Broughton Park Ambulance Service Ltd

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Broughton Park Ambulance Services Ltd is operated by Broughton Park Ambulance Services Ltd. Broughton Park Ambulance Services Ltd is an independent ambulance service based in Manchester. The service serves the communities of Prestwich, Broughton Park and Whitefield in Manchester. It provides an emergency and urgent patient transport service. The service was first registered in June 2017. It is based on a model used in similar organisations both in the UK and globally known as Hatzola. Hatzola means “rescue” or “relief” in Hebrew.

We inspected this service using our inspection methodology. We carried out this focussed unannounced visit to the service on 21 November 2019 in response to concerns around risk.

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

Ann Ford
Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals.

Overall summary

We carried out a focussed inspection of this service that concentrated on specific areas. We did not rate the service. We found the following areas that required improvement:

- Volunteer responders did not understand how to protect patients from abuse and the service did not work well with other agencies to do so. Volunteer responders had received some training on how to recognise and report abuse. This training was not sufficient for the care that they provided and volunteer responders did not consistently apply it.
- Volunteer responders completed risk assessments, however; these were not completed fully and consistently.
- Volunteer responders did not keep detailed records of patients’ care and treatment. Records were not clear and did not consistently include reasons for decisions.
- The service did not have systems and processes to safely prescribe, administer, record and store medicines.
- The service did not manage patient safety incidents well. Volunteer responders did not recognise incidents and near misses and did not report them appropriately. Managers investigated some incidents and shared lessons learned with the whole team.
- The service did not make sure volunteer responders were competent for their roles.
- Leaders did not operate effective governance processes, throughout the service and with partner organisations. Volunteer responders were not clear about their roles and accountabilities.

We found the following areas of good practice:

- Ambulances were visibly clean and well-organised.
- Keys were securely stored.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care		We carried out a focused inspection of elements of safe, effective and well-led domains and found significant concerns.

Summary of findings

Contents

Broughton Park Ambulance Services Ltd

Services we looked at
Emergency and urgent care.

Summary of this inspection

Background to Broughton Park Ambulance Service Ltd

Broughton Park Ambulance Services Ltd , also known as Hatzola, is operated by Broughton Park Ambulance Services Ltd. The service registered in 2017 and has had a registered manager in post since October 2018. It is an independent ambulance service in North Manchester and Salford. Patients served by the service may be suffering with minor to major illness or injury. The service is wholly funded by a Manchester based beneficiary. It is run by locally trained volunteer responders from the Jewish community.

Broughton Park Ambulance Services Ltd operates 24 hours a day, 365 days a year, providing an immediate response to local medical emergencies.

People access the service by ringing a dedicated telephone number (an alternative to 999), which is advertised locally. Volunteer responders in their own cars and ambulance vehicles are dispatched using radio systems. Response times are monitored.

Our inspection team

The team that inspected the service comprised a CQC inspection manager and two CQC inspectors. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Broughton Park Ambulance Service Ltd

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the base location and a call handler. We spoke with seven responders including; first responders, call handler and management. During our inspection, we reviewed 67 sets of patient records.

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 has been inspected once, and the most recent inspection took place in September 2018. which found that there were areas the service needed to improve.

Activity

- Between January 2019 and October 2019, there were 2,883 emergency and urgent care patient journeys undertaken.

There were 31 first response emergency care (FREC) volunteers who worked at the service, 23 of which were trained to level three and eight to level four. There was also a registered nurse volunteer.

Detailed findings from this inspection

Emergency and urgent care

Safe	
Effective	
Well-led	

Are emergency and urgent care services safe?

Safeguarding

Volunteer responders did not understand how to protect patients from abuse and the service did not work well with other agencies to do so. Volunteer responders had received some training on how to recognise and report abuse. This training was not sufficient for the care that they provided and responders did not consistently apply it.

At inspection we were not assured that the service had appropriate arrangements in place to ensure patients were protected from harm. There was a safeguarding children and vulnerable adults policy dated September 2019. However, the policy did not reflect current guidance including the Adult Safeguarding: Roles and Competencies for Health Care Staff and Working Together to Safeguard Children 2018.

The service reported safeguarding alerts via the NHS ambulance service. However, there was no formal arrangement in place. At inspection we asked how many safeguarding referrals the provider had made in the previous 12 months. They could not provide this information from their own data and had to rely on another organisation to provide this information. Post inspection the provider confirmed that over a 12-month period they had made 10 safeguarding referrals but were unable to confirm whether the referrals were for adults or children and any outcomes for patients following the referrals. CQC have not received any statutory safeguarding notifications from the provider, which is a legal requirement for an independent ambulance service when a safeguarding is submitted.

At inspection we were told that there were no arrangements in place for oversight of safeguarding concerns. There was no way to flag addresses where concerns had been raised. This represented a potential risk to children and vulnerable adults that when frequent visits occurred this would not be identified and acted upon appropriately.

We asked the provider about safeguarding training. All volunteer responders could be asked to respond to a call where the patient was a child. As approximately one third of patients seen by the provider were children, and in approximately 40% of instances children were assessed and treated at home, best practice guidance outlines that all responders should have level three safeguarding training for children. At inspection managers told us that 27 of 31 volunteer responders had not received level three safeguarding training for children. This represented a potential risk to children that safeguarding concerns would not be identified and acted upon appropriately.

We were concerned that whilst volunteer responders we spoke with told us they understood how to make a referral and were confident to do that, evidence in PRF's did not support this was happening in practice. Volunteer responders completed patient report forms (PRF's) when they attended a patient. We reviewed 67 PRF's. None of these indicated that a safeguarding referral had been made. We reviewed 20 patient report forms relating to care of children. We found three instances where safeguarding referrals were indicated but had not been made. Concerns regarding safeguarding had been highlighted to the provider at our last inspection. At this inspection there was insufficient evidence of action taken to address this area. Following the inspection, we requested an explanation of how the provider assured themselves that volunteer responders understood when and how to make a safeguarding referral, including any documentation. However, we have not received this information.

In response to our concerns regarding safeguarding, we took immediate action with the provider.

Assessing and responding to patient risk

Emergency and urgent care

Volunteer responders completed risk assessments, however; these were not completed fully and consistently.

At inspection we reviewed the process in place when a call came into the service. The local population called a dedicated phone number that rang to a call handler who operated from their own homes. The call handler had a contact sheet, that was updated weekly, for other services such as the local NHS ambulance trust, midwives on call, the poison line and co-ordinators. There were four call handlers who worked on a rota system 24 hours a day, seven days a week. The service was adjusted on Saturdays in line with the Jewish faith and beliefs. There was support from non-Jewish drivers who supported volunteer responders following an emergency callout during these times.

The call handlers followed a script when receiving a call from a member of the public. After the address and phone number were confirmed, the caller was asked if the patient was breathing and conscious. If the answer to either of these questions was no, the caller was advised that an ambulance was being dispatched but requested that the caller hang up and call 999 immediately. Otherwise the call handler continued to ask questions to ascertain the nature of the emergency. There was no clear assurance around the triage process in place.

Call handlers and co-ordinators told us that they used their experience to determine the urgency of a call. If the call was assessed as serious, the call handler authorised the use of 'blue lights and sirens' by responders. Call handlers and co-ordinators also authorised the 'use of blue lights and sirens' in transporting the patient to the relevant acute hospital. Vehicles were not fitted with any form of tracking device which would indicate the use of blue lights and sirens; therefore, the provider could not monitor appropriate use. We reviewed a copy of the policy for using 'blue lights'. This did not include relevant information regarding oversight of blue light training or scenarios when blue lights could be used. However, we were told this was a previous version. We requested the current version at the time of inspection and post inspection. We did not receive a policy that was any different than the version we saw on inspection.

The volunteer responders communicated with each other using two-way radios and received alerts from the call handler via the radios. We were told that volunteer responders with smart phones (about 90%) were also able to receive information via an application. We were shown that, dependent on how a call was interpreted by the call handler, the job was then automatically colour coded as red, amber or green to indicate the urgency needed. This application was still in a developmental phase, not all elements of the system were being used and the system was being used in combination with the paper records.

At inspection we were told that volunteer responders were expected to respond to the call handler within two minutes, if available to attend. Two volunteer responders were required as a minimum, dependent on the call; one to drive and one to attend to the patient in transit. The call handler would repeat the alert every two minutes, for up to 10 minutes. If no response or limited responses were received the call would be handed over to the NHS emergency ambulance service. However, this was not detailed within the provider's call handling procedure.

We were not assured that the service was assessing the risks to the health and safety of patients. We were concerned that the service was not doing all that is reasonably practicable to mitigate any such risks or ensuring that volunteer responders had the qualifications, competence, skills and experience to do so safely.

We were concerned that patients were being cared for by volunteer responders operating outside the scope of their competency. The training provided to volunteer responders was not sufficient for the nature of calls that they responded to. This included gaps in paediatric training across most areas; with the exception of cardio-pulmonary resuscitation. There were two levels of training provided were insufficient without clear clinical pathways and procedures to support volunteer responders' decision making when dealing with patients. The service had no exclusion criteria. Patients were being assessed, treated, transported or discharged by volunteer responders without using any form of triage process, safety-netting system and limited clinical pathways. Volunteer responders told us they used their clinical experience and training to complete patient assessments, provide treatment and make decisions about patient care.

At inspection we saw that each ambulance contained a laminated card detailing information to enable

responders to calculate National Early Warning Scores (NEWS). NEWS is a tool which was developed to help in the detection and response to clinical deterioration of adult patients and is a key element of patient safety and improving patient outcomes. The provider's induction handbook detailed information for volunteer responders on NEWS scores; however, the information was unclear. For example, it indicated that NEWS scores were for the detection of deterioration of sepsis only and there was no information to instruct volunteers what action to take if scores reached a certain level. We reviewed 40 patient report forms (PRF's) and saw that NEWS scores were recorded and reassessed on two occasions. The handbook did not include any details about paediatric early warning scores (PEWS) for monitoring children.

Following the inspection, we were provided with the service's deteriorating patient policy and clinical escalation plan. Both documents contained information for volunteer responders in relation to seeking senior clinical advice in certain circumstances or referring to the local NHS ambulance trust. However, there was nowhere on patient report forms to confirm senior advice or support had been sought when required or that either policy had been considered or acted on. Advice given or sought by volunteer responders was not documented in the free text box in 20/20 patient report forms we reviewed which was not in line with the provider's policy. Volunteer responders we spoke with confirmed to us that they should document that advice had been sought or given when we showed them examples of where this information was not recorded.

The service had a 'Non-Conveyance Guidance' policy; however; this was guidance to support volunteer responders when a patient refused to be transported to hospital rather than guidance about when a patient did or did not need to attend hospital for clinical reasons. The guidance stated that two full sets of observations needed to be completed for patients who refused transportation; however, we saw that this was not always completed in line with the policy. The policy also stated that advice should be given in the event of deterioration in condition; however, it did not specify that this should be recorded. We saw that advice was not always recorded on PRF's. We were told that volunteer responders used their clinical knowledge to assess whether or not they needed to transport the patient to hospital. On the reverse of the PRF there were printed instructions/advice for patients who were not conveyed for certain conditions; for example, minor head injuries or low blood glucose levels. However, there was no corresponding pathway which directed volunteer responders to reach a decision that these patients were suitable to be left at home with advice.

Records

Volunteer responders did not keep detailed records of patients' care and treatment. Records were not clear and did not consistently include reasons for decisions.

Volunteer responders completed patient report forms (PRF's) each time they attended a call. These included the incident date, patient demographics, observations made and history of the event. The forms were in line with NHS ambulance records. However, we found that these were not completed consistently and contemporaneously. Details of advice sought from more experienced volunteer responders, or rationale's for deviating from treatment pathways were not evident in the PRFs we reviewed.

Volunteer responders were required to submit PRF's to the office on completion of jobs. If the office was locked, a post box was available on the office door. Records were stored in filing cabinets in the office.

The call handlers documented calls taken and these were included in monthly reports. They identified numbers of patients seen, the reason for the emergency, any treatment given and if a patient was transported.

We reviewed the logs for September 2019. There were 302 calls taken of which 120 were colour coded as red, 103 were coded as amber and 79 were green. There were 103 calls to children. Of these, 60 were taken to hospital and 43 were not transported. For 20 PRF forms we reviewed, for children not transported, we found that one child had a high pain score of 8, five children had banged their head and one had a suspected broken finger. The care provided did not reflect best practice.

The PRF records were audited monthly with a sample size of 11 to 15 records per month. Any incomplete records were recorded. However, there was no compliance levels recorded or action plans included for any

non-compliance. We reviewed monthly newsletters which did discuss some learning points from PRF completion. However, these were not specific to the concerns we identified.

Medicines

The service did not have systems and processes to safely prescribe, administer, record and store medicines.

We reviewed the three ambulances used for patient journeys and kit bags held by volunteer responders. We saw that medicines were not stored in original packaging and there were no manufacturers' instructions. This meant that, in the event of a reaction to a medicine, the volunteer responder had no written information to refer to regarding side-effects or complications. We observed medicines in blister packs that did not include the dose of the medicine. Salbutamol nebules, of different doses, were stored next to each other and were similar in appearance. This meant that, in an emergency, there was a risk that an inappropriate dose of medicine could be given to a patient.

At the last inspection, we observed that glucagon (a medicine used to treat low blood sugar for diabetic patients) was stored with other medicines at room temperature. Glucagon is routinely stored in a fridge but can be stored at room temperature for a shorter period of time. There was no date to indicate when the glucagon was removed from the fridge. This meant the medicine may not be effective in the event of an emergency.

We observed that intra-venous fluids were being stored, including glucose (sugar) in a warming device, rather than at room temperature. There was no date of when the fluids had been warmed meaning that the fluid may not be effective in the event of an emergency.

There were cannulation kits stored on ambulances, along with the intra-venous fluids. However, the volunteer responders, as FREC three and FREC four did not have the skills or training to cannulate patients. We escalated this during the inspection. We were told that medicines and cannulation kits were carried in case a paramedic or midwife needed them despite it not being the service's responsibility.

Medical gases including nitrous oxide and oxygen were carried on the ambulances. One of the PRF's we reviewed including the administration of nitrous oxide and oxygen. The call was attended by a FREC four trained volunteer responder and two FREC three volunteer responders. This was not in accordance with best practice which requires someone to be trained to give this.

We found these included medicines such as salbutamol (used to treat patients with asthma). The service had attended a meeting with CQC prior to the inspection, where it was agreed that salbutamol would not be administered until governance processes were in place. At the time of our inspection the service did not provide us with evidence of any additional training volunteer responders had undertaken in relation to admission of medication. However, volunteer responders who had received FREC four training were booked onto a medicines management course the week following the inspection.

There were no logs of medicines stored or administered, on the ambulances or in individual kit bags stored in volunteer responders' cars. There was no record of batch numbers, only minimum numbers expected during checks in an overview log where batches were recorded. The record did not identify which batch of medication was placed on which ambulance to aid medicines traceability in the event of a problem.

Volunteer responders told us that kits were checked every six weeks and vehicles were checked adhoc. We found no evidence of this on inspection. We reviewed records relating to medicines and PRFs. On records we reviewed, there was no indication of which ambulance the medicines were taken from, who administered the medicine and no batch number recorded. This was not in line with best practice guidance and meant the provider did not have a safe system in place for medicines in relation to traceability of medicine.

During and following the inspection we requested a copy of any medicines' audits, including the responders kit bag medicines. However, we did not receive any to review.

Incidents

The service did not manage patient safety incidents well. Volunteer responders did not recognise

incidents and near misses and did not report them appropriately. Managers investigated some incidents and shared lessons learned with the whole team.

There was a paper-based system for recording incidents. For the twelve months prior to inspection there were 17 incidents reported. We discussed incidents with volunteer responders. Whilst they could recognise what an incident was, they told us that not all incidents were reported. For example, senior managers told us about a patient that had been transported to hospital, became critically ill and was subsequently treated by volunteers whilst awaiting hospital support. The service had not reported this as an incident as it was on a hospital site.

We reviewed the incidents; there were no serious incidents recorded or medicines' incidents.

Incidents reported included accidents such as damage to ambulances when parking or items accidentally falling onto patients in transit. Incidents were discussed at the weekly de-brief meetings and in newsletters to share any lessons learned.

Are emergency and urgent care services effective?
(for example, treatment is effective)

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure volunteer responders followed guidance but could not evidence action taken when responders did not follow pathways.

Prior to the inspection, the service provided copies of pathways. However, these did not cover all conditions including difficulty in breathing. We were told that volunteer responders follow guidance from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) as well as using pathways and their clinical judgement and experience. During our review of PRFs, we noted for five patients that volunteer responders had deviated from the pathway available, including the lack of vital signs in patients complaining of chest pain.

Following the inspection we requested copies of any clinical audits. Whilst these identified some concerns in relation to deviation from pathways and poor PRF completion, there was limited evidence of action taken to address them.

Competent staff

The service did not make sure volunteer responders were competent for their roles.

Volunteer responders were recruited from the local area. The criteria was that volunteer responders needed to be self-employed and work within the local area in order to facilitate prompt response times.

The volunteer responders were trained in first response emergency care, either to level three or level four. Of the 32 volunteer responders, eight had received level four FREC training and 23 had received level three FREC training. The remaining volunteer responder was a registered nurse. We saw copies of certificates for 16 level three volunteer responders. The certificates were valid for three years. The service did not require volunteer responders to complete an annual refresher course for basic life support training. This was a requirement from the course and is required in best practice guidance from the Resuscitation Council. We found no evidence that the 11 volunteer responders who had undertaken training in 2018 had completed an update in 2019. We saw copies of certificates for the eight FREC four trained volunteer responders, however; one was dated 2016 with no evidence of annual refresher training or continuous professional development portfolio as required in the certificate.

At the last inspection we were told that there was a plan for all volunteer responders to be FREC four trained. During this inspection we were told that a course was being organised for six volunteer responders to attend.

Volunteer responders trained to FREC level three undertook electrocardiograms (ECG's) and then contacted a FREC four colleague to interpret the results. There were four records we reviewed where an ECG had been taken. We noted that these were all interpreted by a FREC four trained volunteer responder.

Of the policies we reviewed, following the inspection, the induction booklet included that mental health cases would need to dealt with on a case by case basis.

However, mental health is not included in either the FREC three or FREC four training course lists. At inspection we were told five volunteer responders had received additional training.

During and following the inspection, we requested a copy of the mandatory training and compliance rates. We were not assured that robust arrangements were in place. Following the inspection, the service advised us that they were revisiting the mandatory training as the arrangements they had previously had in place with a third-party provider had terminated. The service planned for everyone to be up to date with their mandatory training by the end of December 2019.

Following the inspection, we requested information about how the provider was assured that volunteer responders were acting within their training levels and competences. However, we did not receive this.

Are emergency and urgent care services well-led?

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Volunteer responders were not clear about their roles and accountabilities.

At the last inspection, we were told that there were plans to establish a memorandum of understanding (MOU) with the local NHS emergency ambulance service, however; this was not in place. One of the senior managers had contacted the trust regarding an MOU, however; had not been established at time of inspection.

During the inspection, senior managers told us about a patient who deteriorated and resulted in intervention by volunteer responders despite being at the local NHS trust hospital. The service had not identified the situation as an incident and there was no record of the incident on the PRF form. The service considered that the trust would be reporting the incident. The service carried out a de-brief with volunteer responders where lessons learnt were shared.

We were told that there were recruitment processes in place to ensure volunteer responders were fit and proper to undertake the role. We requested employment records for senior managers and volunteer responders during and post inspection, however; did not receive them.

Policies we reviewed, following the inspection, did not reflect what we were told during the inspection. For example, in the induction handbook regarding the providers “Life extinct policy”; this stated that if a volunteer responder arrived to find life extinct, whether CPR is performed or not, the volunteer responder must file out a life extinct form. We saw blank forms stored on the ambulances. However, during the inspection we were told that volunteer responders did not complete these forms and that they would contact the NHS ambulance service.

Of the policies we reviewed, following the inspection, there were inconsistencies between policies. For example, for patients with mental health concerns, the induction booklet included that if a patient presented with a risk to life from self-harm or risk of harm to others that volunteer responders should contact 999 for the police, however; this is not included in providers the escalation policy.

For mental health patients, there was no information in the escalation policy about who to contact for mental health guidance and there is was no pathway or policy in place for mental health conditions.

In the induction booklet with regards to sepsis NEWS scores; the booklet referred to NEWS scores for early detection of sepsis rather than deterioration of patient who is acutely unwell. The booklet did not direct volunteer responders to complete the score and we saw, in PRF forms we reviewed that they were not being completed.

Neither the escalation policy or deteriorating policy included that volunteer responders should assess how far the nearest urgent and emergency care department was in comparison to the response time of the NHS ambulance service response time and make a decision to continue with transportation or await the NHS service. During the inspection we were told that the volunteer responders made the decisions in consultation with call handlers or co-ordinators.

Emergency and urgent care

Following the inspection, we requested details of concerns or complaints, raised by the local NHS trust hospitals, as discussed on inspection, or other stakeholders within the last 12 months, however; did not receive any information.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that volunteer responders understand how to recognise and safeguarding concern and make a referral.
- The provide must ensure processes are in place to monitor safeguarding referrals.
- The provider must submit statutory safeguarding referrals to CQC.
- The provider must ensure that volunteer responders are working within their scope of practice.
- The provider must ensure that any medicines, within scope of practice, are stored and managed safely.
- The provider must ensure that volunteer responders know where to find support from health care professionals.
- The provider must have policies and pathways that are consistent and reflect current national guidance.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1)(2)(a)(b)(g) for the safe use of medicines and assessing and responding to risk appropriately**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (1)(2)(3) for there not being robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1)(2)(a)(b)(c) for a lack of oversight of governance processes**