforcement action issued from the previous comprehensive inspection on 2 and 3 October 2019. We did not rate the service as this was a focused inspection.

Information about IMT Medical Transport Headquarters

The main service provided by this ambulance service was patient transport services. This service was provided 24 hours a day, every day of the year. The service completed 592 patient journeys between October 2019 and 13 August 2020, which equated to an average of 79 journeys per month.

Patient transport services

Safe	
Well-led	

Are patient transport services safe?

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how it apply it.

The service previously did not have a clear procedure or process for the operational staff to follow upon receiving a referral from an ambulance crew.

The service had reported two safeguarding concerns during the period of October 2019 to 13 August 2020. We found improvement in safeguarding processes and procedures since our previous inspection.

All staff we spoke with demonstrated a good understanding of safeguarding principles and were clear on what the process was for making a safeguarding referral.

A safeguarding standard operating procedure (SOP 13 - 01 For staff to report safeguarding concerns) detailed responsibility for escalating safeguarding concerns by ambulance and operational staff to the duty manager who would make the necessary safeguarding referrals to the local authority.

The safeguarding policy did not reference the latest intercollegiate guidance which was identified at our last inspection. The policy had been reviewed in line with current national children safeguarding reviews on good guidance and associated legislation but did not reference Safeguarding Children and young People:Role and competencies for Healthcare staff, January 2019. The service had considered the roles of different groups of staff and determined which level of both children's and adults safeguarding training was required. Following the inspection, the provider told us this would be added to the reference list.

There were plans in place for the registered manager to complete level four safeguarding training which had been delayed as face to face training provided by the training company had been suspended following Covid-19. The registered manager mitigated the risk of not meeting best practice guidance with support from an employed advisor trained to safeguarding level four until training was completed. Arrangements were made for safeguarding level four cover when the advisor was not available. This included a direct contact number for staff to use for advice, support and concerns.

We were told recruitment processes and procedures were undertaken for all new staff in line with policy. This included completing the disclosure and barring service check and obtaining two references. We were unable to see these records at the time of the inspection as they were not on site due to COVID-19 amended working arrangements.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

At our previous inspection we had concerns the service did not have effective systems in place to ensure that only patients who were suitable for transportation with the service were transported; as there was no specific inclusion or exclusion criteria. This also included risk assessments not being completed in line with policy and the risk assessment completed on arrival was not documented.

The service had reviewed the conveyancing policy to reflect exclusion criteria, amended risk assessment documentation, staffing requirements for the patient journey and if the legal paperwork was necessary and completed.

Initial risk assessments were completed by the operational centre staff and formed part of the mental health request and authority booking form. The booking form/risk assessment had been updated to include red flag indicators such as infectious disease status and identified patient's suitability for transport.

Previously there was no documented inclusion/exclusion criteria by either the service or the providers that the work was being undertaken for. The revised policy stated there were no facilities to support a bariatric patient using the vehicle. Patients with mobility issues could use the

ambulance based on a successful risk assessment. Other exclusion decisions were made on a patient by patient decision based on patient risk. Each patient transport was assessed for patient suitability and the number of staff required to transport the patient was agreed with the requestor. This was in line with the amended conveyancing policy.

The risk booking form/risk assessments were checked on arrival to transport the patient. Staff told us they completed a dynamic risk assessment on arrival and if there were no changes the transport would go ahead and no changes were recorded on the form. If there were any changes identified in the dynamic risk assessment staff would contact the control room for advice and any significant change would result in the cancellation of the journey. We saw jobs had been recorded as cancelled from the oversight document.

We reviewed 11 risk assessments/booking forms which had completed patient observation and handover record forms in line with the updated policy. The risk assessments identified patients were suitable for transportation by the service. The amended forms collected the relevant information to mitigate risk to patients. The forms now included key information missing from our previous inspection; for example the questions included if a do not attempt cardiopulmonary resuscitation order was in place, if any clinical intervention was required, if the patient had any infectious disease and identified danger risks if the patient had been given any form of medical restraint (sedation). If this was identified a health professional was required to travel with the patient to safely transport the patient.

The use of visual and audible (blue light) warning systems were not monitored previously. There had been no audit system in place to ensure that the systems were being used appropriately or in line with the providers procedure. The booking form/risk assessment documentation had been amended to identify if the visual and audible warning systems had been used and required an incident report to be completed for investigation. There had been no use of the visual and audible warning systems in the 11 patient records we reviewed.

The booking form/risk assessment identified the vehicle type and the vehicle registration number required for the patient transfer.

The service had written a policy for deteriorating patients which included the patient observation and handover record. The policy detailed how staff managed early recognition, actions to minimise or prevent deterioration, escalation of a deteriorating patient and completion of observation and responsive notes to support a patient handover. Staff we spoke to were confident to recognise and respond to patients during the journey who became ill or agitated. We saw patient observations were documented on all 11 patient observation records stating if there had been any issues and what action had been taken.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

At our previous inspection the service was implementing an electronic system to record patient journeys and transfers. We found the service were still using paper based records as the electronic system was in the pilot stage. At the time of the inspection there was no definitive date for moving to the electronic system as external forces had resulted in the delay the project. It was estimated to be several months. The paper records were retrospectively added to the electronic system. The paper records were stored securely in locked cabinets.

The paper records had been updated and one patient booking form was completed (called the vulnerable patient move (VPN) request), which included the patient risk assessment. The form was completed by the operational centre staff at the booking stage and a copy was given to the ambulance crew as the form contained the patient risk assessment information. The patient journey information was recorded on a patient observation record. We reviewed 11 patient observation records and saw the observations recorded were in line with the policy with no longer than 20 minute observation notes. Notes included no issues or patient activity. For example, a patient had taken off their seat belt and tried to get out of the ambulance. The record documented the action taken which included speaking calmly to the patient and a call for assistance.

Previously there had been no oversight of the completion of any patient records and we were told there were no audits of either paper forms or deployment logs. We saw evidence the management team had reviewed all the

documentation following each patient transfer to check all the relevant information was documented and completed correctly. The registered manager told us they had provided training for staff in relation to record keeping and spoke with staff when needed. Since the introduction of the review, the record keeping had improved and issues were first discussed with the individual staff member and then discussed in team meetings.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.

There had been seven incidents reported during October 2019 to 13 August 2020 of which three related to restraint. The revised booking/risk assessment form identified reportable incidents for restraint, the use of blue lights and changes identified when the dynamic risk assessment was completed. All incidents were recorded on a paper-based system using an incident form. We saw other incidents not relating to patient transport had been reported and investigated too.

Incidents were reviewed and investigated by the registered manager or director. Actions and learning were identified and recorded on the paper-based system. The service had three incidents relating to restraint. The control and restraint monitoring and recording forms we reviewed documented the area of restraint and what restraint had been used. The incident was recorded on the IR1 form which also detailed the investigation to confirm if the least restrictive method had been used. We saw all relevant staff and partner organisations were involved in the review and investigation in the example we saw. We reviewed one of the three restraint IR1 incident forms which identified learning to share with staff and confirmed the least resistant method of restraint had been applied.

Staff we spoke with were all aware of the incident reporting system following staff training and felt supported to raise concerns and incidents. Staff gave examples of incidents reported and told us de-brief sessions were held to support them if needed. Incidents reported were also discussed at team meetings for shared learning. We reviewed staff meeting minutes which evidenced learning from incidents.

There had been no serious incidents recorded or medicine incidents.

Are patient transport services well-led?

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There had been no policy in relation to patient deterioration, restraint, the Mental Health Act 1983 or the Mental Capacity Act 2005 at our last inspection. Policies had not been clear as they had not stated what should be required. For example, patient sedation supervision or caring for infectious patients. All policies had been reviewed bi-annually since our last inspection.

The service had strengthened the governance arrangements to improve the effectiveness of the processes and procedures, but we identified areas for further improvement.

Previously we were told the infection prevention and control policy detailed a standard procedure to care for infectious patients. This had not been produced when requested at the last inspection. We reviewed the most recent infection and control policy which detailed a list of infection control procedures including care of infected patients but did not state what the procedures were. The policy had been updated with additional measures used during COVID-19.

The mental health policy which had been written stated “adults who usually have capacity may, especially in emergency situations, become temporality incapable of having the capacity tests applied”. This was not in line with stage one of the mental capacity assessment which asks “Does the person have an impairment of, or disturbance in the functioning of their mind or brain (permanent or temporary)? Following the inspection, we were told this was a typo error and would be amended.” The policy also stated “…the person needs to be restrained in a way not allowed under the Mental Capacity Act.” It was not clear what restraint this was referring to and by whom. The policy only stated best interest decisions for cases of self

harm assessment and treatment was to be fully documented. This was not in line with the Mental Capacity Act 1983 as all patients best interest decisions should be recorded.

However, we saw some improvement to policies had been made. The service had written a medicines management policy which guided staff in the transportation of the patient's own medicine and stated staff were not to administer medication to patients.

Previously the mental health conveyancing policy had stated that an escourt may be required for patients who had been sedated. This did not specifically state what should be required when transporting patients who had been sedated and what to do if the correct staffing resource was not available to escourt the patients. The revised policy stated "Patients who were given sedation one hour prior to transport were to be monitored by an accompanying health care professional. If this was flagged the operational staff were to seek guidance from the duty manager and requesting trust.

All ambulances had folders with copies of policies and procedures for staff to access if needed with feedback and incident forms. Staff we spoke to confirmed these were readily available on all ambulances for transporting vulnerable patients.

Staff we spoke with were clear about their roles and accountability and reporting structures.

Transportation journeys were all reviewed by the registered manager or director for compliance. This included checking the patient record was completed for every patient journey. An oversight document had been set up to record all requested patient journeys. This document marked incidents which related to a patient journey and patient journeys which had been cancelled. The service was able to seek improvement, highlight areas of concern or good practice with staff after the review of patient booking/risk assessment journey forms. This was done by through team meetings. Staff told us the meetings had taken place by video conference recently and they had discussed shared learning.

Each booking form/risk assessment was checked by the registered manager or director to ensure the documentation had been completed correctly. These checks included if restraint/blue lights were used and if any dynamic risk assessment amendments had been made. Although each booking form/risk assessment was checked for completion there was no specific or targeted audit schedule at present. The service planned to develop an audit schedule going forward using the electronic computer system.

The service had an electronic system to record patient bookings onto. At the time of the inspection the electronic booking system was in the pilot stage. Bookings were added retrospectively from the paper booking forms. The electronic system would help to record response and target times for the patient journeys.

At the time of the inspection it was unclear who supported the service with clinical and mental health input, as the previous lead had left the service. We were told the safeguarding lead could support with the clinical input as a registered paramedic. However, there was no specialist mental health lead.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that polices reference the most recent best practice guidance and legislation.

Action the provider SHOULD take to improve

- The provider should ensure there is clinical and mental health support and input into the service.
- The provider should ensure there is an audit programme in place to monitor the service provided.

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
	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met;** The service did not make sure that all polices and procedures referenced the most up to date legislation and national guidance. Regulation 17 (2)(a)