

Phoenix Medical Services Ltd

# Phoenix Medical HQ

## Inspection report

Unit 23  
North Ridge Park, Haywood Way  
Hastings  
TN35 4PP  
Tel: 0800999244  
[www.phoenix-ems.co.uk](http://www.phoenix-ems.co.uk)

Date of inspection visit: 23 February 2021  
Date of publication: 27/04/2021

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

Requires Improvement



Are services safe?

Requires Improvement



Are services well-led?

Requires Improvement



# Summary of findings

## Overall summary

Phoenix Medical Services Ltd is operated by Mr Darren Cable. We inspected this service using our focused inspection methodology after receiving information giving us concerns about the safety and quality of the services. We carried out the announced part of the inspection, giving 48 hours' notice on 23 February 2021. To get to the heart of patients' experiences of care and treatment, we normally ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? During this focused inspection we focused on part of the domain of safe and the whole domain of well led.

We rated it as requires improvement because:



- The service provided mandatory training in key skills to all staff but did not always document that everyone completed it.
- The service did not always control infection risks well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.
- Staff did not always complete and update risk assessments for each patient and removed or minimised risks.
- The provider did not track or audit records of patients' care and treatment. Information was not used in a way to improve the quality of care delivered.
- Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Data was not collected, analysed or used to improve the quality of the service.

However:

- The provider had taken steps to make changes to the service after working with an NHS trust in 2020. The registered manager was keen to continue to improve and develop the service provided.

# Summary of findings

## Our judgements about each of the main services

Service		Rating	Summary of each main service
Patient transport services	Requires Improvement		Patient transport service is a small proportion of ambulance activity. The main service was urgency and emergency care. Where arrangements were the same, we have reported findings in the urgent and emergency care section. We rated this service as requires improvement.
Emergency and urgent care	Requires Improvement		Please refer to the overall summary

# Summary of findings

## Contents

### Summary of this inspection

Background to Phoenix Medical HQ	5
Information about Phoenix Medical HQ	5

### Our findings from this inspection

Overview of ratings	7
Our findings by main service	8

# Summary of this inspection

## Background to Phoenix Medical HQ

Phoenix Medical Services Ltd is an independent ambulance service based in Hastings. Darren Cable is the registered manager and company director.

The service is registered to provide the following regulated activities:

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

This service has not been previously inspected.

The main service provided by this ambulance service is events work but the provider had also undertaken emergency and urgent care work and patient transport work too. However, at the time of inspection, the provider had no regular patient transport contracts or emergency and urgent care contracts.

## How we carried out this inspection

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 to improve:

We told the service that it must take action to bring services into line with legal requirements.

- The provider must ensure that all training completed is documented so that they are assured that all staff are trained in every mandatory skill or subject. Regulation 12 Safe care and treatment
- The provider must ensure that it follows infection control measures as directed in its processes. Regulation 12 Safe care and treatment
- The provider must ensure that its risk assessment processes for patients are finalised and completed. Regulation 12 Safe care and treatment
- The provider must ensure that it has an audit process for record keeping. Regulation 17 Good governance
- The provider must ensure there are systems or processes to monitor governance, risk or monitor quality in the service. Regulation 17 Good governance
- The service must ensure that it formally collects and analyses information to support all its activities. Regulation 17 Good governance.

# Summary of this inspection

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The provider should ensure hot water is made available at the ambulance station.
- The provider should ensure colour coded mops & buckets are available to enable staff to follow infection control guidance.
- The provider should ensure an acceptance and exclusion criteria is developed to decide whether to transport patients or not based on their individual needs.
- The provider should ensure formal journey logs are kept for audit trail and quality monitoring purposes.
- The provider should ensure that the fire door at the rear of the unit is repaired and made secure.
- The provider should ensure that all policies are pertinent to the particulars of the service and not contain information that is irrelevant or concerns other organisations.


# Our findings

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Patient transport services	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

# Emergency and urgent care

Safe	Requires Improvement 
Well-led	Requires Improvement 

## Are Emergency and urgent care safe?

Requires Improvement 

We rated it as requires improvement because:

### Mandatory training

**The service provided mandatory training in key skills to all staff but there was not always documentation to show that everyone had completed it.**

- In some staff files, there were gaps in training documentation suggesting staff had not received or completed training in certain topics or skills. The registered manager had undertaken a review of all staff files and identified where there was missing documentation. He was in the process of asking staff to supply information to complete and fulfil each record.
- There was an online system for staff to complete mandatory training. This system had been introduced by the registered manager to the organisation in 2020. The documentation gaps were a result of poor record keeping prior to this system being in use.
- The online system now set reminders to prompt staff to undertake refresher training and updates when they were required.
- The registered manager along with a subcontracted human resources team had identified the mandatory training requirements for each staff group employed by the service and the frequency this must be completed to ensure staff were competent to undertake their role.
- Before employees started to work on shifts for the service, there was a checklist to show evidence of the mandatory training they had completed.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

- The registered manager identified as the adult and child safeguarding lead for the service and had completed level 3 adult and child safeguarding training. The registered manager could demonstrate knowledge of the correct way to report an adult or child safeguarding concern.

## Emergency and urgent care

- Staff were trained to level 2 adult and children safeguarding. Safeguarding training was part of the mandatory training programme that all staff completed.
- The service had a safeguarding policy which had been updated in February 2021. The policy was pertinent to safeguarding adults and children. The safeguarding policy detailed the different types of abuse and how to recognise them and the procedures required to report safeguarding concerns.
- When a safeguarding concern was identified, staff filled in a form using an online tool that was escalated to the safeguarding lead.
- The service had previously escalated safeguarding referrals to the NHS ambulance trust it had worked for between July 2021 and September 2021. Referrals were submitted to the trust via their online system. The subcontracting NHS ambulance trust investigated all safeguarding concerns and made onward referrals to the relevant local safeguarding authority where applicable.
- The service had not raised a safeguarding notification to the CQC in the reporting period though understood their responsibility to do so.

### Cleanliness, infection control and hygiene

**The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. However, they kept equipment, vehicles and premises visibly clean.**

- Dedicated mops and cleaning materials were stored in the ambulance station for cleaning the vehicles. There were posters within the unit which advised when and where to use which type of cleaning equipment. However, there was a red coloured mophead for cleaning vehicles but no accompanying red bucket. This posed a risk of cross contamination.
- Whilst there was a system to check that each vehicle had been cleaned, there was no audit of vehicle cleaning to assure the registered manager that cleaning practice was satisfactory. There were records to confirm that each vehicle was cleaned after use. An electronic tool was used to date when the task had been completed. Deep cleaning occurred every six weeks routinely and sooner if there had been a contamination incident.
- There was hand sanitiser on the vehicle inspected but this bottle was empty. The registered manager was made aware of this and replaced the bottle.
- There were hand-washing facilities for staff at the ambulance station and ambulances were fitted with hand sanitising gel dispensers for hand disinfection. However, there was no hot water available on the day of inspection. A shower was being fitted and the lack of hot water was said to be related to the plumbing work. The registered manager told us that he would contact the plumber immediately.
- We inspected one ambulance used by the service. It was visibly clean internally and externally. Reusable equipment such as splints and monitors were visibly clean. All trolleys were clean and disposable clean linen was available.
- Staff were provided with adequate numbers of uniforms which they would wash themselves. They were expected to be properly attired when on duty which staff adhered to.

# Emergency and urgent care

## Environment and equipment

**The design, maintenance and use of facilities, premises, vehicles and equipment generally kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

- Equipment was stored relatively neatly throughout the industrial unit that was the service's base. All electronic equipment was tested on an annual basis. Equipment was labelled with the date of the last test which ensured it was fit for use. Equipment checked had been tested and was in date.
- Staff completed an online form at the start of a shift that linked into the company's electronic management system. This was a checklist used to ensure the vehicle was fully kitted out with all equipment and was clean before driving it out of the unit.
- There was equipment suitable for adults and children on the ambulance inspected. This included paediatric oxygen masks and nebuliser masks. Each ambulance had relevant emergency equipment available for both adults and children, such as seatbelts, airway management equipment and transport boards.
- Vehicle bags were tagged with earliest expiry date displayed. All had wipe clean interiors and identical layouts. All consumables checked that were stored in these bags were in date.
- Medical gases were stored securely on vehicles in a locked cupboard to prevent the risk of injury to staff and patients. Medical gases were also stored at the unit in a designated cupboard behind a locked door. Full and empty cylinders were stored on separate shelves.
- However, the rear fire door of the unit was broken and waiting repair. This posed a security risk and a hazard.

## Assessing and responding to patient risk

**Staff did not always complete and update risk assessments for each patient nor remove or minimise risks.**

- The service did not have an acceptance or exclusion criteria for patient transport services. The decision whether to transport a patient or not was judged on an individual case by the registered manager. However, the service had not had any substantive patient transport service contracts. In the previous 12 months before inspection, only individual private transport journeys had been booked.
- There were no logs of journeys made apart from a basic A4 sheet that recorded patients treated at events. This logged rudimentary details of presenting patient and how these patients were managed clinically or where they were treated.
- There was a policy and procedure for managing the conveyance of patients that detailed how to manage a deteriorating patient. The policy had been updated when working with an NHS trust so some of the information pertained to that trust. For instance, the flowchart for actions following recognition of life extinct bore the logo of an NHS ambulance trust and the patient group table in that document referenced 'facilities in the trust area that don't accept patients under the age of 16'.
- The service had an electronic system which monitored the whereabouts of all vehicles and staff were in constant communication when undertaking work.

# Emergency and urgent care

- There were operational orders for event work that directed how an event would be organised and structured, where patients received treatment, how to respond to a major incident, patient care protocols and staffing and contact list.
- Risk assessments were completed prior to the crew being sent to any public event. Risk assessments considered; how many people were at the event, what was the risk and the number of paramedics and vehicles required.

## Staffing

**The service 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.**

- The service employed 20 staff on a flexible contract. There was a mixture of staff including three paramedics, first aiders and technicians. These staff worked on an ad hoc basis by responding to requests for work submitted via a social media platform.
- Due to the nature of the business, the registered manager felt that this system worked well. If a significant contract was attained with fixed requirements, then staff availability would be reviewed. The registered manager told us that the service had access to enough staff to ensure there was the correct number of staff, at the right level, working at events.
- There were four staff on the management team though three of these were employed flexibly. This consisted of the registered manager who was also the company director, an operational manager, a compliance lead and a clinical lead.

## Records

**Staff did not always keep detailed records of patients' care and treatment.**

- We were not able to check any patient records for recent work as the provider had submitted all these records to an NHS trust that had subcontracted them.
- There was no formal process for auditing records which meant that the registered manager was unable to identify any trends in poor patient care or any areas of good practice.

## Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

- The service had a 'management of medicines and controlled drugs' policy updated in January 2021. The policy had guidance on record keeping, security and destruction of 'controlled drugs' used by the service. However, there were no controlled medicines stocked so this was not relevant to the service.
- Medicines were stored in a locked cupboard in the garage area of the unit and only used for non-regulated activities. Medicines were purchased from a pharmaceutical company which delivered within seven to ten days of ordering.
- There was a process for auditing medicine stock. The registered manager was able to demonstrate using an online tool how much stock was available and how this corresponded to actual medicines in the cupboard.

## Emergency and urgent care

- The medicines used for events work were packed into bags which were tagged and sealed. Surplus medication was available in a drawer in this locked cupboard.
- Medical gases were stored securely on vehicles. Replacement gas cylinders were locked in secure cages at base.

### Incidents

#### **We did not know if the service managed patient safety incidents well.**

- As there had been no incidents reported between February 2020 and January 2021, we could not review any completed forms or assess if incidents were managed well.
- There was a process to report incidents that all staff were aware of. Incidents could be reported using an electronic reporting tool.
- The registered manager aimed to use the reporting tool to monitor themes and trends and for learning purposes that would prevent any incidents from recurring once the business was more active.

## Are Emergency and urgent care well-led?

Requires Improvement 

We rated it as requires improvement because:

### Leadership

#### **Leaders had some of the skills and abilities to run the service.**

- The registered manager was the director of the company and had responsibility for the premises, equipment and staff.
- The service had an identified clinical director who undertook the role on a remote consultancy basis.
- The registered manager was frequently part of the allocated staff at events, giving visibility both to staff working for the service and event organisers. If not working with them, the registered manager was always available via the telephone for advice and guidance.
- The registered manager was candid and admitted that working with an NHS trust had presented challenges and had been a steep learning curve. The registered manager had spent time changing some governance processes, making improvements and was keen to learn also from our inspection visit.

### Vision and strategy

#### **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.**

# Emergency and urgent care

- The coronavirus pandemic had impacted on available business. As an essentially events-based company, there was little work to be had in this sector in 2020.
- The registered manager wanted to create a youth division to introduce young people to the industry so that they could consider this as a future career option.
- The registered manager also recognised that student paramedics did not work at events as part of their training. The registered manager had a vision to support student paramedics to experience not just acute clinical work, but events work too. It was felt that this gave paramedics career options and would help to prevent burnout for those with stressful jobs in the acute sector.

## Culture

- It was difficult to assess the organisational culture due to the non-operational nature of the business.

## Governance

### **Leaders did not always operate effective governance processes, throughout the service and with partner organisations.**

- The provider carried out limited audits of the service. Auditing was confined to checking processes such as medicines management and cleaning of equipment. This meant areas for improvement could not be identified and subsequent changes made to the service to improve patient care and safety could not be actioned.
- There was a process to ensure policies and procedures were reviewed. All policies had a review date on them. Our review of six policies and procedures showed they were written for the operational requirements of the service. All policies reviewed reflected national guidance and best practice.
- However, some of the policies were not entirely pertinent to Phoenix Medical Services. Some referred to jobs and job titles that did not exist within the company structure: for example, the role of national development manager and national fleet manager was cited in the ambulance service policy. Other policies also had information that clearly was irrelevant to the service and needed to be tailored to the organisation: for example, the medicines policy had a section on storage of controlled medicines which the service did not have.
- Checks were made to ensure staff who worked for the service had the necessary skills and competencies to carry out their role. The service did follow a documented process and recorded information in a way that could effectively demonstrate this. However, there were still historical gaps in some personnel files.
- This was a small business though management meetings did occur. Meeting minutes were available from an operational meeting in January which detailed various issues including tasks pending, work allocations and financial plans.

## Management of risk, issues and performance

### **Leaders used systems to manage some aspects of performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

# Emergency and urgent care

- The service had a risk management policy that was in draft format. This policy detailed risks to the service, how to report and assess risks and the event risk assessment but this was not published at the time of inspection.
- The registered manager was in the process of compiling a risk register. He was able to articulate what the risks to his business were. This included loss of work, staff rostering and vehicle breakdowns.
- The service had a business continuity plan that detailed how to be prepared for any events that might happen that could impact on extended service outage.

## Information management

**The service did not formally collect, analyse, manage or use information to support all its activities. However, the service's electronic systems had security safeguards.**

- The service failed to use information in a way to monitor and improve the quality of care.
- The provider did not count the number of journeys undertaken and record the type of journey.

## Engagement

**Leaders and staff did not always actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services.**

- There were feedback leaflets available on vehicles, but the registered manager told us that it was difficult to collect feedback given the limited nature of their work.
- The service kept patient feedback forms within the vehicles. The forms allowed patients to provide feedback following receipt of care at events. Feedback had not come to the service via the NHS ambulance trust it had worked for, despite asking for it.
- The registered manager was able to supply us with one piece of positive feedback received from a patient.
- The company website had a contact us section, but this was generic and not necessarily aimed at feedback or complaints.

# Patient transport services

Safe	Requires Improvement
Well-led	Requires Improvement

## Are Patient transport services safe?

Requires Improvement

Patient transport services are a small proportion of activity. The main service was urgent and emergency care. Where arrangements were the same, we have reported findings in the urgent and emergency care section.

## Are Patient transport services well-led?

Requires Improvement

Patient transport services are a small proportion of activity. The main service was urgent and emergency care. Where arrangements were the same, we have reported findings in the urgent and emergency care section.