

In-Pulse Medical Services Limited

In-Pulse Ambulance Service - Lewes

Quality Report

Orchard Cottage
Brighton Road
Lewes
East Sussex
BN7 3JJ

Tel: 01273 499999

Website: www.sussexambulance.net

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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.

Summary of findings

Letter from the Chief Inspector of Hospitals

In-Pulse Ambulance Service Limited is an independent ambulance company, based in Lewes offering event medical cover and patient transport services across the South East of England.

In England, the law makes event organisers responsible for ensuring safety at the event is maintained, which means that event medical cover comes under the remit of the Health & Safety Executive. The activities at In-Pulse Medical Services regulated by the CQC are; transport services, diagnostic and screening procedures and the treatment of disease, disorder or injury.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 8 August 2017 and did not carry out an unannounced inspection.

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:

- Aside from checklists there was no evidence that the provider monitored safety.
- There was no evidence that staff had received an appropriate level of safeguarding training.
- We did not see evidence of up to date mandatory training.
- Not all staff had a disclosure and barring service (DBS) certificate in place.
- The provider did not keep records of patient journeys and was therefore unable to accurately evidence the volume of work undertaken or the timeliness of the service.
- There was little or no governance of the service, with limited knowledge of what constitutes an incident or near miss, no formal risk register and no version control on service policies.
- The provider had not reported any incidents or near misses in the past 12 months indicating that staff may not be aware of their role and responsibilities around this.
- Policies did not reference national guidance and therefore there was a risk these did not reflect current best practice.
- Feedback forms were only given to patients on one day of the week, therefore the service may not be getting a full picture of the patient experience of the service.
- We saw minutes from team meetings, however these occurred sporadically and there was no set schedule for when these occurred.

However, we also found the following areas of good practice:

- The ambulances were clean, serviceable and well maintained.
- Patient comments about the service were positive about the care they had received.

Summary of findings

- Staff we spoke with described that they felt supported, both inside and outside of work.
- The service had received no complaints in the last 12 months and no complaints came directly to the CQC regarding this service.
- The service utilised online engagement with the public by having social media and web pages displaying information and opportunities to contact the service.

In addition, the provider also reacted promptly in response to the following issues raised:

- The fire extinguishers on the vehicles had not been serviced, however following the inspection we saw evidence that new fire extinguishers had been purchased.
- Several pieces of equipment had not been calibrated or serviced, and following the inspection we saw that the provider had promptly booked these items in for servicing and calibration.

Following this inspection, we told the provider that it must take action to comply with the regulations and that it should make other recommended improvements. We issued the provider with a requirement notice. Details are at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Patient transport services (PTS)

Rating Why have we given this rating?

The main service was patient transport services although they did provide occasional event cover, which was not in the scope of this inspection. The provider completed approximately 19,000 journeys in the past 12 months, however the service was unable to provide exact numbers. Whilst they did not currently have any permanent contracts with the local Clinical Commissioning Groups (CCGs), they were actively looking further afield to gain contracts to enable the business to continue. As a result of the lack of contracts available, the majority of staff were on zero hours contracts. The provider told us they mainly transported adults, however we were unable to see the full demographic of patients transported in the last 12 months.

In-Pulse Ambulance Service - Lewes

Detailed findings

Services we looked at

Patient transport services (PTS)

Detailed findings

Contents

Detailed findings from this inspection

	Page
Background to In-Pulse Ambulance Service - Lewes	6
Our inspection team	6
Facts and data about In-Pulse Ambulance Service - Lewes	6
Action we have told the provider to take	17

Background to In-Pulse Ambulance Service - Lewes

In-Pulse Ambulance Service - Lewes is operated by In-Pulse Ambulance Service Limited. The service opened in 1991. It is an independent ambulance service in Lewes, East Sussex. The service primarily serves the communities of the East Sussex area.

The service has had a registered manager in post since 1991. At the time of the inspection, a temporary manager had recently been appointed and was registered with the CQC in July 2017.

The service was last inspected in February 2014 under the previous inspection methodology and met all of the six essential standards. This meant that the standard was being met in that the provider was compliant with the regulations. This inspection was the first inspection under the new methodology.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Alan Thorne, Head of Hospital Inspection.

Facts and data about In-Pulse Ambulance Service - Lewes

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Diagnostic and screening procedures
- Treatment of disease, disorder and injury

During the inspection, we visited the headquarters which was also the registered location. We spoke with three

members of staff including; patient transport drivers and management. We did not speak with any patients or relatives as there were no journeys that we could join on the day of inspection due to logistics.

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 last inspected in February 2014, which found the service was meeting all standards of quality and safety it was inspected against.

Activity:

Detailed findings

- The registered manager did not keep records of patient journeys and was therefore unable to confirm how many journeys there had been in the last 12 months; they estimated this to be around 19,000 from looking back at calendar entries.
- The service had reported no never events and no clinical incidents over the last 12 months.
- The service had received no complaints over the last 12 months.

Track record on safety:

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- There had been no never events reported for this core service in the last 12 months. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- The service had an incident reporting policy and we saw a paper based system to enable staff to report these formally. The forms were kept at the base which meant that should staff need to report an incident they would need to do these at the end of their shift. No incidents, including driving accidents were reported over the last twelve months; however staff did describe a near miss incident where a member of the public reported observing an attempted break in to one of the vehicles whilst it was unmanned. This near miss was not formally reported and this indicated that staff might not have sufficient knowledge around their responsibility to report incidents and near misses.
- As there were no formal incidents reported in the last twelve months, there was no demonstrated learning or investigations for this service. However, staff told us that when near misses occur they were discussed with the team and manager at the base room.
- The registered manager was able to describe the duty of candour. 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 of certain 'notifiable safety incidents and provide reasonable support to that person. This means providers must be open and honest with service users when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Cleanliness, infection control and hygiene

- We saw a vehicle cleaning policy, however this was not dated. This meant it was not clear whether it had been reviewed and at what point.
- We observed staff wearing clean and serviceable uniforms that were bare below the elbow, except for fleeces that were worn during cold weather.
- We reviewed three out of the four available ambulances. Overall, the inside of the vehicles including the cab area were visibly clean and tidy, as was the reusable equipment such as splints and blood pressure cuffs. We observed checklists completed for both monthly deep cleans of vehicles and daily cleaning of vehicles, however we did not see any evidence that these were regularly audited.
- Personal protective equipment such as aprons and gloves were readily available on vehicles as were decontamination wipes that were to be used in between patient journeys. However, we noted that two out of three vehicles did not have hand-cleansing gel available on board. We were told that the staff have small hand gels containers attached to their uniform to mitigate against this. As we did not accompany any staff on any journeys we were unable to corroborate this.
- We saw the infection control policy; however there was no date to show when it was written and no date for review. This meant it might not have been updated to reflect current guidance or best practice.

Environment and equipment

- The service ran from a residential address and the service vehicles were all parked within the grounds of the address.
- The provider had four ambulances and one support car which was a 4x4 vehicle used purely for events and therefore outside the scope of this inspection. The service had two further ambulances but these were not in use and we saw documentation that demonstrated these were for sale.
- We observed all three vehicles to have essential emergency equipment such as defibrillators, suction units and blood pressure units available, however, we noted that these items had not been calibrated. Calibration of medical equipment is important as it ensures that the equipment is working correctly. We spoke to the registered manager about this who advised

Patient transport services (PTS)

us that the defibrillators were self-calibrating. This was in line with the manufacturers operating notes when we checked these online. However, following the inspection, we saw evidence that all of this equipment had since been calibrated.

- We observed vehicle harnesses available for safely transporting adults and children.
- Sterile, single use items were stored appropriately in two out of the three vehicles. In one of the vehicles, we observed that the gloves were out of date. We informed the registered manager who immediately replaced these.
- Fire extinguishers were available on all the vehicles we reviewed, however there was no evidence of servicing on these. We raised this with the registered manager and following the inspection we saw evidence documenting that new fire extinguishers had been purchased for the vehicles.
- Vehicles were serviced every 12,000 miles and we saw evidence that all vehicles on site had in date servicing records and were all taxed appropriately. Three of the vehicles had had valid MoT certificates in place, with the fourth not due for its first MoT until January 2018 as it was a new vehicle.

Medicines

- The provider had a Medicines policy, however this was dated 2013. This meant that the policy did not reflect most recent guidance or best practice. However, we saw that the policy stated that a patient's own medicines must be kept in the lockable cupboards on board the vehicles – we saw the lockable cupboards on the vehicle to enable this to happen.
- Medical gases such as Oxygen and Entonox canisters were stored securely on board the three vehicles we reviewed.
- The provider held medicines and controlled drugs on site in a securely locked cupboard within the main building, which was in line with national guidance. The registered manager advised us that only registered paramedics used the medicines bags when attending events, which was outside the remit of this inspection. However, we did advise the registered manager that several medicines were past their expiry date and that

one type of medicine required refrigeration. Following the inspection, the provider returned all expired medicines to a pharmacy for disposal and we saw documentation for this.

Records

- The service provider did not hold any patient records or details other than the booking details entered onto an electronic calendar. This meant it was difficult for the provider to obtain accurate information about amount of activity completed over the year.
- When patients were collected from their starting point, records would be passed to In-Pulse staff in a sealed envelope, and this would travel with them to the venue where it would be handed over with the patient. This ensured that confidential records were appropriately transported and stayed with the patient at all times. No other records of care were stored on board the ambulance.

Safeguarding

- We spoke to the registered manager regarding safeguarding training who advised us that staff received yearly refresher training. However, we only saw certificates for safeguarding training from 2011 and the level of the training was not clear. Different levels of safeguarding training are required depending on the type of patients that a provider may interact with. This meant the provider could not demonstrate all staff had received an appropriate level of safeguarding training. The provider told us following the inspection that they were enlisting on a different course to ensure appropriate documentation could be obtained.
- The registered manager advised us that they had not made any safeguarding referrals in the last 12 months. They were able to give us an example of a scenario where they had concerns about a frail and elderly patient they transported home from hospital. When they arrived at the patient's home, there were six flights of stairs and no heating available within the house, and they were concerned for the patient's welfare. In this instance, they decided to return the lady back to the hospital as it was late at night to ensure their welfare. Whilst the provider ensured the patient was returned to a place of safety, a safeguarding referral was not submitted as the provider informed us that the hospital advised they would ensure this was followed up.

Patient transport services (PTS)

- The CQC did not receive any safeguarding concerns regarding this service in the last 12 months.

Mandatory training

- The registered manager told us that mandatory training covering areas such as first aid, medical gases and manual handling were held three yearly. However, we were not able to see these on the inspection as they had been incorrectly saved on the computer by another member of staff. Following the inspection we were shown certificates of staff that had completed courses such as basis life support, oxygen therapy and AED, along with first aid at work courses. However, certificates from safeguarding and mental capacity act training were from 2011. The provider told us that they had completed more up to date training, but the online course had not provided them with certificates.

Assessing and responding to patient risk

- All patients' needs were assessed informally when taking the booking, however there was no written record of this. Each booking had a white card complete with patient name, address and destination. All assessments were completely verbally and not documented.
- In-Pulse did not transfer any patients that were high dependency in the last 12 months. High dependency patients are patients who are in a critically ill or in an unstable condition and require intensive care or monitoring. Patients that were sectioned or required ongoing medical attention would only be transferred with a registered nurse or designated escort from the hospital or care home.
- If a patient deteriorated whilst on route, staff would call 999 for emergency support.
- We saw appropriate risk assessments dated October 2016 for the use of medical equipment and for disposal of soiled bed linen.

Staffing

- The majority of staff working for In-Pulse worked on a zero hours contract. This meant that the provider was not obliged to provide any minimum working hours to employees, and employees were not obliged to accept any work offered. The registered manager was contracted to work full time hours and acted as the operational manager for the service.

- When a patient journey was booked with In-Pulse, the registered manager would send out a text message to all the employees and would allocate the shift on a first come, first served basis.
- Staff always worked in pairs, and therefore there was no lone working policy required.
- The provider worked seven days a week, 365 days a year to meet the needs of the service user.

Response to major incidents

- There was no specific business continuity plan. The registered manager advised us that if there were issues affecting business continuity, they would contact staff on an individual basis to update them or discuss at a team meeting.
- There was no major incident plan, however the registered manager advised us that if they encountered a road traffic incident and they were the first on scene, they would stop and provide basic first aid until the emergency services arrived. There was no written guidance for staff regarding this.

Are patient transport services effective?

Evidence-based care and treatment

- The service had a number of policies available for staff. However, all of the policies we reviewed either did not have dates or were dated over two years ago. This meant there was a risk that the policies were not up to date with current guidance.
- None of the policies we reviewed evidenced references of best practice or national guidance, meaning that these policies may not reflect best practice or current guidance.

Assessment and planning of care

- All patients needs were assessed informally when taking the booking on a job sheet form. These were then handed to the staff allocated to the transfer. We saw a blank version of one of these forms and saw that details such as name, address and destination, along with other factors such as the patient's diagnosis and whether the patient could walk and if they had their own wheelchair. Once the trip was complete and staff

Patient transport services (PTS)

had returned to base, this form was destroyed. If they later needed to know who they transported and when, they would look the details up on the electronic calendar held at the office.

- The provider had a policy of not restraining patients but this was known verbally within the staff and not within a written policy which meant that not all staff may be fully aware or up to date with the procedure for this. Following our inspection, the provider advised us that they were producing a policy to support this.
- In-Pulse had undertaken the transport of voluntarily sectioned patients under section two or three of the Mental Health Act 1983. However, these were only undertaken with a registered nurse escort.

Response times and patient outcomes

- The service did not hold any formal records of patient journeys so was unable to provide us with information about levels of activity and timeliness of the requested pick-ups. The registered manager informed us they estimated the service had carried out 19,000 journeys in the last 12 months. Following the inspection, the provider informed us that they would produce a spreadsheet to enable more accurate monitoring of patient journeys.

Competent staff

- We saw a copy of the registered managers Disclosure and Barring Service (DBS) check that had been undertaken in 2007. This is a check that helps organisations make safer recruiting decisions by identifying candidates who may be unsuitable for certain work, especially that involving children or vulnerable adults. However, we did not see DBS certificates for all members of staff. This meant that the service could be employing staff that were not suitable for the work they were undertaking. We advised the registered manager that this needed to be addressed and following the inspection we saw evidence that DBS checks were being processed for staff.
- A staff handbook was available for members of staff with details about the company and how to access policies and help. We saw there were some blank sections of the handbook indicating that this was still a draft document which the provider informed us was for staff to add their comments into.

- We reviewed seven appraisal documents dated October 2016, indicating that seven out of the nine members of staff had an appraisal within the last 12 months. The registered manager had not had an appraisal within the last 12 months. None of the appraisals we reviewed had personal development plans or action plans although the staff handbook said that they should. This meant that the company was not following their own policy on appraisal of staff.
- There was a staff supervision policy within the handbook but we did not see any evidence of written supervision plans for staff, indicating that this was not occurring. We were unable to corroborate this with any other members of staff as they were unavailable to speak with.

Access to information

- The registered manager was aware of do not attempt cardio pulmonary resuscitation (DNA CPR) forms and that they must travel with the patient and if the form was not present the patient would be treated for resuscitation. However we were not able to speak with other staff to ascertain if they understood this and there was no evidence that formal training for this was undertaken.
- If patients were being collected from a hospital, staff would obtain a full handover prior to transferring the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had not received any specific training relating to consent or the mental capacity act. However, the registered manager was able to explain the principles of consent. We were not able to see evidence of mandatory training so it is unclear if consent was covered as part of mandatory training.

Are patient transport services caring?

Compassionate care

- There were patient transport journeys booked for the day of our inspection but this was outside the normal geographical area so we were unable to accompany the

Patient transport services (PTS)

provider and observe patient care on these journeys. Therefore we were unable to make any observations or judgments regarding care provided to patients by this service.

- We reviewed 15 comment cards completed by patients in the last twelve months. 12 of these were positive comments including 'superb service, cannot fault it', 'lovely crew, reassuring and professional'. The three non-positive comments received related to the bumpiness and noise experienced whilst on board the vehicle, not the care from the staff.
- The providers website stated that their ambulances had tinted windows and blinds to ensure full privacy and dignity when being transported and we saw this in the vehicles.

Understanding and involvement of patients and those close to them

- The provider's website explained the services available to patients and provided contact details and an online form to complete if they needed further information.

Emotional support

- As we did not observe any patient care, we could not comment on the level of emotional support given to patients.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- Due to the unavailability of local contracts in the area, the service provider had been working to gain contracts further afield and was currently undertaking work in the outer London area.
- The service did not have any contracts with local clinical commissioning groups (CCGs) as these were outsourced to an alternative provider in 2016.
- The registered manager explained that of the four operational ambulances currently within the company, only three would be used at any one time with the

fourth as a contingency vehicle. This enabled the spare vehicle to be used in case of one of the other ambulances suffering a fault and to allow the transfer to continue.

Meeting people's individual needs

- The provider's website stated that they had a specific vehicle that could accommodate patients of up to 70 stone in weight and we observed the vehicle and trolley that could cater for these patients. This meant that bariatric patients could access the service.
- We spoke to the registered manager regarding how the service responded to patients with complex needs including learning difficulties or dementia. They advised us that these types of patients usually travelled with a carer, but they ensured extra time for this group of patients to ensure they understood what was happening and were made comfortable prior to travelling. An example was given about one patient who was only happy to travel with a particular favourite stuffed toy, and ensuring this was available before commencing the journey.
- There was no formal procedure for providing translation services for patients who did not speak English as a first language.

Access and flow

- The registered manager did not formally keep a record of the number of transfers carried out by the service in the last year. They gave an approximate number of transfers of 19,000 transfers per year, which equated to an average of 1583 patient transfers per month.
- The provider did not monitor on scene or turnaround times which meant they may not have an overview on the timeliness and performance of their service. They explained that they would always contact a patient if they were running late.

Learning from complaints and concerns

- The CQC received no enquiries relating to this service in the last 12 months.
- The provider had not received any complaints, either directly or through any contractors in the last 12 months.

Patient transport services (PTS)

- The provider had a complaints policy and this outlined a three stage process whereby a complaint would be dealt with and the agreed timescale for these stages.
- At the time of the inspection, the provider obtained feedback from patients by giving those who travelled on a Wednesday a survey form to complete. Patients assessed by the crew to lack capacity to complete the form were excluded from the survey. Those returned without a comment were discarded and only forms with a comment on were kept in the file. There was no record of the number of patients travelling on Wednesday nor the total number of surveys distributed so the context of comments were hard to assess. Only distributing cards on one day of the week may mean that the provider was not getting a reflective picture of the service provided. Following the inspection, the provider informed us that these were now being distributed on additional days of the week.

Are patient transport services well-led?

Leadership / culture of service

- The registered manager acted as the operational manager for the company and were responsible for business development, line managing the technicians and answering all calls into the business telephone line.
- We spoke with two members of staff who told us they were happy to raise issues with the provider and there was an open culture where disagreements could be discussed openly.
- At the time of the inspection the service did not have any permanent patient transport contracts. This meant that many members of staff who were previously on permanent contracts had to reduce to zero hours contracts. We spoke with the registered manager who gave examples of how the provider had tried to ensure that staff could work even when there were no patient transport journeys booked by helping out at the registered address and doing additional cleaning or sorting on the vehicle.
- There was a policy for valuing diversity and dignity at work in the handbook. We spoke with two members of staff who testified that no discrimination was tolerated within the provider.

Vision and strategy for this this core service

- There was no written strategy or values for this service, but the registered manager told us that this was to treat people with dignity and how you would expect your own family to be cared for.

Governance, risk management and quality measurement

- The provider did not keep a risk register. This may have meant that key risks were not identified or assessed which could pose a risk to patients. The registered manager was able to describe what they thought were the key risks to the service, the highest rated one being the lack of contracts currently and retention of staff.
- Staff told us that they would use the team meetings to discuss incidents if one had occurred but none had occurred or been recorded in the last year. Whilst on inspection we discussed some near miss events that could have been reported formally as a near miss incident. We discussed this with the registered manager who acknowledged there may need to be more training and education around the identification and recording of incidents and near misses.
- There was no method of version control or review dates on any of the policies that we reviewed and some of them had members of staff listed in them that no longer worked for the company.

Public and staff engagement

- The service had a website and social media page that was used for advertisement of its service and to provide information to patients. On the website there was a testimony page that service users could add their recent experiences to, however, these were not dated so we could not assess whether these comments had been left for the last 12 months.
- The provider had a whistleblowing policy dated September 2014. We were unable to speak to staff about whether they knew about the policy and if they felt confident to use this as a process if they felt they needed to escalate an issue.
- We saw minutes from three team meetings in February and one in May. The meetings had attendance from a

Patient transport services (PTS)

range of staff and focused on the future of the business and options for staff going forwards. For example, the effect of redundancy and zero hours contracts on the staff.

- Staff told us that the service was “like a family” and that they felt supported, both inside and outside of work.
- The provider’s website had a section for testimonials from patients and companies that the provider had

worked with. We saw that there were five positive testimonials listed, however these were not dated so it was unclear whether they were from the last 12 months or older.

- We saw examples of positive patient feedback through text messages sent to the registered manager. However there was no formal way of documenting or logging plaudits from service users other than on the testimonials page on the public website.

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the hospital **MUST** take to improve

- The provider must ensure that all staff have an appropriate level of safeguarding training.
- The provider must ensure that governance processes such as risk registers, incident reporting and learning are embedded throughout the organisation.

Action the hospital **SHOULD** take to improve

- The provider should formally document activity and performance where possible.

- The provider should ensure that appraisals and supervision is carried out in line with the provider's own policy.
- The provider should ensure that all mandatory training is up to date and that there is documentation available to evidence this.
- The provider should ensure a formal translation policy is implemented.

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

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
All staff must have an appropriate level of safeguarding training.

Regulated activity

Diagnostic and screening procedures
Transport services, triage and medical advice provided remotely
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance
The provider must ensure that governance processes such as risk registers, incident and near miss reporting processes are embedded and that staff are aware of their responsibilities around this.