Kernow Ambulance Service

# Kernow Ambulance Service

## Quality Report

Unit 3
Woods Browning Industrial Estate
Respryn Road
Bodmin
Cornwall
PL31 1DQ
Tel: 01208 75621
Website: www.kernowambulanceservice.co.uk

Date of inspection visit: 24 October 2017 to 01 November 2017
Date of publication: 08/02/2018

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

Kernow Ambulance Service is based in the South West of England and provides transport for mental health patients throughout the UK and Europe. There is one depot located in Bodmin. The service is provided for people between the ages of 14 and 65 and includes individuals with various mental health issues and learning disabilities.

The service held an agreement with an NHS purchasing and supply alliance to provide non-emergency patient transfer services which include qualified staff and secure transport.

Kernow Ambulance Service is registered with the CQC to provide the regulated activity:

- Patient transport services, triage and medical advice provided remotely

We inspected this service using our comprehensive inspection methodology. The announced part of the inspection on the 24th October 2017 along with a further announced visit on the 1st 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 Health Act 1983 and 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 areas where the service provider needs to improve:

- There was no relationship between the management of incidents and risks. Incidents were not used to identify, control, or measure risk related to patient safety. The review of incidents involving violence and aggressive behaviour was not scrutinised to identify learning and potential changes to practice.
- Patient documentation when mechanical restraint was used was not consistent and there was no recorded rationale, escalation and de-escalation plan for each patient. Where behaviour is deemed to present risk to the individual or those providing care, restraint may be used to restrict a persons free movement. The restraint may be physical, where the individual is held by others, or mechanical which describes the use of devices such as harnesses or hand cuffs. The provider could not assure themselves that staff only used physical and mechanical restraints as a last resort and in line with best practice.
- Mental capacity was not consistently considered and recorded as part of a patient's health status.
- Thorough risk assessments for patients were not consistently undertaken to safeguard the health, safety, and wellbeing of the patient for every transfer. The provider could not evidence appropriate steps to mitigate or remove any risks identified through this process.
- The provider could not evidence sufficient numbers of staff, who had the correct competencies and experience were identified for each journey.
- The provider did not ensure that policies and practices reflected the current legislation and any associated codes of practice.
- The provider could not evidence for longer distance journeys that risk assessments in relation to health, safety, and wellbeing of patients or staff had been conducted.
- There were no clear processes for the disposal of clinical waste including contaminated linen and bodily fluids; there were no audits regarding hand hygiene or infection control.
- The provider did not ensure recruitment processes and practices were in keeping with regulation requirements.
- The provider did not have a major incident policy.

# Summary of findings

- The provider did not have any clinical audit programme or evaluation of processes to identify where improvement could be made. Information was not collected to provide key performance indicators and the provider confirmed they did not monitor response times and patient outcomes.
- Kernow Ambulance management communicated with other services when needed but did not meet regularly with other providers who used their services to assure the quality of the service.
- Kernow Ambulance management did not have agreed safety practices with providers who used their services.
- Clinical governance arrangements did not underpin quality and safety across all areas of the business. Systems or processes were not established and operated effectively to ensure all areas of clinical risk were monitored and reviewed to improve quality and safety for patients and staff. We found no assurance framework which monitored compliance to standard operating procedures or evidence the safe introduction of new practice.
- The provider did not have any formalised systems to challenge decisions or have an independent overview of the service. The registered manager also provided clinical leadership, but did not receive any clinical or peer supervision to help them stay up to date with current practice.

However, we also found areas of good practice:

- The environment of the depot was clean, secure and suitable for safe storage of ambulances and equipment.
- Infection control practices were documented within local procedures and understood by staff; practices were in accordance with the provider policy.
- Kernow Ambulance Service offered an induction programme and mandatory training for all staff.
- Procedures were in place to safeguard children, adolescents, and adults from abuse.
- Staff had the right skills and knowledge to do their jobs. An induction was provided for all staff. Staff received an appraisal to identify learning needs, and a plan was created to support staff to develop their practice.
- During the inspection we were not able to observe any patient journeys or direct patient care; however staff told us how patient care was their priority. People's individual needs and preferences were central to the delivery of the service.
- For patients who were not detained under the Mental Health Act 1983, their understanding and involvement was recorded. Staff told us they provided support to the patient with the aim of reducing distress and any associated negative behaviour.
- The providers had a shared vision for the service and an agreement about scope of development. The management team were accessible to receive calls, manage bookings and respond to queries.
- The service was operational 24 hours a day, seven days a week, allowing direct contact with the management team, including out of hours.
- Patient and staff feedback was encouraged and was under further development.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, to help the service improve. We issued the provider with two requirement notices and one warning notice that affected patient transport services.  Details are at the end of the report.

**Amanda Stanford**
**Deputy Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| **Patient transport services (PTS)** | | The service provides non-emergency ambulance transport, predominantly for people with mental health conditions, most of whom are detained under the Mental Health Act 1983.<br><br>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.<br><br>We found areas where the service performed well during our inspection. For example safeguarding procedures were in place and staff understood their responsibility to report concerns. Staff had the right skills to do their job, a comprehensive induction and update training programme was given to all employees alongside a review of driving skills. Vehicles were well maintained, clean, regularly checked, serviced, and maintained. During the inspection, staff told us of their caring approach to patients, which we saw evidence of in feedback the provider had received. There was a good relationship between staff and the management team; we saw how staff feedback was used to drive improvements.<br><br>However, we also found areas where improvement was needed. Thorough risk assessments were not consistently in place to safeguard the health, safety, and wellbeing of staff and patients. We found no evidence of journey planning, including staffing numbers, skills, mix and scheduled breaks.There was no overview of risks to monitor incidents, for example, the investigation of incidents was not robust and did not influence how clinical risks were managed by the organisation. The use of mechanical restraint was not in keeping with the Mental Health Act Code of Practice 2015. We found no assurance programme in place to evaluate processes or performance to identify potential improvements. |

# Kernow Ambulance Service

## Detailed findings

**Services we looked at**
Patient transport services (PTS);

# Detailed findings

## Contents



## Background to Kernow Ambulance Service

Kernow Ambulance Service was first registered in 2014 as an independent provider transporting vulnerable adolescents and adults. The service is based in Cornwall and provides patients transport services across the UK and Europe.

Kernow Ambulance Service is registered with the CQC to provide the regulated activities of patient transport services and triage and medical advice provided remotely.

We inspected this service using our comprehensive inspection methodology with the announced part of the inspection on the 24th October 2017 along with a short notice announced visit on the 1st November 2017.

The service has had a registered manager in post since 2014 and has not previously been inspected by the CQC.

## Our inspection team

The team that inspected the service comprised of a CQC lead inspector,who was accompanied by other CQC inspectors which included expertise in Mental Health.

The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

# Patient transport services (PTS)

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |
| Overall | |

## Information about the service

Kernow Ambulance Service provides transport between psychiatric hospitals, specialist units, alongside repatriations to hospital wards and home addresses. The service performs short-notice work and is a preferred provider with a number of NHS organisations.

The company operates from one location in Bodmin which is the administrative headquarters and the depot for three vehicles. There were changing and laundry facilities available for staff. The company is a partnership which employs a total of 25 staff which includes two managers (one of whom is the registered manager and qualified as a mental health nurse), two administrative personnel (one of whom is a registered mental health nurse and specialist community public health nurse) and 21 ambulance crew. The ambulance crew consists of 20 healthcare assistants and one registered mental health nurse.

In the period September 2016 to August 2017, the provider undertook 857 transfers, 742 of which involved persons detained under the Mental Health Act 1983. For the time period from April to October 2017 there had been 39 transfers of young people between 14 and 16 years. The provider predominately operates across the south west peninsula with provision to Cornwall, Plymouth, and Devon; journeys to other parts of the country were also undertaken.

The service provided 24 hour, seven days a week cover, with weekend and out of hours work undertaken.

The provider has not reported any never events or incidents resulting in serious harm. The company has received two complaints in the last 12 months.

During the inspection, we visited the providers' only location in Bodmin. We spoke with eight staff including the management team and ambulance crew. We did not speak with patients or relatives as part of this inspection, but we did review feedback held by the provider. During our inspection, we reviewed a total of 40 sets of patient records.

# Patient transport services (PTS)

## Summary of findings

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

We found the following areas where the service provider needed to improve:

- There was no relationship between the management of incidents and risks. Incidents were not used to identify, control, or measure risk related to patient safety. The review of incidents involving violence and aggressive behaviour was not scrutinised to identify learning and potential changes to practice.
- Thorough risk assessments for patients were not consistently undertaken to safeguard the health, safety, and wellbeing of the patient for every transfer.
- Patient documentation when mechanical restraint was used was not consistent and there was no recorded rationale, escalation and de-escalation plan for each patient. Kernow Ambulance management did not have agreed safety practices with providers who used their services.
- The provider could not evidence sufficient numbers of staff, who had the correct competencies and experience were identified for each journey. The provider did not ensure recruitment processes and practices were in keeping with regulation requirements.
- The provider did not ensure that policies and practices reflected the current legislation and any associated codes of practice. Mental capacity was not consistently considered and recorded as part of a patient's health status.
- The provider did not have any clinical audit programme or evaluation of processes to identify where improvement could be made. Information was not collected to provide key performance indicators and the provider confirmed they did not monitor response times and patient outcomes.
- The provider could not evidence for longer distance journeys that risk assessments in relation to health, safety, and wellbeing of patients or staff had been conducted.
- Clinical governance arrangements did not underpin quality and safety across all areas of the business. Systems or processes were not established and operated effectively to ensure all areas of clinical risk were monitored and reviewed to improve quality and safety for patients and staff.
- The provider did not have any formalised systems to challenge decisions or have an independent overview of the service.
- However, we also found areas of good practice:
- The environment of the depot was clean, secure and suitable for safe storage of ambulances and equipment.
- Infection control practices were documented within local procedures and understood by staff; practices were in accordance with the provider policy.
- Kernow Ambulance Service offered an induction programme and mandatory training for all staff and procedures were in place to safeguard children, adolescents, and adults from abuse.
- Staff had the right skills and knowledge to do their jobs. An induction was provided for all staff. Staff received an appraisal to identify learning needs, and a plan was created to support staff to develop their practice.
- During the inspection we were not able to observe any patient journeys or direct patient care; however staff told us how patient care was their priority. People's individual needs and preferences were central to the delivery of the service.
- For patients who were not detained under the Mental Health Act 1983, their understanding and involvement was recorded. Staff told us they provided support to the patient with the aim of reducing distress and any associated negative behaviour.
- The providers had a shared vision for the service and an agreement about scope of development. The management team were accessible to receive calls, manage bookings and respond to queries.The service was operational 24 hours a day, seven days a week, allowing direct contact with the management team, including out of hours.
- Patient and staff feedback was encouraged and was under further development.

# Patient transport services (PTS)

## Are patient transport services safe?

### Incidents

- Kernow Ambulance Service had a clear incident reporting process for staff to follow. An incident reporting form was available for staff to complete and there was an Incident Reporting Policy which had been reviewed in July 2017. Staff were aware of the company policy and knew how to report concerns via an electronic form. The electronic form was part of the journey log, allowing crew constant access to the incident reporting system. The provider was aware of their responsibility to review incidents and develop learning from incident investigation. A member of the senior management team undertook investigations of each incident. Investigations involved a review the patient's notes and the associated incident report, before recording the outcome on an incident database.
- Incidents involving violence and aggressive behaviour were not scrutinised to identify learning and potential changes to practice. There was no assurance that the clinical lead reviewed incidents consistently. There was no template for incident investigations and we did not see a record of comprehensive investigation when reviewing incidents. We looked at incidents where information was missing, such as the time a mechanical restraint had begun; the review had not identified this. The clinical lead was the only person who reviewed incidents, this included incidents they were involved in. We raised our concerns with the provider at the time of our first inspection. At the second visit, the provider told us they were in the early stages of identifying a tool for incident investigation. The senior management team could clearly articulate how this would allow consistent and more thorough investigation of incidents. This work was part of a wider piece work which is currently being collated into an action plan to address these issues.
- Learning was cascaded to staff via team meetings, newsletters and memorandums. Staff told us they had received feedback from incidents they had reported and reporting was encouraged.
- We saw from records and data that approximately 39% of all violent and aggressive incidents had resulted in mechanical restraint. The Mental Health Act Code of Practice 2015 identifies mechanical restraint must be used in exceptional circumstances.
- 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. A duty of candour policy was available to staff on line and management demonstrated a good understanding of their responsibilities under this regulation.

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

- There were no clinical dashboards available to establish an overview of the safety and quality of the service provided. Data about the service was not gathered or used to monitor or demonstrate the quality of the service provision.
- Regulation 17 of the Health and Social Care Act 2014 requires providers to establish effective governance including assurance auditing of systems and processes. The provider does not gather information about the service provided; there was no evidence of periodic review of the quality or safety of the service.

### Cleanliness, infection control and hygiene

- Infection control practices were documented in local procedures and understood by staff; practices were in accordance with the provider's policy. An infection control policy was available online for staff and had recently been reviewed in February 2017.
- Infection control training was provided for staff but not all staff had completed the training. Of the 23 staff employed, this included four new staff member pending full training, ten staff had not completed the infection control training. This meant that not all staff were up to date with current infection control good practice.
- Personal protective equipment was available on the vehicles for staff use. Equipment included masks, aprons, and protective eye wear. Hand hygiene products were available on all ambulances, with additional supplies carried on board. We were unable to undertake a patient journey during the inspection so we could not observe if staff undertook good practice in hand hygiene.
- All three ambulances used to transport patient were found to be clean and tidy. Weekly deep cleaning schedules were completed. We also saw records of cleaning before and after each transfer as part of the

journey log. All vehicles carried a limited supply of cleaning materials on board. These were stored safely and were not accessible to service users. We were told there was a process for staff to alert the provider if a deep clean was required following a transfer.

- The provider did not have complete oversight of all aspects of infection prevention and control processes. There were no clear processes for the disposal of clinical waste including contaminated linen and bodily fluids, there were no audits regarding hand hygiene or infection control.
- There was no clear process for managing the risk regarding contaminated linen. All used linen was collected and laundered at the depot. During the inspection we were told this would be disposed of as general waste at the depot as no other process was available. Clinical waste was placed in a marked yellow bag and disposed of at the receiving organisation. There was no provision for clinical waste disposal at the depot and we were told the provider did not hold any contracts with external companies.
- Each ambulance carried a sharps box for the safe disposal of used items. The boxes were in good condition with the temporary closure was applied to prevent spillage. We found the labels on all three boxes had not been completed. This meant we were unable to determine how long the contaminated sharps had been held within the vehicle or any risk from the prolonged storage of used products. We were told sharps boxes were disposed of through a local chemist; there was no contract and no information within the policy which determined the frequency of disposal.

**Environment and equipment**

- The environment of the depot was clean, secure and suitable for safe storage of ambulances and equipment. The depot acted as the company headquarters housing offices, vehicles, and supplies. Service users did not attend the facility.
- The ambulance depot was located on an industrial unit which was secured at night. Sensor activated alerts were linked to the on call telephone carried by the management of the service. A fire system had been installed which was also linked to the on call telephone and the fire service.
- Vehicles were serviced to ensure safety for use. Records showed all three ambulances had been regularly serviced within the year, held current MOT certificates, insurance and breakdown cover. Staff also completed checklists prior to each journey to ensure vehicle safety. We saw evidence of completed documents during the inspection.
- We found the vehicles carried equipment identified as being needed, such as suction equipment, and items to ensure the comfort of the service user during journeys. A box containing incontinence products was carried on each ambulance in case it was required by patients. Further supplies were held at the depot which staff could access both in and out of hours.
- All equipment was checked, serviced and suitable for use. First aid equipment, including defibrillators, were carried on each vehicle and within easy reach of the crew. The defibrillator kits included items for both adult and paediatric use which reflected the service user groups.
- Staff told us they felt able to raise concerns regarding equipment and they could bring any issues to the attention of the management team through incident reporting or raise it directly. We were told prompt action was always taken.

**Medicines**

- Kernow Ambulance Services did not store medicines or medical gases at the depot or within the vehicles. The provider had a Medication Management Policy, updated March 2017 available to staff on line. The policy outlined staff responsibility for medicines during a patient's journey.
- Any medicine which was required during patient transfer was prescribed and supplied by the discharging organisation. During a transfer, medicines were held within a sealed bag and stored at the front of the vehicle.
- If a patient required prescribed medicines during a transfer, a registered mental health nurse took responsibility for the administration and this was recorded in the patients' record. On arrival at the destination, all medicines would be checked with the receiving organisation and a copy of the medicines record given to ensure continuity of care. The management of patients' pain was planned by the referring provider prior to discharge and medicines were only administered if the transfer was staffed by a registered mental health nurse. The provider told us transfers would not proceed if a registered nurse was unavailable.

- Kernow Ambulance Service told us they did not transport patients who require medical gases such as oxygen during transfer.

**Records**

- There were clear systems and processes to ensure paper medical notes were kept safe. However, the confidentiality of electronic records could not be assured.
- At the initial point of referral, the management lead on call would gather as much information about the patient as possible. When the journey was confirmed, this information would be uploaded onto an electronic form on portable tablet, this was held by staff on the vehicle. The electronic document then continued to be the patient record for the duration of the journey. The format enabled staff to record ongoing observation and monitoring of the patient and also recorded the times of arrival, departure and arrival at the final destination. Once the journey was complete, information was printed and held as a paper record at the depot. The electronic copy was then deleted. The paper records became the services only record and were stored securely in lockable cabinets at the ambulance depot.
- Whilst on inspection we raised concerns regarding the confidentiality of electronic records. We found portable devices were not encrypted and records containing patient identifiable information were not secured. During our second visit, the provider told us all devices had been encrypted and additional password protection placed on the unsecured record. This ensured confidentiality was maintained. Other patient information was secured within a sealed bag during the journey.

**Safeguarding**

- Kernow Ambulance Services had procedures to safeguard children, adolescents and adults from abuse. The provider policy was accessible to staff on line a Child and Adolescent Safeguarding Policy, reviewed July 2017 and Adult Safeguarding Policy, reviewed July 2017.
- Staff were aware of the provider policy regarding safeguarding procedures and knew their responsibilities in raising concerns. As transfers took place across a large geographical area, the service had developed an 'Out of County' referral process which enabled staff to raise their concerns for onward management.
- The named professional for safeguarding was a registered specialist community public health nurse, specialist in the care of school-aged children and trained to level three. Within safeguarding policies, the named professional was not clearly stated but staff could identify the individual when discussing safeguarding processes.
- Most staff had completed safeguarding training. It was expected that staff would complete level two training on induction and receive an annual update. At the time of inspection, 88% of staff had received safeguarding children training, 92% had completed updated safeguarding adults training.

**Mandatory training**

- A programme of mandatory training offered to all staff and was provided to all employees on induction and updated on an annual basis. A variety of teaching methods were used including face to face and e-learning. An overview of mandatory training was available, and included the management of moving and handling, violence and aggression in adults and children and infection control. In addition to mandatory subjects, bespoke training was also offered as required, for example training in mental health legislation. Kernow Ambulance Service had clear processes for the proper induction and mandatory training of staff. When training was not able to be completed by staff, we were told those staff did not undertake transfers.
- The provider monitored all training completion rates, reminding staff when training was due, and booked update sessions. However, there were no systems to monitor performance indicators such as if levels of training were lower than expected or targets not met. The training records showed that the majority of gaps were in infection control training. There were also some out of date training recorded for mechanical restraint and management of violence and aggression in adults and children.
- The provider had a Driving & Care of Company Vehicles Policy, reviewed February 2017. The service had recently embarked on a driver assessment programme for 'Safe and Defensive Driving'. The company contracted qualified instructors to observe and evaluate the driving behaviour of 18 employees. The third party instructors spent four hours with drivers to provide immediate advice and guidance alongside written feedback which had been provided to the company. This programme

was developed by Kernow Ambulance Service in response to comments raised during staff appraisals. The company partners had since received positive feedback from the staff who found the programme had improved their driving techniques and behaviours. The company has plans to include this training in annual requirements.

**Assessing and responding to patient risk**

- We could not be assured that the risk assessment undertaken prior to patient transfers was sufficient to ensure the safety of patient and staff. The risk assessment process was not clearly documented to evidence the identification of key risks, management strategies, or an agreed plan of care with the referring clinician. The managers confirmed that the level of information varied depending on the type of journey and this information was used to assess the level of risk, the staffing levels and skills mix required for the journey. For example, a referral to transfer a patient from a hospital ward to home varied when compared to a referral to attend a mental health assessment for potential patient transfer The managers told us they used their experience to risk assess rather than a proforma to establish key factors in patient safety were addressed. During our first visit we highlighted the issue to the provider who has reviewed the process as part of an ongoing action plan.
- There was no evidence at the booking stage in the 32 records reviewed of a formalised risk assessment. All referrals for patient transfers were received by a company manager and recorded in a 'referral book'. At the initial referral, the provider did not use any risk proforma or headings to prompt themselves about risk issues,. We looked at the initial referral book and saw that the assessments all consisted of single words and did not follow any consistent approach. The on-call manager then recorded this risk information in the journey log under a risk assessment. The risk assessment consisted of broad risk categories, such as self-harm and neglect, but did not have any more prompts. We reviewed 32 sets of notes and found eight sets were not recorded in the initial referral book, this demonstrated an inconsistency in how information was gathered to assess risk. We saw that the risk recorded consisted of one or two words for example "physical and verbally aggressive". There was no further detail of how the patient would present and where known to services, and what may trigger a change in the patient's behaviour. We did not see evidence of discussions regarding prevention or management of the risk of violence or aggression.
- Kernow Ambulance management did not have agreed safety practices with other providers who used their services. Under the Mental Health Act Code of Practice 2015, transport service providers should agree what type of restraints can be used with those requesting the service. Kernow Ambulance Services told us they had never discussed the type of restraints they use with other providers and had not given this information to them.
- Within the Mental Health Act Code of Practice 2015 appropriate patient monitoring is required during restraint. Evidence demonstrated that monitoring records were not consistently completed. The provider told us when mechanical restraint was used, a staff debrief took place after the incident to see how the situation had been managed and to take learning from it. We did not see any record of this de brief taking place. The service did not offer an opportunity for debrief to patients following physical interventions.
- During our first inspection, we raised our concerns with the provider regarding the risk assessment processes, the lack of documentation, and the use of mechanical restraint. At the time of the second visit the provider had implemented a risk assessment process and the use of mechanical restraint as part of a new strategy. We saw the documentation and spoke to staff who were using the process in practice. The management team were clear that the process was still in development stages and the document was being revised following feedback from crew.
- The processes used to update risk assessments for each patient journey were not consistently performed to ensure that care and safety were well managed. Due to the nature of work undertaken by Kernow Ambulance Services, there could be a significant fluctuation in the behaviour of patients. This would impact on patient care and staff safety. The management team told us that prior to arriving at the collection point, staff undertaking a journey were expected to contact the staff at the collection point. The purpose of this conversation was to gather more information and provide an estimated time of arrival. This was inconsistent with Kernow Ambulance providers' operational procedures and the

feedback we received from staff confirmed this was not what took place. When reviewing patient records we found the majority of records did not record this pre-arrival discussion.

- We found patient documentation when mechanical restraint was used was not consistent and there was no recorded rationale, escalation and de-escalation plan for each patient. The provider told us that each form of mechanical restraint was justified; however, the patient's records did not clearly identify the rationale for the decision. Records seen did not document what escalation and de-escalation interventions staff had tried and why they had decided to use a more restrictive intervention. We saw incidents where a patient's level of aggression had decreased but staff then used a more restrictive intervention. The provider told us that during a journey requiring mechanical restraint only one member of staff needed to be trained its use. It was unclear how the use of mechanical restraint was predicted prior to the journey to allow appropriate staff allocation, or how other staff would not be able to identify if the correct procedure had been followed. There was no record of how mechanical restraint supervision was managed on longer journeys when driver rotation every two hours was required.
- The provider did not record observations of a patient in mechanical restraints in line with the code of practice. The provider did not record observations every fifteen minutes; records we reviewed had inconsistent observation intervals between five minutes and one hour. Sometimes there were no observations of patients in mechanical restraints.
- At the patient collection point, staff told us they completed a further risk assessment of the patient following a handover from the referring team. The provider told us the risk assessment should be documented in the journey progress notes. Records demonstrated that this was a summary of what was happening, with no key factors identified and no management plans.
- Staff told us they received a verbal handover of information for each patient transfer alongside the written information but there was no evidence of this handover within the documentation
- The Mental Health Act Code of Practice 2015 states that patients should always be transported in the most appropriate vehicle to meet their needs. The provider told us they would not consider transporting a patient unless they were confident they had the appropriate vehicle. There was no recorded evidence to demonstrate that the provider considered the type of vehicle during the referral process.
- The provider was not correctly recording all incidents of mechanical restraint (a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control). The provider used a five-point safety harness for the transport of some patients. This was sometimes applied due to aggressive and violent behaviour and use of the harness was part of the physical intervention training course. We asked the provider why its use was not recorded as a mechanical restraint and they told they had not considered it as one but would review their procedures to ensure it was recorded correctly in the future.
- Staff training for the management of violence and aggression including mechanical restraint was provided but training records showed that this had not been updated for all staff. Of the 23 staff currently being used, four staff were new to the business and one did not travel on the ambulances. Of the remaining 18 staff, seven did not have updated mechanical restraint training and three did not have management of violence and aggression training. This meant not all staff were updated to manage risk.
- Systems were in place to manage patients who deteriorated either mentally or physically. If a patient deteriorated physically, the driver would pull off the road at a safe point and an emergency ambulance would be called. Initial first aid equipment was available and a cardiac defibrillator was carried on each vehicle. Staff received training in first aid and resuscitation. If a patient deteriorated mentally staff would pull off the road at a safe point and call the emergency services. They would also contact the local police for that county to advise of the issues as per provider standard operating procedures. Kernow Ambulance Service did not share information with the police service in advance of a journey, including when travelling across different police constabularies with high risk patients.
- The provider runs a manager on-call system to provide support 24 hours a day, seven days a week. Staff gave us examples of when they felt the transfer would not be safe and had escalated their concerns to the manager

on-call. They told us solutions were found. In one case the crew number was increased. Staff told us they felt able to refuse to transfer patients if safety concerns could not be addressed.

**Staffing**

- There was no documented evidence of the rationale or a risk assessment tool used to ensure a consistent calculation of safe staffing levels. Staffing requirements were determined from the information provided at referral. However, no specific staffing tool was used to identify how many staff should attend each journey, therefore the management of risk on that journey could not be identified or assured. The minimum staff on a journey would be a driver and one escort. The maximum would be a driver and three escorts. The level of risk and associated staffing requirement was gauged by the management using personal and previous experience. They told us that if a risk assessment was used, they would always send more staff which they felt was not always appropriate. The providers told us most attendances were over staffed and a referral would not be accepted without sufficient information to establish the risks to patients and staff.
- Recruitment procedures were not consistently applied to ensure all staff met the legal requirements for schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider had a Recruitment Policy, reviewed in June 2017. It was evident that considerable work had been undertaken to ensure that staff personnel files were monitored and updated. Further employment advice was currently being investigated to support the management to ensure full compliance. We looked at three staff files and each had evidence of an application and interview process. However not all had two references to confirm their suitability for employment. We saw an overview of recruitment checks and four staff did not have any references. The management told us this was because they knew the staff and had managed them previously in other employment. We saw that 12 out of the 21 staff employed had only one reference. Of the three files reviewed, two of the staff only had one reference with no explanation of why this was. All staff had a Disclosure and Barring Service check except one which we were assured was in progress but had been delayed due to a change in service provider.
- Checks were made to ensure all staff had appropriate drivers licences. The management kept a record of all staff drivers licence numbers and gained staffs permission to access their online DVLA record. This enabled an annual check of the staff licence. In the interim 12 month period it was the responsibility of the staff to inform the management of any convictions. This was made clear at induction and reminded at staff meetings and newsletters. The staff responsibility was currently being written into the employment contract.
- Kernow Ambulance employed staff on a temporary basis to meet the demand for their service. At the time of inspection, Kernow Ambulance Services employed a total of 25 staff. The service had four permanent employees; two were the business partners and two office based managers. Due to the inconsistency of work, a zero hour's contract was offered to the remaining 21 staff. This included one registered mental health nurse and 20 healthcare assistants. Some staff took employment elsewhere; we saw evidence of 17 employees who opted out of the working time operative. Staff wore a uniform, including an identity badge which enabled others to be aware the person worked for Kernow Ambulance Service.
- In accordance with the Health Professions Act 2002, state registered health professionals are expected to maintain their registration with the appropriate professional body. The registered manager ensured that Registered Mental Health Nurses were registered with the Nursing and Midwifery Council (NMC). The NMC is the professional body that is responsible for the registration of trained nursing staff.
- As part of staff safety and under the provider's policy, drivers were expected to rotate every two hours. Each ambulance had a mobile telephone with a tracking device, so management of the service could at any time see where the ambulance was and if it had been stopped for any reason. A journey log was maintained which included who was driving at any given time, any stops and any delays. Staff we spoke to understood the driver policy, however we found five records which demonstrated drivers had breaks but did not change, demonstrating that staff did not always follow the company policy. There was no evidence that the management had reviewed this area or taken any action to assure them that staff had taken breaks.

**Response to major incidents**

# Patient transport services (PTS)

- Kernow Ambulance Service was not prepared in the light of advice from the Department of Health: NHS Planning Guidance 2005, Civil Contingencies Act 2004. The provider did not have a major incident policy. There was a business continuity protocol with clear actions to be taken for major interruption, including a nominated individual should the management team be unavailable.

## Are patient transport services effective?

Effective means that your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.

**Evidence-based care and treatment**

- The provider did not always ensure policies and procedures reflected the current legislation and any associated codes of practice. Kernow Ambulance Service regularly transported patients under the jurisdiction of the Mental Health Act 1983. The provider had reviewed their Management of Violence and Aggression policy in July 2017 but this did not reflect the most up to date Mental Health Act Code of Practice issued in 2015. The clinical manager told us this was a printing error and that they would change the policy. When we reviewed the policy updated in October 2017, it still had references to older versions of the Mental Health Act Code of Practice 2015.
- Policies for staff were available electronically via the provider's website. Policies were also available to staff at the providers location. They were printed out and left on a table for staff to read. There were also staff training away days when the service managers would discuss policies with the staff team.
- Staff we spoke with said they knew there were policies and procedures and were able to access them. Policies were referenced to National Institute for Health and Care Excellence (NICE) or The UK Ambulance Services Clinical Practice Guidelines 2016 to ensure they followed national guidelines.
- The provider could not assure themselves that staff only used physical and mechanical restraints as a last resort and in line with best practice. The Mental Health Act Code of Practice 2015 identifies mechanical restraint be used in exceptional circumstances. There was no record of planning for using physical interventions or the monitoring of patients described within the code of practice. This did not ensure that patients subject to the Mental Health Act 1983 were protected under the Code of Practice 2015.

**Assessment and planning of care**

- The two managers shared the responsibility of the referral process and assessed the staffing requirements per transfer. The registered manager is qualified as a Registered Mental Health Nurse (RMN) and used their experience and the support of other staff to assess and plan patient journeys. All employees were expected to play an active role, and be an integral part of any given team during transfers. Policies were developed and available to staff on line to support planning patient transfers. These included a Conveyance of Informal Patients Policy, reviewed March 2017 and Conveyance of Children and Adolescents policy, reviewed July 2017. The conveyance policy offered guidelines and protocols to the ambulance staff on their duty in relation to the conveyance of patients. The policy included instructions and expectations for staff. Staff could also access the providers Mental Capacity Act policy, June 2017.
- From their base in Cornwall, Kernow Ambulance Services perform long distance patient transfers, for example to northern England and Scotland. The provider could not evidence that specific assessment and planning in relation to health, safety, and wellbeing of patients or staff had been conducted. There was very limited, if any evidence to identify that a comprehensive assessment of the patients' needs had been taken at the initial booking stage that would enable staff to plan a longer journey. We saw no evidence that journey planning took place with regard to service stations and facilities. A key had been obtained for disabled toilet access to enable swift access to facilities if needed; this was carried on all ambulances. Staff told us two way radios were used to ensure the patients privacy and safety during comfort breaks. If the patient had a forensic mental health history the journey would be undertaken without stops being made. We did not see evidence of journey planning for comfort breaks.
- Should a patient require food and drink, staff would stop and purchase the items. Staff told us that when the patient was of a higher risk , the patient would not leave the ambulance and a member of staff would purchase food for the patient to eat in the ambulance. Kernow

Ambulance Service provided additional snacks and drinks to supplement meals; staff told us this was also used during de-escalation, we saw evidence of this within patient records. During transfers, crew were able to access company funds to purchase further supplies on the journey should they have a particular preference for food or other items.

- Under Mental Health Act Code of Practice 2015 the service provider should agree what type of restraints can be used with commissioners. The provider told us that they had never discussed the type of restraints they use with service commissioners and had not given this information to them.

**Response times and patient outcomes**

- Information was not collected to provide key performance indicators such as times of collection of patients and the monitoring of delays and aborted journeys. The provider confirmed they did not monitor response times and patient outcomes. They explained the service they provided was specific for mental health patients and as such, varied in how situations were managed and so would not provide useful comparable data.

**Competent staff**

- Staff had the right skills and knowledge to do their jobs. An induction was provided for all staff with training face to face for some subjects, and online for other subjects. Staff training was provided twice a year in dedicated training blocks and included external trainers for management of violence and aggression, resuscitation and first aid. If new staff started work between the training days, the management told us the staff did not work until the training was completed even if this meant delays in staff starting work.
- Staff spoke highly of the training they received, they felt it was useful and equipped them for their roles. There was no formally recognised training for ambulance care assistants (ACAs). The responsibilities of ACAs included, driving, moving and handling of patients, patient care and comfort during journeys. The provider had implemented an on-going programme of training to support health care assistants in their role. We saw four new staff were in the process of starting work and had not yet completed the training. The staff training overview was used by the management team to identify any shortfalls in training and plan for further updates.
- An induction and training policy, reviewed in October 2017 outlined the providers training commitment. A training overview was maintained to enable the provider to see at a glance the current training staff had received and any shortfalls which may need to be addressed.
- Specific training had been offered when needed. For example, the service transferred patients under a mental health section process. Paperwork relating to the section was required to be checked by Kernow Ambulance staff to ensure the documentation was sufficiently completed to enable them to legally transfer the patient. This was considered essential by the management and there had been occasions where staff had refused to transfer a patient when the documentation was not accurate.
- An appraisal was used to identify learning needs, and a plan was developed to support staff to develop their practice. We reviewed four staff records and all had completed appraisals for the previous year. An overview of appraisal showed that of the 25 staff employed, 17 had a completed their annual appraisal.
- There was an informal process for staff supervision; however no records of the discussions held were completed. The providers both worked as part of ambulance crew and would use this opportunity to observe staff practice and feedback to staff.

**Coordination with other providers and multi-disciplinary working**

- Kernow Ambulance management communicated with other services when needed but did not meet regularly with providers who commissioned their services. An arrangement with a local supply chain recognised Kernow Ambulance Services as a provider for patient transport. We were told the service did not routinely report to the supply chain or organisations represented within the contracting arrangements. We were told the company did not undertake sub contracted work on behalf of other third party providers.
- The provider was not aware of any agreements with the police and other parties relating to transporting patients. The provider did not liaise with local police or forces with jurisdiction in the areas patients were transferred within.

**Access to information**

- Guidance and support information for staff was accessed on the intranet, which all staff could access through secure log in. All staff we spoke with confirmed the availability of senior staff to discuss any issues they had or to access further information.
- Patient information was provided to staff from the provider's referral details and input onto an electronic tablet located in the ambulance. This became the patients documented log and was updated by the ambulance staff during and after the journey. Should further information be needed from the provider, staff could use the ambulance mobile telephone to make contact.
- The information provided from the initial referral varied and as previously identified documentation was not sufficient to allow a thorough risk assessment and did not ensure staff had enough information to ensure both patient and staff safety. Staff told us they received a verbal handover alongside the written information but there was no evidence of this within the documentation.
- Each ambulance carried leaflets that explained patients' rights under the Mental Health Act. Staff had reported that patients had asked about their rights and they had been unable to provide them with the leaflets. The service managers had supplied copies of patients' rights to address this.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Mental capacity was not consistently considered as part of each patient's health status or included in any planning of care. Mental capacity describes the ability of an individual to understand their care in order to make informed decisions. We found the provider had policies to guide practices in relation to the Mental Capacity Act 2015. During our inspection we reviewed 32 records to look for evidence that a patients' capacity to consent was considered at booking or discussed with the referring clinician, we did not find any evidence. Due to the fluctuating nature of capacity, we also looked for evidence that capacity was evaluated during the transfer. We did not find any documentation regarding changes in capacity, despite altered behaviours of some patients.
- The provider had a policy in place for the Conveyance of Children and Adolescents which outlined the practices for taking consent from under 18's, We reviewed records involving the transfer of children and found examples of discussion with the patient and their parents prior to transfer.
- The provider told us staff received training in aspects of the Mental Capacity Act 2015, including dementia care through online and classroom based learning. The provider used an 'Informal contract' for patients who were not detained under the Mental Health Act 1983 as evidence of discussion regarding the transfer. The informal contract described what the service provided, rights of the patient, and expectations in regards to behaviour. A member of the ambulance crew and the patient signed the document which was stored in the journey record. We saw completed examples during our review of patient notes. We also found examples of staff providing information to patients during transfer, this was documented and contained statements such as "patient understands". As part of their current improvement plan following our initial inspection, the provider has investigated a tool to improve the recording of events by staff, but it was not clear if this incorporated decisions regarding capacity or discussions pertaining to consent.
- The service had a clear understanding of their responsibilities when a patient held a treatment escalation plan. These plans were used locally to record clinical decisions about the patients care and included resuscitation decisions agreed with the patient.

## Are patient transport services caring?

**Compassionate care**

- During the inspection we were not able to observe any patient journeys or direct patient care. We spoke with a person who had involvement with the service. They told us staff were helpful, they did a good job and were professional. The person also told us staff were empathetic but firm which they considered to be a good thing.
- When we spoke to staff they told us how patient care was their priority. They told how emotional needs were part of handover processes during referrals. We heard examples of care where dignity was maintained during journeys, including how toilet breaks were managed to respect the patient's privacy.

# Patient transport services (PTS)

### Understanding and involvement of patients and those close to them

- For patients who were not detained under the Mental Health Act 1983 their understanding and involvement was recorded. Kernow Ambulance Service used an informal contract. Staff told us this provided documented evidence that the patient had received an explanation which included what they could expect from crew members. Patients were asked for verbal agreement and also signed the form as part of the consent process but also to confirm their understanding and involvement.
- We looked at two journey logs which demonstrated the involvement of relatives. In both cases the crews had engaged with the relatives to ensure the patient's preferences and needs were met. This included discussion regarding techniques to prevent behaviour escalation. We were told of instances where journeys had been coordinated to allow relatives to follow the ambulance during the transfer of their family member.

### Emotional support

- Kernow Ambulance Service specialised in transferring patients with mental health needs. At times behaviour could be challenging and violent, emotional support was considered essential to support the patient's needs. Staff told us they provided support to the patient, with the aim of reducing distress and any associated negative behaviour. Each ambulance carried a distraction box which contained items such as fidget spinners, playing cards, and colouring activities for patients to use during their transfer.

## Are patient transport services responsive to people's needs?

### Service planning and delivery to meet the needs of local people

- Kernow Ambulance Service provided a specialist service for patients with mental health needs. The work was variable in demand and varied in what was required. The service did not hold third party contracts for pre-booked work. Demand was not predictable due to the ad-hoc basis of bookings. The provider estimated that 60% of calls received were for same day transfers with the remaining 40% being for planned journeys.
- The service was mostly provided in the Cornwall area but trips for repatriation took place across the country, two trips had taken place outside of the United Kingdom. Five trips had been to Scotland where there were different mental health regulations which required a wider understanding of the services legal responsibilities. The provider had consulted a Mental Health Act advisor and trainer for further information and advice. The transfers of patients came under two categories, informal and formal. Informal patient transfers were for patients with capacity and who were not under any legal section of the law. Formal transfers were of patients under a Mental Health Act section of the law and required secure transfer.
- Kernow Ambulance Services held an agreement a NHS purchasing and supply alliance for the secure mental health patient transfers including children between 14 and 18 years in the south west of England. The arrangement did not include parameters for planned workload, the overall amount of work the provider was expected to deliver, or requirements such as staffing levels or skills mix. Kernow Ambulance Services determined the required response and service delivery through their booking processes.
- We spoke with a qualified health professional that had involvement with the service who told us the service would not take on a journey if they did not have the right staff. This included ensuring that should the patient be female, the service insisted on having a female crew member and would not take the journey. This would ensure the dignity of the patient should a bathroom stop be needed.

### Meeting people's individual needs

- People's individual needs and preferences were central to the planning and delivery of the service. Kernow Ambulance service provided a range of patient information. We saw patient leaflets pertaining to sections of the Mental Health Act available on all ambulances. Staff told these were used if patients needed further support to understand actions being taken and to confirm their rights.
- The organisation had access to translation and interpretation services through the office based staff if needed. The portable tablet had a translation application which the staff could use to communicate with patients.

# Patient transport services (PTS)

- To support patients with communication difficulty, each vehicle carried British sign language cards to support understanding. We also saw useful phrases translated into various languages including polish, Spanish, and Portuguese for example, "Would you like a drink?", "We are taking you to the hospital", "Are you feeling ok?"
- Staff had received training to support patients with learning disability or dementia. The providers told us they would only undertake this work if they had sufficient information to support the patient.
- Each ambulance carried items such as blankets and cushions for the patients comfort. The company also provided a mother and baby bag which contained nappies, wipes, comforters and further baby items. This had been purchased following a mother and baby transfer where the family had been unable to bring provisions for the child.

**Access and flow**

- The management team were accessible and operational 24 hours a day, seven days a week, to receive calls, manage bookings and respond to queries. The depot office was only open Monday to Friday. Out of hours and at weekends the management were available by a dedicated telephone line.
- The providers confirmed work at short notice could be undertaken if there were staff available with the specific skills and training needed. They told us the most difficult staffing problem was balancing demand with staff availability.
- The management told us when the on call referrals came through they encouraged the referrer to transfer in daytime hours. However, they would provide evening and overnight cover if needed and if it was in the patient's best interest.

**Learning from complaints and concerns**

- Complaints were managed responsively and although they were not often received they were used to develop the service provided. Kernow Ambulance service had a complaints policy, this was made available to staff on line. The policy stated the provider aimed to promote patient satisfaction and ensure the patient's voice was at the heart of their service. The policy established a framework for dealing with enquiries and concerns in an equitable, prompt, sensitive and open way. The policy gave guidance on the timescale for response, the investigation procedure and how outcomes would be managed. The policy identified that external investigation procedures were available if needed.
- Complaints were managed by the registered manager in line with the company policy. Two complaints were recorded between August 2016 and August 2017. One complaint investigated by the provider, referred to an external safeguarding authority and had been reviewed by the Ombudsman. No further action was taken. The second complaint involved concerns raised by an external organisation. The investigation was conducted by the management team and feedback given.
- During our first visit we found patients were not routinely advised on how to make a complaint. We saw no evidence of patient information or guidance regarding raising concerns to Kernow Ambulance Services. We raised these concerns to the provider at the time of inspection. At our return inspection, the provider had an action plan to improve access to information about making a complaint and had designed a leaflet for patients and providers about how to make a complaint. The intention was for this to be given at the end of each transfer.

## Are patient transport services well-led?

**Vision and strategy for this this core service**

- The managers (who are the owners) of Kernow Ambulance Service have a shared vision for the service and an agreement about scope of development. They started the business in 2013 having recognised they had a shared vision to provide a patient transport service specifically for mental health patients. Their vision was to provide a good quality, reliable service which was patient focussed. The managers spoke about the importance of providing patient care and about the importance of valuing good staff. We did not speak to staff about their input or inclusion in the vision.
- The service was registered with CQC in 2014. The management structure was divided with one partner taking a clinical role and one partner being accountable for finance and maintenance. The strategy for the service had been discussed and whilst not formalised, there was an agreed plan by the management to continue to develop the service.

# Patient transport services (PTS)

**Governance, risk management and quality measurement**

- Clinical governance arrangements did not underpin quality and safety across all areas of the service. There was no assurance framework to monitor compliance to standard operating procedures or evidence the safe introduction of new practice. During the inspection, the providers' core processes were not monitored to scrutinise performance and identify areas for change. The provider had not established key performance indicators, clinical audit or similar arrangements which helped evaluate service delivery.
- Systems or processes were not established and operated effectively to ensure all areas of clinical risk were monitored and reviewed to improve quality and safety for patients and staff. An overview of risk was not used to monitor incidents and incident management. The use of incident reporting in risk management would allow the provider to prevent the likelihood or consequence of re-occurrence and therefore prevent harm. We reviewed the providers risk register and did not see any link between concerns raised from incident reporting and review of risk.
- Corporate and clinical risk registers were used by the provider; these were reviewed as part of monthly management meetings. Corporate risks were monitored through audits of the times of journeys, which referrers used the service, and monthly business spending. These audits were used to guide the business direction. Clinical risk management in relation to safe transfer of patients was not managed appropriately, this placed staff and patients in a vulnerable position. The patient transport risk register included hazards such as manual handling and the use of physical restraint; this was recorded as a high risk. However, the risk register showed no evidence of monitoring or changes to the risk, we found timescales described an 'ongoing' with no timescales for periodic review.
- Another risk recorded as high risk related to transfer toilet breaks. The risk was noted as a risk of aggression and a control measure was to use restraint techniques as taught annually. The risk was recorded as the responsibility of all staff and was ongoing. The risk register did not record any reviews or updates and noted the risk as ongoing without timescales for review. There were no other risk records that recorded how this was being monitored or managed to reduce its high rating.
- The Mental Health Act Code of Practice 2015 identifies mechanical restraint be used in exceptional circumstances. Data from the registered provider recorded that 39% of incidents where violence and aggression occurred resulted in the use of mechanical restraint. The provider had not identified this trend or considered the risk of inappropriate use of restraint.
- Staff and management meetings took place regularly. Management meetings were seen to be recorded monthly and had minutes available to all staff. Discussions about clinical aspects of the service were not recorded as undertaken to identify the service's strengths and areas for further development.
- The staff meetings each had an agenda and were used for discussion of issues and development of ideas for the service and for the cascading of information. All meetings had recorded minutes for staff to reference.
- The managing partners did not have any formalised systems to challenge decisions or have an independent overview of the service. The clinical lead did not receive any clinical or peer supervision to help them stay up to date with current practice. We found policies were not always in keeping with best practice, for example the legal framework referenced a superseded version of the Mental Health Act Code of Practice 2015.
- A satellite navigation system was available for office staff to know where the ambulance crews were located. There was no other system for alerting the office based staff if the ambulance was not at the correct location or had been stopped for any length of time. Each ambulance had a mobile telephone which the office could call or staff could ring the management if journeys were delayed or changes impacted on patients.
- The provider told us that they had recently developed patient feedback systems in the form of questionnaires. There were no formal records or systems to record any responses made by the provider and how the feedback was being used to develop the service.

**Leadership / culture of service related to this core service**

- The service was led by the registered partnership and office managers. The management team had a plan should there be an occasion when they all not be

available. A staff member had been identified by them as having sufficient skills to manage the business in the short term would assume the role. This was a verbal agreement and was not recorded formally, but the management told us this arrangement had been practiced.

- During the inspection, staff spoke highly of the leadership team. They told us they felt the leadership team was very visible, approachable and made them feel valued in their work. Staff felt invested in through access to training and appraisals.

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

- Patient and staff feedback was encouraged and was under further development. The provider has recently introduced a patient feedback questionnaire, we saw copies on the ambulance and distribution was part of the journey checklist completed by staff. Within the ambulance station we saw a 'Service feedback board' where patient and professional comments were displayed for staff. We also saw a completed patient questionnaire and comments such as "Excellent service, really amazed and really helpful". The company website displayed feedback from professionals who used the service and we saw positive comments about the staff and service provided.
- The management had leaflets printed about the service they provided, as patient feedback had identified that there was a lack of information provided about the service. They had supplied these leaflets to the wards who used Kernow Ambulance, however, because of further patient feedback they had considered this plan unsuccessful. As a result, the leaflets had been discontinued and no other process put in its place.
- The company website contained a dedicated feedback page and email address for use by service users and members of the public. The company regularly engaged with social media platforms to share their work and promote a positive attitude towards the wider issue of mental health and well-being.
- Opportunities were created for staff engagement including a monthly newsletter. As part of a training exercise, staff described and discussed positive and negative aspects of working for Kernow Ambulance. There were many positive aspects noted including the availability of training and the support by management. Negative comments included the detail of referral for journeys not being sufficient.

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

- The provider told us there were plans for service development to ensure sustainability of the service, however, it was unclear what these developments were as they were not formalised or documented

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital SHOULD take to improve

- The provider should ensure all clinical waste is managed to avoid the spread of infection including the handling of contaminated linen and disposal of sharps.
- The provider should ensure sufficient numbers of staff, with the correct competencies and experience are identified for each journey.
- The provider should ensure the named lead for safeguarding is clearly documented within policies and associated procedures.

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<br><br>12(1) Care and treatment must be provided in a safe way for service users.<br><br>12 (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include:<br><br>(a) assessing the risks to the health and safety of service users of receiving the care or treatment;<br><br>(b) doing all that is reasonable practicable to mitigate any such risks;<br><br>(I) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of service users.<br><br>**How the regulation was not being met:**<br>The risk assessment process was not clearly documented to evidence the identification of key risks, management strategies, or an agreed plan of care with the referring clinician.<br><br>Kernow Ambulance management did not have agreed safety practices with other providers who used their services.<br><br>When mechanical restraint was used, the rationale, escalation and de-escalation plan was not consistently recorded for each patient.<br><br>Within the Mental Health Act Code of Practice 2015 appropriate patient monitoring is required during restraint. Evidence demonstrated that monitoring records were not consistently completed. |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Transport services, triage and medical advice provided remotely | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><br>19 (1) Persons employed for the purposes of carrying on a regulated activity must-<br><br>(a) be of good character<br><br>19(2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in HSCA 2008 Regulation 19 (1).<br><br>**How the regulation was not being met:**<br><br>Recruitment procedures were not consistently applied to ensure all staff met the legal requirements.<br><br>References had not been sought for all persons employed by the provider. |

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<br><br>17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part.<br><br>(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular to-<br><br>(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);<br><br>(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of the service users and others who may be at risk which arise from the carrying on of the regulated activity;<br><br>(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).<br><br>**How the regulation was not being met:**<br>Clinical governance arrangements did not underpin quality and safety across all areas of the business. Systems or processes were not established and operated effectively to ensure all areas of clinical risk were monitored and reviewed to improve quality and safety for patients and staff. We found no assurance framework which monitored compliance to standard operating procedures or evidence the safe introduction of new practice. |