Devon Ambulance And First Aid Services CIC

The Colin Sully Centre

Quality Report

The South Devon Railway
Buckfastleigh
Devon
TQ11 0DZ
Tel: 01803 315251
Website:ambfas@devonems.org

Date of inspection visit: 14 November 2017
Date of publication: 07/02/2018

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

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Colin Sully Centre is operated by Devon Ambulance and First Aid Services CIC. They provide a patient transport service. Devon Ambulance and First Aid Services is a Community Interest Company owned by Devon EMS, a Registered Charity, which provides an event ambulance service, specifically where there is an actual or identified need to provide off-site transportation. In addition, Devon Ambulance and First Aid Services provides a limited patient transport service either using a two-man ambulance crew or single person wheelchair accessible vehicle. All staff who work for this organisation are volunteers who do this in their spare time.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 14 November 2017.

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.

Services we do not rate

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 issues that the service provider needs to improve:

- An incident reporting procedure was not in place which meant they were not able to monitor, investigate and learn from any untoward incidents. Following our inspection the registered manager sent us a copy of their new incident reporting policy and procedure which included a copy of the incident reporting form to be used. This was going to be shared with staff.
- Equipment on the ambulances was not up to date with servicing and there were no records of ongoing maintenance. Immediately following the inspection the registered manager notified us they were in the process of addressing this and none of the ambulances would be used until the equipment had been serviced.
- A thorough assessment of the patients' needs for the planned transport service was not undertaken or recorded.
- All vehicles used by the service were not clean, therefore there was a risk of cross infection. The cleaning products used on the ambulances and the wheelchair car did not meet national guidance to prevent the risks of cross infection.
- The service was not recording or asking for details about infection control risks associated with patients to prevent and control the spread of infection for the planned transport service.
- Staff had received safeguarding training for both adults and children but the registered manager was not able to tell us at what level this training was (levels one to three, with three being the highest level of training).
- There were no effective systems in place to be able to assess and monitor the service in terms of quality, safety, performance and risk.
- Not all staff had received their yearly appraisals to formally monitor their competence to carry out their role.
- A suitable recruitment procedure to safeguard patients against unsuitable staff was not in place.

Summary of findings

Following this inspection, we told the provider 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 four requirement notices and two warning notices that affected safe and well-led. Details are at the end of the report.

We found the following areas of good practice:

- All staff including the registered manager and directors were volunteers and undertook this work around their other commitments, for example full time jobs. The work they carried out for the service was unpaid.
- The company was set up to help the local communities provide first aid cover at reduced costs, to enable smaller events so they could go ahead.
- Staff were up to date with the mandatory training needed to meet the demands and needs of the service.
- A clinical waste contract was in place with an external provider to make sure it was disposed of correctly. Clinical waste was also stored securely to prevent unauthorised access.
- All vehicles were serviced and maintained with access to a breakdown service.
- Patient records from the unplanned events transfers were very detailed and contained assessments of the patient's condition.
- A member of staff from the planned patient transport told us they made sure all patients arrived in plenty of time for their health care appointments.
- Staff had weekly training sessions which included scenarios, for example using a spinal board.
- Staff told us that as this work was voluntary, they would not stay if it was not a supportive and enjoyable place to work.

Amanda Stanford

Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		The main service provided by Devon Ambulance and First Aid Services CIC was planned and unplanned patient transport. We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

The Colin Sully Centre

Detailed findings

Services we looked at
Patient transport services (PTS).

Detailed findings

Contents

Background to The Colin Sully Centre

The Colin Sully Centre is operated by Devon Ambulance and First Aid Services CIC. The service opened in 2015. It is an independent ambulance service in Buckfastleigh, Devon, which primarily serves the communities of the south west peninsular.

The service has had a registered manager in post since March 2015. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC on 31 August 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector and a specialist advisor with expertise in ambulances. The inspection team was overseen by Daniel Thorogood, Inspection Manager and Mary Cridge, Head of Hospital Inspections.

Facts and data about The Colin Sully Centre

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

Activity (July 2016 to November 2017):

- In the reporting period July 2016 to November 2017 there were eight unplanned patient journeys undertaken from events.
- There were 29 planned patient transport journeys undertaken.

Amongst the eight volunteers there were two ambulance technicians, one emergency care assistant and five ambulance care practitioners who volunteered at the service.

Track record on safety

- No never events
- No clinical incidents
- No serious injuries
- No complaints

Detailed findings

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

During the inspection, we visited Devon Ambulance First Aid Services CIC base, The Colin Sully Centre. The service had two ambulances and one wheelchair accessible vehicle. We spoke with five staff, including: ambulance practitioners, patient transport drivers and management. We were unable to speak with any patients because there were no bookings during our inspection. We received two 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed 29 planned journey record sheets and eight unplanned events transfers.

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 was registered with us on 20 March 2015 and therefore had not been inspected prior to this inspection.

Summary of findings

Are services safe?

We do not currently have a legal duty to rate independent ambulance services.

We found the following issues:

- An incident reporting procedure was not in place. This meant staff were not able to report any incidents and incidents could not be investigated or learned from. Following our inspection the registered manager devised an incident reporting policy, procedure and a reporting form.
- There was no evidence equipment on the ambulances was serviced as required by the manufacturer or that it had been maintained so it was safe to use. Following the inspection the registered manager told us they were in the process of getting all equipment serviced and the ambulances would not be used until this had been completed.
- A thorough assessment of the needs of patients was not in place for patients using the planned transport service.
- The ambulances and wheelchair car were not clean, therefore there was a risk of cross infection. Following our inspection, the registered manager devised a new vehicle cleaning policy which included checking by a senior manager following their use.
- Cleaning products used on the ambulances did not meet national guidance to prevent the risks of cross infection. Following our inspection the registered manager sent us details of their new vehicle cleaning policy, which included cleaning products recommended for this role.

Patient transport services (PTS)

- The provider was not actively assessing the infection risks associated with patients to prevent and control the spread of infection for the planned patient transport service.
- Staff had received safeguarding training for both adults and children but they were not able to determine the level of this training to ensure patients were protected.
- There was no suitable recruitment procedure to safeguard patients against unsuitable staff.

We found the following areas of good practice:

- A system was in place to ensure the servicing and maintenance of the vehicles kept patients safe.
- A clinical waste contract was in place to make sure this was disposed of as required. The storage of the clinical waste was secure to prevent unauthorised access.
- Mandatory training for staff was up to date, which ensured patient safety.

Are services effective?

We do not currently have a legal duty to rate independent ambulance services.

We found the following issues:

- The assessment of a patient's care needs and requirements taken at the booking stage for the planned patient transport was very brief and contained limited details.
- The provider did not report on any response times or patient outcomes to monitor the quality or performance of the service being provided.
- Not all staff had received their yearly appraisals to formally monitor their competence to carry out their role.

We found the following areas of good practice:

- Staff had access to weekly training sessions, which included scenarios, for example using a spinal board.
- The staff were following national guidance within their roles and their training was based on these.
- The staff worked well with other health care providers to make sure patients received the correct treatment.

Are services caring?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- We received two comment cards from patients, which provided positive comments about Devon Ambulance and First Aid Service.

Are services responsive?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- The provider set up the charity as a non-profit organisation to help local communities with affordable medical support for events.
- A member of staff from the planned patient transport service told us they made sure patients arrived in plenty of time for their healthcare appointments. However, they were not auditing this.

We found the following issues:

- There were limited communication aids to use with patients and there was no access to translation services.

Are services well-led?

We do not currently have a legal duty to rate independent ambulance services.

We found the following issues:

- There was no governance framework in place to evidence and support the delivery of good quality care.
- There were no processes for risk management, including assessing, monitoring, recording and mitigating the risks relating to the services provided.
- The views of stakeholders were not formally obtained and recorded.
- Performance outcomes and measures were not monitored, therefore no action was taken to improve the service.
- There was no programme of audits to help identify the strengths of the service and where improvements were required.

Patient transport services (PTS)

- Disclosure and barring service (DBS) checks were not stored in line with the Revised Code of Practice for Disclosure and Barring Service Registered Persons 2015.

We found the following areas of good practice:

- All staff were volunteers and they said they would not stay if they were not supported or enjoyed the work.
- Staff felt they were supported by the senior managers and could report any concerns they had to them. They were confident they would take action if required.

Are patient transport services safe?

Incidents

- There was no incident reporting process to report accidents, incidents or near misses. The registered manager felt they had not had any incidents which needed reporting and investigating. Staff spoken with also confirmed this. However, we identified an incident that should have been reported. This related to a planned journey where the patient was found to be living with dementia at the time of the journey and not discussed at the time of booking. This should have been reported and investigated to see where lessons could have been learned. No policy was in place for incidents and the reporting of these. However, following our inspection the registered manager sent us details of a new policy which they had put in place for incident reporting and a copy of the new incident reporting form.
- The registered manager was able to define duty of candour and knew what their responsibilities were to meet this regulation. There was a policy in place regarding duty of candour available to support a culture of openness and transparency. This also quoted the regulation. The registered manager had not needed to invoke this regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. 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. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- There was no clinical dashboard or an equivalent system in place to monitor the safety and quality of the service. This meant the provider had no means to help identify areas of the service which were performing well, or areas which required improvement to ensure quality and safety. The registered manager told us this was an area they were looking into at the time of our inspection.

Patient transport services (PTS)

Mandatory training

- Staff received mandatory training in safety systems, processes and practices. Staff we spoke with confirmed they had undertaken mandatory training. Mandatory training included a number of topics, for example moving and handling, information governance, patient handover and documentation. For staff involved in the unplanned transport from events, there was a list of other training to complete before they were able to do this. For example, first aid, patient assessment, cardiac arrest and the use of medical gases. The parent company had a training arm which provided training for all the staff.
- Staff who were in permanent positions in care or NHS ambulance services also had mandatory training as part of these roles. The registered manager was in the process of collecting evidence of completion from staff.
- All but one member of staff had undertaken driver training when they started volunteering for the provider. This member of staff does not undertake driving duties. We saw this had been recorded on the spread sheet of training undertaken. The registered manager told us all volunteers who were involved in the unplanned transfers from events had to undertake this prior to being able to drive the ambulances.

Safeguarding

- Systems and processes reflecting relevant safeguarding legislation were up to date to effectively safeguard adults and children from avoidable harm and abuse. The majority of staff had other permanent roles within care services or the NHS ambulance service and also had this training with them as well. A member of staff told us at one of their training evenings they had an update on safeguarding for both adults and children.
- The provider had not needed to made any safeguarding referrals to the local council.
- The provider had a safeguarding policy for children and adults. The registered manager was in the process of updating the adult policy. Both policies made reference to recognising abuse and how to report any suspicions of abuse. The children's policy made reference to child sexual exploitation and the action needed if identified. The registered manager said that at each event a senior member of staff was always available to guide and support staff.
- The safeguarding lead for the service was a member of senior staff. Safeguarding training for staff about children and adults was provided by their parent company and was up to date. However, the registered manager was not aware what level of safeguarding training all staff members had. 'Safeguarding children and young people: roles and competences for health care staff Intercollegiate document 2014' states all clinical staff working with children, young people and their parents and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person must be trained to safeguarding children level three.

Cleanliness, infection control and hygiene

- There was limited evidence to demonstrate the provider was assessing the risk of infection, or taking action to prevent, detect and control the spread of infections. The provider did not have a policy for infection prevention and control. The registered manager was not aware of, or working in accordance with, the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (2015).
- Staff undertook infection control training as part of their induction training but there were no records to show if this was followed up with any refresher training. However, all staff, including the registered manager, had other permanent job roles within the NHS ambulance service or care services where they received this training. However, the registered manager was not able to provide us evidence of this.
- There was no evidence to suggest patient-related infection prevention and control risks were considered and managed appropriately for the pre-planned transport. The booking forms did not have a specific area to record infection control risks and there was no evidence questions about this were asked when a booking was accepted. This potentially placed the member of staff and other patients at risk of cross-infection.

Patient transport services (PTS)

- Each ambulance had a supply of personal protective equipment such as gloves, hand gels and specialist cleaning wipes. These were available to enable staff to protect themselves and patients from transfer of infection.
- The procedure for the disposal of linen was not formalised and so not monitored to ensure risks were safely managed. This practice was not covered by a service level agreement. The wheelchair accessible vehicle held blankets and pillows for patients. On arrival at the drop-off destination, used blankets would be replaced and new disposable covers for the pillow would be collected from that provider. We were told the driver knew where to leave the dirty linen and where to collect the new linen from. It was unclear whether the various organisations had any awareness of this practice.
- The provider did not have cleaning schedules or checklists to ensure effective prevention and control of infection. There was no evidence to demonstrate vehicles had been cleaned. The policy for vehicle cleanliness stated twice yearly deep cleans were required, and at other times as directed. The policy also stated ambulances should be cleaned post shift. However, the two ambulances and the wheelchair adapted car were visibly dirty. This was fed back to the registered manager and other senior staff during our inspection. Following our inspection, the registered manager sent us evidence they had put cleaning checklists in place and these would be overseen by senior staff.
- Each ambulance had a fluid spill kit on board to manage any spillage. Discussions with the registered manager and other senior staff identified the cleaning materials being used to clean each ambulance were not suitable. For example, disinfectant and anti-bacterial household cleaning products were being used. Following the inspection the registered manager contacted us and said they had contacted an outside contractor regarding cleaning of the vehicles, devised a new cleaning of vehicles policy, and purchased suitable cleaning products.
- The organisation had a clinical waste contract with an external provider. They contacted them when their clinical waste containers needed emptying. These were also secure to prevent unauthorised access.

Environment and equipment

- The maintenance and use of equipment did not always keep patients safe. The provider was not able to give us details of up to date maintenance and servicing of equipment on the ambulances. This included suction machines and an automated external defibrillator (AED). A senior member of staff told us they were in the process of setting up an assets list and arranging servicing from a local NHS trust.
- Some of the consumables found on both ambulances were out of date, for example oxygen masks and tubing. This was reported to a senior member of staff who told us these would be replaced immediately. No stock was held at the office location. Consumables were purchased when they needed replacing.
- At the time of our inspection the organisation had three vehicles: two ambulances and one wheelchair accessible car. These were not owned directly by Devon Ambulance and First Aid Services but by their parent company who rented the ambulances to them. We saw each of the three vehicles had an in date MOT certificate and servicing records. Insurance was in place for each of the three vehicles and there were arrangements for breakdown cover and replacement of tyres. There was a process and policy for staff to follow in relation to faulty vehicles. If a fault was discovered (depending on the severity), vehicles could be removed from use until repaired. Staff told us when there was a fault on a vehicle they would record this in the defect/mileage book for that specific vehicle. Faults were also reported verbally to the registered manager or another senior member of staff who would action the repair.
- Both ambulances were equipped with blue lights and were used by two members of staff who had been trained to use these as part of their permanent roles in the NHS ambulance service.
- The wheelchair accessible car used for transporting patients on planned journeys had a secure system to make sure the wheelchairs were held safely during transit. On the two ambulances they had seat belts for the seats and the trolley was secured during transit.

Medicines

Patient transport services (PTS)

- The arrangements for managing medical gases mostly kept patients safe. The organisation only managed oxygen and a pain-relieving medical gas, nitrous-oxide. No other medicines were kept on the ambulances.
- The provider had a contract with an external provider of medical gases for the supply of the cylinders. They were replaced as required as no spares were kept at the office due to the cost. We found one oxygen cylinder on one of the ambulances was out of date and a senior member of staff said they would replace it immediately. Following our inspection the registered manager contacted us to say this had been replaced.
- Staff told us they needed to complete training prior to using nitrous-oxide (pain relief medical gas). This included training by the provider and on line training from the company who supplied the nitrous-oxide. The records we examined also confirmed that seven of the eight members of staff had completed this. However, some of this training was in 2013 and 2014. There was no evidence that staff competencies were checked after this. The registered manager told us at times their ambulances were not used for long periods, especially over the winter months. During the winter months the nitrous-oxide cylinders were stored in the office. There were no warning signs at the office to alert the fire service that nitrous-oxide was stored there in case a fire was to break out. Also, there were no warning signs on the ambulances to highlight medical gases were stored on them. Warning notices should prohibit smoking and naked lights within the vicinity of the storage.
- There was no protocol in place for the administration of nitrous-oxide gas during unplanned events transfers. This meant staff might not be following the correct procedure.
- Documentation of medicine administration varied for the unplanned events patient transfer records. This was due to the lack of standardisation of the patient record form used throughout the service. The form which had been identified as the main patient record was not continually in use, and we saw three other similar versions of the form during our inspection. The main form had a specific section to record any medicines administered, whilst the other three forms did not all contain a section for this to be documented.
- We saw one example of nitrous-oxide (pain relieving gas) being administered. This record contained limited details, for example the patient's record just stated "given to good effort." There was no further information as to the time the gas was administered or the duration. This meant there was no way to review this administration after the journey if any issues or queries were to arise. We raised this with senior staff at the time of our inspection. The registered manager immediately identified the need for further documentation about the administration of nitrous-oxide and the use of oxygen. The registered manager recognised this oversight was due to the lack of the prompt for medicines administered on the old patient record form which had been used.
- A medicines policy was in place but it had been written for the parent company and made no reference to Devon Ambulance and First Aid Service. The policy also referenced national guidance, but some of this was out of date. For example, 'Outcome 9 of the Essential Standards of Quality and Safety Care Quality Commission 2010'. This has been updated to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records

- Patients' individual care records were not all written and managed in a way which mostly kept people safe. There were inconsistencies between the depth and detail of completed patient assessments between the patient transport and the unplanned events transport arms of the service.
- Patient records were stored securely in the office.
- We reviewed 29 planned patient transport journey sheets which contained very little or no information about the patient. All forms included the patient's name, the journey date, the pickup and drop off details and the vehicle needed for the journey. However, only eight of the 29 records included (limited) additional information about the patient taken at the initial booking stage. The form contained no additional prompts to ensure a detailed assessment of the patient's need was taken. For example, the patient's presenting condition, their mobility status and whether there were any infection control issues were not documented. Of the eight records we reviewed which contained additional

information, there were question marks against some of the information. We were told the majority of the information added to this section was from the driver's observation of the patient on collection rather than information that was provided at the initial booking stage. Several patients had an escort for their journey. Despite this, we were told very little information was provided by the referrer at the initial booking stage. We saw no evidence of management plans for patients for their journey. During the inspection no bookings for the patient transport service were made so we were unable to hear a typical referral telephone call.

- Patient records from the unplanned event transportation service contained detailed information about the patient and a thorough assessment. Records contained the names of the members of staff treating the patient and the time and date of treatment. Despite there being four different versions of the patient assessment documentation in circulation, all eight assessments we saw identified the patient's presenting complaint, past medical history, medicines, detailed sets of patient observations, an objective assessment, impression and treatment plan. The aim was to move to using one consistent form. This form had been identified, however at the time of the inspection other versions were still in circulation and the form was not in consistent use.

Assessing and responding to patient risk

- There were inconsistencies between comprehensive risk assessments being completed and documented for patients managed under the planned patient transport service and the unplanned events transport service.
- No documented risk assessments or risk management plans had been completed for the 29 planned patient journey records we reviewed for the patient transport service. The patient journey record did not contain any prompts to ensure important risks, such as infection control, were captured at the initial handover stage. Of the 29 forms, only eight contained very limited information about the patient. Most of this information was taken from the driver's observation of the patient at the pick-up stage. We saw no documented evidence of a further discussion or handover of any risks at the pick-up stage. We were not provided with assurance the service was aware of the full extent of patient risks.
- We saw an example of a recent planned patient transport journey for a patient with dementia. We discussed the journey and were told the driver was not made aware of the patient's condition when the booking was taken. This should have been recorded as an incident and investigated to see where lessons could have been learned. The documentation on the patient journey form was an observation of the driver due to the patient's presentation during the journey. On this occasion, the patient was alone with no escort. The driver told us this patient had challenging behaviour, which was only identified during the journey. The driver told us it would have been helpful to know this information prior to the journey to enable better preparation and risk management for the journey to help the patient remain calm.
- Detailed risk assessments and management plans were completed for patients under the unplanned events transport service. Of the eight records we reviewed, each patient had a comprehensive risk assessment completed to rule out serious conditions which required urgent medical attention. Further risk assessments were completed if the situation required. For example, we saw an example of a risk assessment involving treatment of a problem presented to the team. The problem and risk was clearly defined, along with a comprehensive risk management plan outlining a clear plan to manage the risk depending on the outcome of the treatment.
- The registered manager told us they did not have a policy in place for deteriorating patients as they only transported stable patients from events. If a patient's condition changed they would refer this immediately to the local NHS ambulance trust for support and to hand over the patient.

Staffing

- Staffing levels and skill mix were planned to meet the requirements of the service and reviewed to ensure patients received safe care and treatment at all times. As all staff were volunteers, they only provided unplanned events transport if they had the staff to do this. Senior staff said they often covered the same events each year so they knew when they were due and staff were asked if they could attend. The registered manager said staff

who worked for this organisation were volunteers and did not get paid. They continually tried to recruit staff to make sure they have enough to meet the needs of their service.

- Records held by Devon Ambulance and First Aid Service did not contain the required information to meet the legal requirements, including Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed staff files for all eight of the staff who worked for the service. Three out of the eight files contained a volunteer application to work for the service, whilst just one file contained one reference. Only five out of the eight files included a recent photograph. There was no documented evidence of their previous employment, or where their duties had involved working with children or vulnerable adults. There was no satisfactory evidence of their conduct in previous employment. We were told all recruitment for the service was managed through the parent company. They also maintained the recruitment records for the staff. This meant the registered manager did not have oversight of the recruitment procedures or documents for the staff working for the service. Following our inspection the registered manager contacted us and said he was in the process of updating all of the staff files to meet this regulation.
- There was no system or process in place to regularly review the fitness of the employees.
- The service was not compliant with the Revised Code of Practice for Disclosure and Barring Service Registered Persons 2015. There was no policy around the secure handling of information from the Disclosure and Barring Service (DBS). We found full copies of DBS certificates were held in six out of eight staff members' individual files. There was no explanation as to why two members of staff did not they did not have a DBS check. We found DBS checks in staff files which were several years old, for example one was from 2013. There was no evidence of a self declaration form to state staff had not received any criminal convictions etc. since their DBS check. To comply with data protection legislation about the retention of confidential personal information, DBS must not be stored by the provider and must be given back to the staff member.

Anticipated resource and capacity risks

- As the service was run by volunteers they were only able to provide unplanned events transport if they had the staff to do this. The registered manager said they often covered the same events each year so were aware when their resources were needed.

Are patient transport services effective?

Evidence-based care and treatment

- Training provided to the volunteers joining Devon Ambulance and First Aid Service was based on national standards and guidelines. The training manual forming the basis of the training programme was based on guidance from the National Institute of Health and Care Excellence, the Health and Safety Executive, the Association of Ambulance Chief Executives and the Joint Royal Colleges Ambulance Liaison Committee.
- The registered manager told us they followed the Ambulance Care Essentials (ACE) to make sure they were meeting recognised guidance and to keep patients safe. The list of training received by the staff covered the topics included in this book. We saw copies of this book were available in the office.
- Posters around the office which were published by nationally recognised organisations provided staff with guidance. Examples of these included adult basic life support, dynamic risk assessments and the '5 moments for hand hygiene' which was published by the National Patient Safety Agency.
- Following our inspection, the registered manager had devised some new policies and procedures, including vehicle cleaning, lone working, incident reporting and mental capacity and deprivation of liberty safeguards. These all made reference to national guidance.

Assessment and planning of care

- A limited assessment of patients' needs and care required during transportation was taken at the initial booking stage for patients travelling under the planned patient transport service. This meant the driver may not have been aware of all the patient's needs prior to the journey. The patient journey form contained no prompts to find out details about the patient, for example their presenting condition, infection control, their mobility status or their ability to communicate. We were told at

the initial booking stage they would always ask whether the patient was continent. Otherwise, we were told whoever referred the patient would tell them anything important they needed to know about the patient. We observed 29 patient journey records. Only eight contained (minimal) information about the patient, which was mainly from the driver's observation rather than information which had been handed over at the initial booking. Despite some patients bringing an escort, we were not assured the service was aware of each individual patient's needs prior to their journey.

- Detailed assessments and treatment plans were completed for patients under the events unplanned transportation service. We reviewed all eight patient records which accounted for all of the jobs completed for the previous 18 months prior to the inspection. Each record contained a detailed description of the patient's presenting complaint, documented evidence of a physical examination, the impression of the condition and a detailed treatment plan.
- Arrangements were made to ensure patients using the planned transport service arrived in plenty of time for their appointments. The patient's destination and their appointment time were always requested at the initial booking phase. The main driver, who received all the bookings for the patient transport service, then identified a pick up time with the referrer. The pick-up time suggested always accounted for the time of day and for any traffic problems which may occur. This ensured patients arrived to their appointment in plenty of time.
- The registered manager told us they did not transport patients with mental health conditions on either service. If a patient with a mental health condition presented for an unplanned transfer from an event, they would contact the local NHS ambulance provider as staff were not trained to manage these patients.

Response times and patient outcomes

- Times of bookings, pick up times, waiting times and return times were recorded on the journey log. The registered manager told us each individual job was scrutinised individually and discussed with the crew after each journey. However, data was not collected to enable the registered manager to review trends or themes with regards to response times. Therefore, the registered manager was unable to gain an overall picture of the performance of the service.

Competent staff

- Staff we spoke with told us that every week they had a training session at their office location. These included a number of topics and scenarios, for example using a spinal board. Staff felt these were beneficial to their development. One member of staff felt this organisation had given them the confidence through training and support to apply for a permanent role within an NHS service.
- Half of the staff had not received an annual appraisal. This meant there was no formal assessment of the ongoing competence of the staff. Appraisals are an important aspect of ensuring staff are competent and identifying any learning needs within their current role. We checked the records of the eight members of staff. Four contained an appraisal, which was recorded on a template to ensure consistency of the process. Three of these had been carried out in 2017, whilst one did not have the date it was carried out. Completed appraisals contained the employee's and employer's comments, goals for the year ahead and an action plan to identify how goals would be achieved.
- There was a process to review staff competencies on a yearly basis; however, this process had not been completed annually for all of the staff. Three out of eight staff files contained a personal development plan. We were told this plan was to be used annually to assess staff competency in their role. One of the three personal development plans was dated 2013, one 2014 and the third did not have a date of completion on it. None of the forms had been completed in full and none of the staff had up to date forms in their files from 2017.
- Driving assessment reviews were not consistently carried out for all staff. The review looked at staff knowledge of policies, vehicle roadworthiness, fuelling safety and a practical driving assessment. Four out of the eight staff had received a driving assessment review in 2017. One member of staff also had completed a

review in 2015. The other four files did not contain any driving assessments. It was unclear to us whether this assessment should have been carried out annually or just when staff joined the service.

Coordination with other providers and multi-disciplinary working

- Care was delivered in a coordinated way when services were involved in the patient's care. The registered manager told us they worked with a local NHS ambulance service when they had to call on them for additional support at times, for example when unplanned transport took place from events. This was due to the patient having a serious injury or their condition was unstable.
- For planned transport, the provider worked with other health care services to make sure patients attended their appointments on time.

Access to information

- Staff on the planned transport service were not made aware of do not attempt resuscitation orders prior to a journey, unless the referrer provided this information. Booking forms did not have a section to record if this had been discussed or raised at the initial booking stage. We saw evidence on the 29 forms we reviewed that this had been discussed.
- Satellite navigation systems were available to be used in the ambulances and the wheelchair accessible car. The systems provided staff with information to establish the quickest route to their destination. However, most staff were local and were aware of the locations they needed to get to.
- Staff had access to the provider's policies and procedures at the office. A senior member of staff was also available to provide additional guidance and support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider did not have a policy or any procedures available with regards to capacity to consent. Only one member of the eight volunteers had completed specific training in Mental Capacity Act and Deprivation of Liberty Safeguards. However, the registered manager told us in the training for 'assessment of the scene' this included a section on consent as this was based on the Ambulance Care Essentials (ACE). However, as patients came to them voluntarily for treatment and unplanned transfers at events, they were not likely to meet a patient who had a Deprivation of Liberty Safeguard in place. The registered manager, senior staff and other staff told us they always asked for consent from the patient prior to an examination and treatment. Following our inspection, the registered manager sent us a copy of their new Mental Capacity and Deprivation of Liberty Safeguards policy. This made reference to national guidance and was going to be shared with staff.
- The provider had a chaperoning policy which mentioned consent and that patients must be offered the opportunity of being treated by a member of staff of the same gender with a witness present. A decision tree was also provided for staff to follow which gave them guidance on the action to take.
- The registered manager told us they did not use any form of restraint for any patient. If a patient presented with a mental health crisis during an event and they needed transporting to hospital, they would call for the local NHS ambulance trust. This was because staff were not trained to manage patients with mental health conditions.

Are patient transport services caring?

Compassionate care

- During the inspection we were not able to observe any patient journeys or direct care because there were no planned transfers booked in.
- We received two comment cards from patients who had received care from Devon Ambulance and First Aid Service. Both cards contained positive comments about the service. These said the service provided "excellent assistance" and "a professional service."
- We received one comment card written by a parent whose child had received treatment by the service. They told us how the service had taken a calm and gentle approach to their child's treatment.

Understanding and involvement of patients and those close to them

Patient transport services (PTS)

- During the inspection we were not able to observe any patient journeys or direct care because there were no planned transfers booked in. We were unable to collect evidence for this section. There was also no feedback on the comment cards we received about this.
- The registered manager told us they always discussed treatment options with patients to include their family so they can make an informed decision.

Emotional support

- During the inspection we were not able to observe any patient journeys or direct care because there were no transfers booked in. We were unable to collect evidence for this section.

Are patient transport services responsive to people's needs?

- Devon Ambulance and First Aid Services CIC provided a private patient transport service and an unplanned events ambulance service, where there was an actual or identified need to provide off-site transportation. The service did not hold any contracts with local Clinical Commissioning Groups or other third party contracts for its patient transport or events transportation work. All work was carried out privately. Demand was not predictable due to the infrequent nature of bookings for the patient transport service. However, work was more predictable over the summer months for the events transportation arm of the service.
- The service was a non-profitable organisation which relied on donations to be able to fund the service and continue to meet the needs of the local community. The events transport service provided cover for the majority of local community events taking place. Donations paid for the rental of the vehicles from the parent company and also went towards the upkeep of the vehicles.
- Services were planned and delivered in a coordinated and efficient way which responded to the needs of the local community. The service was run by volunteers who also had full time employment elsewhere. Care was needed when taking bookings for the patient transport or the events transportation service to ensure volunteers were available. Patient transport work was always booked in advance to suit needs of the individual requesting the service. Events work requiring transportation was always pre-planned to ensure staff availability to cover the event. The biggest challenge for the service was staff availability due to the voluntary nature of the service.
- Information about planned community events and national guidance was used to inform how the service was planned and delivered in conjunction with the event organisers. Events which could involve transportation of a patient were booked via Devon Ambulance and First Aid Services CIC parent company. Both services worked together to provide cover for planned events. Guidance to manage the health, safety and welfare of people attending events and the Health and Safety Executive was also used to ensure the correct cover was provided depending upon the type and size of event.

Meeting people's individual needs

- There were limited systems to support patients with communication difficulties, or those whose first language was not English. There was no access to translation services and staff told us they would rely on friends or family members to translate for them. We were shown a visual pain scale used by one member of the team; however, this was the only communication aid available.
- It was unclear whether staff were fully aware of the needs of the patients transported by the planned transport service. We were told the service asked at the initial booking stage whether the patient had dementia or a learning disability. If this was the case, the service encouraged a family member or friend to accompany the patient. This ensured patients' needs were met and that they did not become distressed during the journey. However, we only saw evidence on one patient journey form where dementia had been identified. We were told that this was an observation of the driver rather than what the service had been told at the initial referral stage.
- The wheelchair accessible vehicle had additional equipment to manage the needs of bariatric patients using the service.
- The service tried to ensure patient comfort during a patient transport journey. The wheelchair accessible vehicle had blankets and a pillow on board available for patients should they require these during a journey.

Patient transport services (PTS)

Access and flow

- The service was operational during working hours seven days a week to receive calls and manage bookings. Planned patient transport work was pre-planned at least 24 hours in advance to ensure the service had staff available to carry out the journey. Events transportation work attended by Devon Ambulance and First Aid Service was also pre-planned. However, due to the nature of the service, transportation of a patient from an event site was unplanned. Vehicles had to be on standby at the event and ready at all times for use.
- We were told there had been no delays associated with the private patient transport service. Details of patients' appointment times were collected at the initial booking stage. We were told journeys were carefully planned to leave enough time to get to the patient's destination on time, accounting for travel time and any other traffic disruptions. They were not auditing this.

Learning from complaints and concerns

- The service had a complaints policy in place. However, the procedure set out to manage complaints was incomplete. The policy stated complaints would be acknowledged within a week of receipt. However, there was no timeframe outlining when the complainant would receive a full response and an outcome. The registered manager was responsible for investigating complaints. If a complaint was made about the registered manager, we were told the chairman from the parent company would investigate this complaint. This, however, had not been identified in the complaints policy.
- Devon Ambulance and First Aid Services CIC had received no complaints between November 2016 and October 2017.
- There was no information available on the ambulances to inform patients about how to make a complaint. The complaints policy stated a slip containing contact details for the organisation was given to patients on discharge from the service.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The registered manager had registered with us in August 2017, although he had been with the provider for a number of years. A management structure was in place for this provider and their parent company. Each senior member of staff had responsibilities for different areas, for example the registered manager was also the care quality director. The chairperson had overall responsibility for clinical issues.
- The management structure also included a reporting system and staff were aware of who had what responsibility. There were four directors in place and staff said they were visible as they were also part of the team at events. We saw a copy of the minutes of one meeting held in January 2017 where they discussed the business for example how the patent company worked with this company. The provider had a process in place for appointing directors based on our guidance for fit and proper person requirements. However, we did not see any evidence that this was followed for the appointment of two new directors at the beginning of 2017.
- Prior to our inspection there was a change in the registered manager. However, it was unclear to us when the previous registered manager left the service. It is a condition of registration that a registered manager is in position to manage the regulated activity.
- The registered manager had a basic understanding of the Health and Social Care Act 2008 (Regulated Activities) 2014, following their recent interview with us to be considered for registration. However, the registered manager did not have full oversight of the service in terms of quality, risk and performance. For example, there was no monitoring of performance, outcomes, or risks to the service.
- Staff told us they were supported by the registered manager and other senior staff. They felt able to report any concerns they might have and action would be taken by senior staff. Staff knew how to access the management team as they worked ad hoc hours based on their availability.
- Staff said it was an enjoyable place to work as they felt respected and valued. One staff member described it as being like a "big family". As it was voluntary, staff said if they did not enjoy the job they would not continue

working for the provider. Another member of staff said the provider and fellow staff gave them the confidence and support to apply for a job they had always wanted to do.

- Following our inspection the registered manager had devised a lone working policy for the staff on the planned transport service to make sure the drivers were safe.

Vision and strategy for this this core service

- The vision for this provider and their parent organisation was "to actively promote voluntary pre-hospital care via our community groups and to become a market leader within the first aid sector". Their mission was "to provide a reliable cost effective service actively engaging with our customers to provide a personal and professional experience". Not all staff were aware of these statements. Senior staff felt their overall goal was to keep doing what they do well.

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

- There was no effective governance framework to support the delivery of the strategy and good quality care. The registered manager and other senior staff told us they received verbal feedback from stakeholders, but this was not recorded. There was no system in place to routinely request feedback from stakeholders for the unplanned events transport or the planned transport services. They had tried to obtain feedback from patients who had received unplanned transport from events by giving them information about their website, but no feedback had been received.
- The provider or registered manager did not maintain a risk register or any other document to identify risks to the service provision for both unplanned and planned patient transport. There were no processes in place to assess, monitor and mitigate any risks relating to the service, or the health and safety and welfare of patients and others. This was not an area the registered manager or other senior staff had considered. Senior staff told us a risk assessment took place for each event they took part in, as this included how many ambulances and staff they required. These were often for events they had done in the past so they were aware of the location and environment in which they would be working. They were not able to show us any of these risk assessments as they were stored by their parent company.
- There was no comprehensive assurance system or service performance measures. This meant it was not possible for the provider to record and monitor performance, and action taken to make necessary improvements. The provider did not collect and monitor any data, for example collection or drop-off times. There was no monitoring or auditing, for example around infection control or the cleanliness of vehicles. Therefore, we were not confident the provider or the registered manager had oversight of the performance of the services provided.
- A whistleblowing policy was in place to enable staff to raise concerns. However, it was devised in 2014 and the registered manager was in the process of updating this as they had just completed a training course around this. Staff told us any issues they had could be raised and discussed.

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

- Devon Ambulance and First Aid Services CIC had tried to engage with patients in order to assess their experience of the quality of the service provided. However, they had received no feedback from the eight unplanned transport journeys from events. There was no evidence they had tried to obtain feedback from patients who used the planned transport service. We did view one letter from a patient who had used this service and they were complimentary about it.
- We had received feedback in April this year via our website where a person told us they felt the ambulances were dirty. We fed this back to the registered manager and senior staff.
- Staff told us they were kept up to date with changes in the organisation at their weekly training meetings or via e-mails. They were also able to make suggestions at these meetings for improvements to the service. Staff in management roles held meetings where changes were discussed and staff said these were fed back to them.

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

Patient transport services (PTS)

- The provider was considering developments to the planned transport service by increasing the volume of the transfers so they could upgrade their vehicle and appoint more drivers. Their longer term plans included looking at becoming more commercially viable with paid drivers.
- The registered manager said they were continually trying to appoint new volunteers to the service to enable them to cover more events and unplanned transport. They were also planning to implement a team of bank staff.

Outstanding practice and areas for improvement

Outstanding practice

- All staff, including the registered manager and directors, were volunteers who did this work around their full time jobs and other commitments. They also received no payment for this work.

Areas for improvement

Action the hospital MUST take to improve

- Devise an incident reporting procedure and a system to investigate and act upon areas that require improvement following the investigation.
- Take prompt action to make sure all equipment on the ambulances is tested and maintained so it is safe to use.
- Ensure their booking form used for the patient transport service includes more details about patient needs and risk assessment.
- Ensure a thorough assessment of the patient's need is completed and recorded for patients using the planned transport service.
- Take prompt action to make sure the ambulances and wheelchair car are clean and ready for use to reduce the risk of cross infection.
- Make sure cleaning products used on the ambulances meet national guidance to prevent the risks of cross infection.
- Actively assess the infection risks associated with patients to prevent and control the spread of infection.
- Ensure staff have received the correct level and frequency of safeguarding training for both adults and children so patients are protected.
- Devise effective systems to be able to assess and monitor the service in terms of quality, safety, performance and risk.
- Ensure staff receive their yearly appraisals and formally monitor their competence to carry out their role.
- Ensure there is a suitable recruitment procedure to safeguard patients against unsuitable staff, and ensure there is a process to review the fitness of the employees.

Action the hospital SHOULD take to improve

- Devise cleaning schedules for each vehicle and monitor their cleanliness.
- Review their linen exchange process and look to formalise the arrangements in place.
- Devise a system to make sure all consumables on the ambulances are in date and safe to use.
- Devise a protocol for the use of nitrous-oxide to make sure staff are using this correctly.
- Install warning signs for the vehicles and the office to warn people compressed gases are present.
- Devise a medicine policy for Devon Ambulance and First Aid Services CIC.
- Devise a policy for deteriorating patients and the actions staff need to take.
- Make sure they comply with data protection requirements in relation to Disclosure and Barring Service certificates.
- Include a timescale for when a complainant should hear back from them with the outcome of an investigation in their complaints policy.
- Look to introduce more communication aids and a translation service to meet the needs of the population.

Outstanding practice and areas for improvement

- Make sure all staff have a driver assessment undertaken and recorded to make sure they are competent to drive the vehicles.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. 12(2)without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (a) assessing the risks to the health and safety of service users of receiving care and treatment; (b) doing all that is reasonable practicable to mitigate any such risks; Comprehensive risk assessments were not carried out for patients transported with Devon Ambulance and First Aid Services CIC pre-planned patient transport journeys. There was no further information detailing the extent of these risks, or guidance for the management strategies to be used to mitigate these risks. There was no incident reporting system in place to review, investigate and learn from any incidents.

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 13(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. 13(2) Systems and processes must be established and operated effectively to prevent abuse of service users. There was no evidence to demonstrate what level child and adult safeguarding training had been completed by the staff.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15(1) All equipment used by the service provider must be – (a) clean (e) properly maintained 15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. All equipment on the ambulances was out of date for servicing and there were no records to demonstrate on-going maintenance. All three vehicles used by the service were not clean. Cleaning products they had in place were not suitable for this purpose.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. 18(2)Persons employed by the service provider in the provision of a regulated activity must – (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, The provider did not carry out annual appraisals or regular supervision with the crew. The organisation did not carry out annual appraisals with all the staff.

This section is primarily information for the provider

Requirement notices

There was limited evidence of a competency assessment for new staff or a checklist to prove when they completed their induction period and they were passed as competent to undertake the role.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements of this Part. 17(2)Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of the service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; There was no system to identify the service's strengths and areas for further development. There was no evidence of any internal reviews or audits of the service. There was no evidence of any performance dashboards or reports completed with regards to the service. There was no documented evidence that the provider was actively seeking the views of other stakeholders for their experience of the service they provide. The organisation did not maintain a risk register or any other similar documents to identify risks to the service

This section is primarily information for the provider

Enforcement actions

provision. Therefore, there were no processes to assess, monitor and mitigate the risks relating to the organisation, or the health and safety and welfare of patients and others.

There were no documented detailed assessments of patients using the planned patient transport service.

Regulated activity

Transport services, triage and medical advice provided remotely

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

19(1) Persons employed for the purposes of carrying on a regulated activity must –

(a) be of good character;

(b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them,

19(2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in –

(a) paragraph (1)

19(3) The following information must be available in relation to each such person employed—

(a) the information specified in Schedule 3, and

(b) such other information as is required under any enactment to be kept by the registered person in relation to such persons employed.

19(5) Where a person employed by the registered person no longer meets the criteria in paragraph 1, the registered person must –

(a) take such action as in necessary and proportional to ensure that the requirement in that paragraph is complied with

There was no evidence to identify a safe recruitment procedure was in place to safeguard patients against unsuitable staff.

This section is primarily information for the provider

Enforcement actions

There was no documented evidence of satisfactory conduct in employment in health and social care or with children or vulnerable adults.

There was inconsistent proof of identify of the staff including a recent photograph.

There was no documented evidence that the registered manager was regularly reviewing the fitness of the employees.