Ikon Ambulance Services Ltd

Grange Farm

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated Emergency and Urgent Care and Patient Transport Services as inadequate.

Following our inspection, we issued an urgent notice to suspend the registration of the service. We took this action because a person will or may be at risk of harm. We had serious concerns about both services and suspended Grange Farm's registration for 12 weeks, preventing it from operating regulated activities during that time.

We have told the provider that it must take some actions to comply with the regulations and a review of these actions will be completed at the end of the suspension.

We will reinspect the service to check that improvements have been made. We will produce another report of that inspection and include an update of our actions.

For details of the individual services, see the service sections of this report.

This is the first time we have rated the service. We rated this service as inadequate because:

- Safety systems, processes and standard operating procedures were not fit for purpose. The service did not evidence that staff had training in key skills. The service could not evidence that staff could protect patients from abuse and did not manage safety well. The service did not control infection risk well. Staff did not assess all risks to patients. They did not manage medicines well. The service did not manage safety incidents well and did not learn lessons from them. Staff did not collect safety information to improve the service.
- The service did not monitor response times. Managers did not monitor the effectiveness of the service and could not evidence that staff were competent. Staff were not supervised or managed effectively.
- The service did not account for patients' individual needs.
- Leaders did not have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. There was no stable leadership team. There were limited examples of leaders making a demonstrable impact on the quality or sustainability of services. Leaders did not run services well using reliable information systems. Leaders did not support staff to develop their skills.

We did not rate caring as we had insufficient information to rate. We did not observe any patient care.

However:

- Key services were available 7 days a week.
- The service had adequate supplies of personal protective equipment at the base and within vehicles.
- The service had enough suitable equipment including defibrillation equipment and manual handling aids.
- The service had enough staff to care for patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	We rated this service as inadequate because it was not safe, effective and well led. There was insufficient evidence to rate caring. We rated responsive as requires improvement.
Emergency and urgent care	Inadequate 	• Leaders did not have a clear understanding of the needs of the service and did not manage the issues the service faced. The service did not operate effective governance processes that monitored the quality of the care provided and had no process for quality and improvement. As a result, risks and performance were not managed effectively. • The service did not safely manage medicines. • There was not a system to demonstrate or monitor if the staff had training in key skills. • The governance and leadership of the service did not fully protect the safety of the patients. • Guidance for staff was not clear, policies and procedures did not always relate to the service provided and did not always include current national guidance. • Leaders did not monitor the effectiveness of the service. There were no key performance indicators to enable senior staff to monitor response or journey times. • Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development. • There was limited evidence of regular staff and leader's engagement. • There were limited systems and processes to take account of patients' individual needs. • The service did not monitor response times • Staff did not have regular opportunities to meet, discuss and learn from the performance of the service. Leaders had limited oversight of their service's risks. • Staff did not always fully complete patient risk assessments and patient risk assessments did not consider physical health needs. However:

Summary of findings

- Key services were available 7 days a week.
- The service had adequate supplies of personal protective equipment at the base and within vehicles.
- The service had enough suitable equipment including defibrillation equipment and manual handling aids.
- The service had enough staff to care for patients.

Summary of findings

Contents

Summary of this inspection

Background to Grange Farm

Grange Farm is operated by the registered provider IKON Ambulance Services Ltd. It is an independent ambulance service that supplies paramedics, emergency technicians, first responders. The service provides first aid support at organised sporting and public events such as stock car racing, horse shows, and agricultural shows - this activity is out of scope of our regulations. As part of the events support, IKON Ambulance Services Ltd also provide medical transportation that includes emergency transfers to local emergency departments. This onward travel to a hospital is regulated by CQC.

The service also provides a patient transport service however at the time of the inspection there had been three journeys between September 2021 and September 2022.

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

The provider was registered with the Care Quality Commission in 2018 to deliver a patient transport service and urgent and emergency care.

The service is registered to carry out the following regulated activities:

• Transport, triage, and medical advice provided remotely

• Treatment of disease, disorder, or injury

This was our first inspection of this location.

How we carried out this inspection

We carried out this inspection of Grange Farm on 6 September 2022 using our comprehensive inspection methodology. This was a short notice announced inspection, meaning that we told the provider 24 hours before our inspection.

During the inspection visit, the inspection team:

- Spoke with members of the leadership team.
- Reviewed patient documents and other documents relating to the running of the service.
- Reviewed the storage and management of medications.
- Assessed the environment at the ambulance station.
- Inspected 5 vehicles and equipment on them.

We could not speak with ambulance staff as there were none available at the ambulance station during the inspection. We requested details of staff members however these were not submitted in time to be considered with this report. We could not speak with patients or observe interactions between staff and patients as we did not observe any patient transport journeys. We requested details of patients, but the service did not supply this information.

Summary of this inspection

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in ambulance patient transport.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

The service must ensure that all staff are compliant with mandatory training compliance. (Regulation 12(2)(c).

The service should ensure there are systems and processes to support an effective cleaning regime. (Regulation 12(2)(h)).

The provider must ensure policies accurately reflect the service provided and current national guidance. (Regulation 17(1)(2)(d)).

The provider must ensure the risk management process identifies current risks to the service, monitors and identifies actions to reduce the level of risk, and risks are kept under review. (Regulation 17(1)(2)(b)).

The service must ensure staff manage clinical waste in line with clinical guidance. (Regulation 12(2)(h)).

The service must have processes that demonstrate staff are trained and competent to use medicines. (Regulation 12(1)(2)(c)(g)).

The service must ensure there is an effective and documented system in place for managing and monitoring staff compliance with mandatory training and reviewing staff competency. (Regulation 17 (1)(2)(b)).

The service must have a full audit trail of use of medicines and their storage. (Regulation 12(1)(2)(g)).

The service must have assurance that controlled drugs are stored correctly. (Regulation 12(1)(2)(g)).

The service must complete staff appraisals and supervisions. (Regulation 18(2)(a)).

The provider must ensure governance processes provide an assurance of the quality of the service. (Regulation 17(1)(2)(a)).

The provider must ensure that medicines are managed safely. Staff responsible for the management and administration of medication must be suitably trained and competent and this should be kept under review. Staff must follow policies and procedures about managing medicines. (Regulation 12 (1)(2)(g)).

Summary of this inspection

The provider must ensure that staff who are inducted into the service are competent and receive appropriate training, supervision, and appraisal. Regulation 18 (1) (2) (a)).

The service must ensure that it operates a robust recruitment procedure, including checks to ensure all staff employed are fit and proper people for their roles. The service must ensure robust procedures are in place for ongoing monitoring of staff to make sure they remain able to meet the requirements. This also includes ensuring DBS checks are undertaken prior to employment start and monitored ongoing and staff risk assessments are undertaken where required. Regulation 19 (1)(2)(3)(4).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate
Emergency and urgent care	Inadequate	Inadequate	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Requires Improvement
Well-led	Inadequate

Are Patient transport services safe?

Inadequate

This is the first time we have rated the service. We rated safe as inadequate.

For mandatory training, safeguarding, cleanliness, infection and control and hygiene, environment and equipment, staffing, records and incidents please see the urgent and emergency.

Assessing and responding to patient risk

Staff did not always fully complete patient risk assessments and patient risk assessments did not consider physical health needs. The service did not have a policy to manage a deteriorating patient.

Although the transport booking process included an assessment of patient risks, the process and booking form did not capture all patient risks. Of the three booking forms we reviewed, none had any reference or assessment of whether the patient had any physical conditions, other than whether they had mobility issues. The booking form did not capture mental health information.

For all records, staff had not completed a dynamic risk assessment developed from the assessment to promote the safety of the patient during their conveyance. The lack of a plan to manage a patient's wellbeing during transfer increased the risk to patients of avoidable harm.

Are Patient transport services effective?

Inadequate

This is the first time we have rated the service. We rated it as inadequate.

For information for evidence-based care and treatment, competent staff, multidisciplinary working, health promotion, consent, mental capacity act and deprivation of liberty safeguards please see urgent and emergency care section of this report.

Inadequate

Patient transport services

Nutrition and hydration

The service did not routinely provide food and drink to patients as the transfer journeys were generally over a short distance. However, leaders told us that patients were welcome to bring their own refreshment if needed.

Response times

The service did not require staff to monitor response times so they could not monitor patient experience or effective outcomes for patients.

The office staff arranged patient pick-up times in advance. There was no mechanism for recording drop off times.

Are Patient transport services caring?

Insufficient evidence to rate

There was insufficient evidence to rate caring.

For information about this key question please see urgent and emergency section of this report.

Are Patient transport services responsive?

Requires Improvement

This is the first time we have rated the service. We rated it as requires improvement.

For information about meeting people's individual needs, access and flow, learning from complaints and concerns please see urgent and emergency section of this report.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The service provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. All patient journeys involved transporting patients from a care home. The service did not have an NHS contract. The service did not record pick up or drop off times and therefore could not monitor performance.

Meeting people's individual needs

The service did not always take account of patients' individual needs and preferences.

The service did not make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was limited assessment of patients' personalised care needs. At the time of booking there was a prompt about a person's mobility needs, whether they had any communication issues and

Inadequate

Patient transport services

whether they needed a female escort. The mental health risk assessment completed at time of picking the patient up had a prompt about the patient's mobility needs, but no consideration of other characteristics such as communication, religion or disability. This meant there was lack of consideration of the need for adaption in the way the service was planned and provided for individual patients.

Staff established some of each patient's needs in advance. This included if they would be carrying oxygen, if they needed specific support or equipment during a journey. The vehicle was wheelchair accessible and the service provided wheelchairs, carry chairs or stretchers.

Are Patient transport services well-led?

Inadequate

This is the first time we have rated the service. We rated it as inadequate.

For well led please see urgent please see and emergency section of this report.

Inadequate

Emergency and urgent care

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Requires Improvement
Well-led	Inadequate

Are Emergency and urgent care safe?

Inadequate

This is the first time we have rated the service. We rated safe as inadequate.

Mandatory training

The service could not evidence that everyone completed mandatory training.

The service was unable to evidence that staff completed mandatory training. We requested evidence following the inspection and were sent an attendance register however it was not clear what subjects had been covered.

Managers did not monitor mandatory training and did not alert staff when they needed to update their training. The service had identified the training staff needed to perform their roles but there were no records to show that this had happened. This meant leaders did not have oversight of mandatory training completion. The service was not assured staff had the correct training and skills to deliver the service safely.

Safeguarding

The service was unable to evidence that staff were up to date with training in safeguarding. Safeguarding policies were not based on current national guidance.

The service could not demonstrate all staff had received training specific to their role on how to recognise and report abuse.

We were not assured that the service had systems to allow staff to identify adults and children at risk of, or suffering, significant harm.

The service had a safeguarding policy that had been reviewed September 2020. The policy did not have a review date and did not reflect best practice such as: The intercollegiate document 'Adult safeguarding: roles and competencies for health care staff (August 2018)'. The service's policy categorised some forms of abuse but did not outline female genital mutilation and modern slavery. Staff could potentially fail to take action to protect patients from abuse.

We were unable to speak to staff to understand if they knew how to make a safeguarding referral and who to inform if they had concerns. However, the process did not follow best practise and the reporting process was not consistent. The safeguarding policy directed staff to report any safeguarding concerns to the company director rather than local authority directly, therefore it did not follow best practice.

The service did not have a consistent safeguarding reporting process. The policy outlined that safeguarding concerns should be detailed in a specific patient report form however we found that the service was using another type of form which was not included in the policy. This meant there was a risk of harm to patients if these were not raised to the local authority in a timely way.

The service had made no safeguarding referrals from October 2021 to September 2022.

Leaders relied on staff receiving safeguarding training from their substantive NHS employers, however, they did not routinely check this. The service could not demonstrate that staff had received training in line with the safeguarding policy.

The service had a named safeguarding lead who was trained to level 3 in safeguarding for children. This was not in line with the Intercollegiate Document which sets out that the safeguarding lead should complete safeguarding training to level 4. The service did not have an arrangement in place for staff to access support from a professional trained to level 4 in safeguarding children.

The service had a recruitment and selection policy and employment checks to prompt safety. However, this was not fully implemented and embedded in practice. For example, staff had not always had Disclosure and Barring Service (DBS) checks undertaken at the level appropriate to their role. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. If a member of staff declared any convictions on their application form, a DBS risk assessment must be completed by the line manager. This was not being done consistently and therefore not in line with the service's policy for recruitment and DBS checks.

Following our inspection, the service suspended 16 members of staff as there was no record of a DBS check in their staff file.

The process for obtaining references when staff were employed was not always adequate. Since thorough staff checks were not consistently performed for all staff, we could not be assured recruitment processes promoted patient safety.

Cleanliness, infection control and hygiene

The service did not control infection risk well. They did not keep equipment, vehicles, and the premises visibly clean.

There were limited processes or systems in place to ensure all areas were clean and had suitable furnishings which were clean and well-maintained.

The interior of all 5 vehicles we inspected were visibly dirty. We were told by leaders that vehicles were cleaned towards the end of the week as they were primarily used over the weekend. All vehicles had a notice on the windscreen that made clear that the vehicles required cleaning

There was no assurance that the service generally performed well for cleanliness.

The provider's operating base was a static caravan and a barn that was being used to store the vehicles. The service was using water from tap and a hose. The service had a portable toilet for staff use that was covered in spiders' webs. There was no evidence that the toilet had been cleaned and kept tidy.

Staff did not clean the vehicles at the end of the shift. A 'make ready' member of staff cleaned the vehicle before it was needed again. We saw evidence that vehicle cleaning was recorded but there was no evidence that cleaning had been audited by leaders. The service was not able to provide assurance that vehicles had been cleaned to an acceptable standard.

Leaders told us they completed staff observations of care which included IPC (Infection, Prevention and Control) techniques. However, there were no formal or documented IPC audits such as hand hygiene audits.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. However, there was a lack of oversight of the cleanliness of vehicles.

Vehicle cleaning records were in place but not always effective. The service had a record of the vehicles that had been cleaned. The service did not have a policy that covered deep cleans. Vehicle cleaning records showed deep cleans were being recorded. However, there was no assurance that the cleaning was effective. A microbial count was not taken before or after the clean. A microbial count indicates how many microorganisms are present in a sample.

We were not assured that staff followed infection control principles including the use of personal protective equipment (PPE).

The service had an infection prevention and control policy that was dated 1 January 2019 but the policy had not been ratified with the appropriate director signature. The policy included staff requirements for personal protective equipment, cleaning and exposure to blood-borne pathogens. The policy did not reflect the processes of the service. The policy did not cover how the vehicles should be cleaned and audited to make sure infection risk was controlled.

Staff did not clean equipment after patient contact and labelled equipment to show when it was last cleaned. The service could not demonstrate staff always cleaned equipment after patient contact.

Staff cleaned the inside of vehicles with a liquid in a reusable spray bottle. Bottles were not labelled to show when the product was prepared. This meant there was a risk that cleaning would be ineffective due to the product having a limited shelf life once diluted. Detergent sprays and other cleaning products were stored on an open shelf without any control measures. This was not in line with Control of Substances Hazardous to Health (COSHH) requirements. Under the COSHH regulations, an employer has a duty to protect its workers from exposure. This means it must assess the risks associated with the use of chemicals, solvents and other agents, and take all necessary steps to prevent exposure to risks.

Clean linen, hand sanitiser and decontamination wipes were on board the vehicle. Unused linen was stored on vehicles that were left dirty. This increased the risk of infection.

Environment and equipment

Processes were not in place to ensure the maintenance and use of facilities, premises, vehicles and equipment kept people safe. The service did not have an effective system for clinical waste disposal.

The vehicle depot was also used for storage and the storage shelves was cluttered with vehicle and events equipment. Faulty equipment was stored within a corner of the vehicle depot but there was no signage to determine that the equipment should not be used. Staff would be unable to distinguish between working and faulty equipment.

The vehicle depot did not have any fire extinguishers fixed within the depot. Fire extinguishers were only stored on the vehicles. There was a risk to staff if there was a fire. There was no indication where the fire escapes were. We raised this concern on inspection and we were told that the service would conduct an external review of fire safety. The review of fire safety had not been completed at the time of drafting the report.

Vehicle keys were not stored securely. Keys were left within the vehicle depot and were accessible if the doors to the vehicle depot were open, we highlighted this risk to managers. The service did not take any action following the inspection.

The service had a total of 5 vehicles. All vehicles had appropriate insurance and MOT checks to maintain road safety requirements of the vehicles. Staff completed vehicle check lists to ensure the appropriate equipment was available and in working order before the vehicle was used.

Staff carried out daily safety checks of specialist equipment. Grange Farm had a 'make ready' member of staff who ensured the vehicles were fully equipped with the required equipment. Processes were followed to ensure all vehicles had up-to-date MOTs and were serviced to ensure they were safe to drive. Appropriate insurance cover was in place for all vehicles.

The service had enough suitable equipment to help them to safely care for patients. We saw that vehicles contained emergency equipment including defibrillation equipment and manual handling aids. All equipment we saw was labelled to show it had been appropriately serviced and electrical testing undertaken.

Leaders told us staff were trained to use all equipment, however, we did not see any evidence of this. We did not see any evidence that leaders inducted staff on vehicles.

The medical gases were stored within a locked metal cage that was secured to an exterior wall. There was no signage to indicate that medical gases were being stored onsite.

Staff did not manage clinical waste in line with national guidance. We found 2 sharps' bins in ambulances were in use but were not dated when opened. Therefore, there was no record of how long sharps bins had been in use for. There was no audit trail to ensure sharps bins were disposed of every 3 months in line with the National Institute for Health and Care Excellence (NICE) guidelines.

The make ready area had a sluice sink however this had not been connected to running water. We highlighted this concern on the inspection and no action has been taken following the inspection.

Assessing and responding to patient risk

Staff did not always fully complete patient risk assessments and patient risk assessments did not consider physical health needs. The service did not have a policy to manage a deteriorating patient.

Staff completed National Early Warning Score (NEWS2) risk assessments on the patient records however the service did not have a deteriorating patient policy. Leaders said staff would call the office and use blue lights if there was a deteriorating patient.

Inadequate

Emergency and urgent care

In all of the patient records we reviewed, staff had not completed a dynamic risk assessment developed from the assessment to promote the safety of the patient during their conveyance. The lack of a plan to manage a patient's wellbeing during transfer increased the risk to patients of avoidable harm.

Staff shared key information to keep patients safe when handing over their care to others. Staff completed patient records on a paper form and provided duplicate records when the patient was handed over to the hospital.

Staffing

The service could not evidence that staff always had the right qualifications, skills, training, and experience to keep patients safe from avoidable harm. There was not an established induction process. Leaders reviewed and adjusted staffing levels

The service could not demonstrate that staff had the right qualifications and training for their roles and to keep patients safe. We requested this information onsite and following the inspection. The service did not provide an assurance that all staff were competent. We saw no evidence that staff received blue light training.

Leaders said that all staff employed were to First Response Emergency Care Level 3 (FREC 3) as a minimum but did not provide evidence.

The service did not have an induction policy that staff could access. Staff received a limited induction and managers did not formally observe and assess competencies within the role. Staff were required to sign off they had read policies but there was no evidence that these records were audited for completion. The service could monitor data relating to driver behaviour such as speeding and harsh breaking. Leaders did not monitor driving data or provide examples where poor performance had been managed.

Managers supported staff out of office hours. Ambulance staff could call one of the directors, who took turns to be on call.

Records

Staff kept detailed records of patients' care and treatment. Records were not being stored consistently.

Patient notes were comprehensive. We reviewed 3 patient records and they had been completed appropriately.

Records were not being stored consistently. The registered manager had stored some patient records offsite at their house. We requested to see these records however they could not be accessed on the day. Some patient records and staff personnel records were stored in a locked cupboard within a locked room with access restricted to managers. Electronic personnel records could only be accessed through use of individual usernames and passwords to prevent unauthorised access. The service had a record management policy that was last updated in November 2021 and had not been ratified. The policy stated that patient records should not be moved offsite unless there was a good reason for doing so. We were told the documents were being stored securely but there was no reason these documents were stored offsite.

Leaders said they reviewed patient records however there was no record of an audit.

Medicines

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

Inadequate

Emergency and urgent care

The service did not have effective systems and processes to prescribe and administer medicines safely. We reviewed 6 medicines, and all had been counted incorrectly. There was a water-based training ampoule that was counted within the naloxone medications. This is an ampoule used for training purposes, in an educational environment to practise the safe administration of the drug. Naloxone is used to provide urgent treatment for opioid overdose. There was a risk that the training ampoule could have been used on a patient. We raised this concern during the inspection. The service responded by recounting the medicines.

The service had no patient group directives. Patient Group Directives (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). The service did not have a PGD in place for staff to legally use Tranexamic Acid and Clopidogrel.

The provider's medicine management policy had not been signed. The policy available to staff referenced a medical director that had left the service. The service did have updated versions of these policies however staff could not access the current version. There was a risk that staff were working to a different version of the policy.

Incidents

The service did not manage incidents well.

The service did not have processes systems in place to ensure that incidents were reported and investigated effectively. The service had 2 policies that covered incidents, a serious incident policy and a management of incidents policy. Both policies had not been ratified. The serious incident policy had not been adapted for the requirements of the service and referred to an 'Avoidable Mortality Group'. There was no reference of that group within the services governance structure.

The service did not identify and report serious incidents. Following a review of data provided by the service, we saw a medication error that was reported to leaders through an end of shift feedback note. The incident had not been investigated through the incident reporting process that would have ensured feedback was provided to promote a culture of reflection and learning. There was no mechanism for service improvement following incident investigation.

We were told by leaders that the service had no incidents since being registered in 2018. Leaders were unclear on what constituted an incident and not recall a near miss within the service. There was no assurance that staff were being encouraged to report incidents or near misses. We could not speak to staff to ask if they knew how incidents should be reported. We were made aware of an incident involving controlled drugs that had been reported in 2021. This incident had not been investigated in line with the management of incidents policy.

The service did not communicate with staff on safety. There were no actions from the director's governance meetings on safety.

The service could not evidence how lessons were learnt, and themes identified, and appropriate action was taken when things go wrong.

Inadequate

Emergency and urgent care

Are Emergency and urgent care effective?

Inadequate

This is the first time we have rated the service. We rated it as inadequate.

Evidence-based care and treatment

Leaders did not always check to make sure staff followed guidance. Staff did not have access to up-to-date policies and procedure while working remotely. Although the service had some policies and procedures in place, they did not always reference national guidance and evidence-based practice.

Leaders were unable to evidence if staff had up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Service leaders did not complete formal checks to make sure staff followed guidance.

We reviewed policies and procedures and found that most had not been reviewed within the last 12 months. Some policies did not have a review date and it was not clear if they had expired. Policies did not always reference best practice.

Staff could access most policies using their phones. Some of the policies had not been updated to reflect national guidance and best practice. The safeguarding policy did not reference the intercollegiate document that sets out the required safeguarding level by role.

Managers did not have robust arrangements to check that staff followed guidance as the process for auditing records was not effective.

Pain relief

Staff had access to pain reliving medications and could administer these to patients when needed.

We reviewed the 3 patient forms that we had access to and saw that 1 patient had been treated with pain relief as nitrous oxide was administered appropriately.

Response times

The service did not monitor response times.

Patient outcomes

The service did not monitor the effectiveness of care and treatment.

The service did not monitor information to assess how patient outcomes could be improved. The service did not record response time or audit patient record forms to ensure staff provided care and treatment in line with national guidance and best practice.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not appraise staff's work performance and did not hold supervision meetings to provide support and development.

Leaders said staff were self-employed and were not subject to a formal appraisal. Staff performance was not regularly reviewed. We requested evidence of staff training and were supplied with an attendance sheet however it was not clear what subject areas had been covered.

Managers did not provide a full induction tailored to a staff member's role before they started work. Managers did not provide an induction tailored to their role before they started work. Managers did not assess competency before staff started their role.

Managers did not support staff to develop through yearly, constructive appraisals of their work. Leaders claimed that staff were self-employed and were not subject to a formal appraisal. There was no process for reviewing staff performance.

There was no team meetings and limited forms of communication between staff and leaders. Managers did not hold any team meetings so there was no formal communication channel between leaders and staff.

There was no ongoing formal assessment of driving standards. Managers completed shifts with staff to meet demand and it also allowed them to monitor driving standards.

The service could not assure that staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Leaders told us that staff were qualified in First Response Emergency Care Level 3 (FREC3), a recognised qualification in the sector. We requested evidence of staff competency, and the service was unable to provide evidence that all staff had received training.

Multidisciplinary working

There was not sufficient evidence to assess this during the inspection.

We saw from patient records that staff handed over information about the patient's condition to hospital staff. Records showed that hospital staff received a copy of the patient observations.

Health Promotion

The service did not routinely give patients practical support and advice to lead healthier lives.

Due to the nature of the service there was limited evidence to demonstrate health promotion within the service.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

The service had a policy for mental capacity and consent. Leaders could not evidence that staff had received training on consent and the Mental Capacity Act (2005).

The service had a capacity to consent policy that was in date and referenced the Mental Capacity Act 2005 and staff responsibility towards the Mental Capacity Act. The consent policy gave staff guidance about diverse types of consent and the consent they would use during the management of a patient transfer.

We were unable to ascertain staff compliance with consent and Mental Capacity Act training as the service was unable to provide this information.

Inadequate

Emergency and urgent care

Staff understanding and application of the Mental Capacity Act and understanding of consent processes was not obtained, as we were not able to speak with staff during the inspection. On the day of the inspection the service did not have any staff on duty as there were no planned events where staff provided medical cover.

Are Emergency and urgent care caring?

Insufficient evidence to rate

There was insufficient evidence to rate caring.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Due to the small number of regulated journeys, there was limited evidence to demonstrate that staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs.

Emotional support

There was not sufficient evidence to assess this during the inspection

We were unable to speak with patients to determine if staff provided emotional support.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There service had a feedback slip that was attached to their patient record. There was no evidence that staff encouraged patients to provide feedback.

Are Emergency and urgent care responsive?

Requires Improvement

This is the first time we have rated the service. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Due to the nature of the service the urgent patient journeys from an event to a hospital were all unplanned. Leaders allocated staff based on the need at the event and to facilitate onward care if the patient required transporting. Leaders at Grange Farm worked with event organisers to plan to provide medical cover.

Inadequate

Emergency and urgent care

Meeting people's individual needs

The service did not always take account patients' individual needs and preferences.

The service did not have equipment to support the transport of bariatric patients. The local NHS ambulance service was used if a patient was assessed as needing bariatric equipment to be transport them safely.

Leaders did not understand the ways to meet the information and communication needs of patients with a disability or sensory loss. Leaders we spoke to were unsure how to communicate with patients with a sensory disability. Staff did not have any communication aids to support in communication such as pictographic cards.

Ambulances had different points of entry, including sliding doors with steps and tailgates so that people who were immobile or in wheelchairs could enter safely. Patients were transported in their own wheelchair where this was safe to do so.

Access and flow

People could access the service when they needed it however there no assurance that patients received the right care in a timely way.

Leaders did not audit information about patient conveyance. Leaders did not review the time the ambulance crew left the site and the time it took to reach the hospital.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received.

The complaints policy was not available on the website so it was not clear how patients could make a complaint.

The complaints policy was not appropriate for the service as it referred to a quality governance committee reporting on complaints to the board. We saw no evidence that the service had a quality governance committee.

Leaders were unable to give an example of service improvement based on customer feedback.

The service had received no complaints in the last twelve months.

Are Emergency and urgent care well-led?

Inadequate

This is the first time we have rated the service. We rated it as inadequate.

Leadership

Leaders did not have all the skills and abilities to run the service.

During our inspection the leadership team did not demonstrate a good understanding of their responsibilities in relation to compliance with the Health and Social Care Act and the associated regulations.

Inadequate

Emergency and urgent care

The registered manager was not available during our inspection. The day after the inspection we were informed that the registered manager had resigned from their position. There was a lack of attention and focus given to governance processes. Leaders did not have oversight of emerging risks and were slow to respond appropriately to issues within the service.

The operations director had applied to the CQC become registered manager and their application was being considered.

On the inspection we were told that the service had appointed directors within the service. CQC was not notified of these appointments by the service. There is a legal requirement for providers to notify the CQC when a director is appointed so the governance arrangements are transparent and there is clear accountability within the service.

There were few examples of leaders making a demonstratable impact on the quality or sustainability of services.

Vision and Strategy

The service did not have a clear vision or credible strategy to deliver high-quality sustainable care to people who use services

The service did not have a clear vision and set of values that set out quality and sustainability as top priorities. We were unable to speak with staff to understand how leaders engaged with them. The service submitted limited evidence that leaders engaged with staff. We requested information relating to the services vision and strategy. Leaders said doing well was their main priority but did not expand on how this could be measured.

Leaders did not have effective systems in place to monitor and improve the service.

There was no method of monitoring, reviewing, or providing evidence of progress against delivery of any strategy or plans.

Culture

Leaders did not promote a culture based on delivering high-quality care. The service did not demonstrate a strong culture of learning when things went wrong.

We did not see any evidence that managers investigated and shared leaning following patient safety incidents or near miss incidents. We could not see any evidence of staff satisfaction, feelings of respect, being valued, supported, or appreciated. There was no attention given to staff appraisal we flagged this on inspection and no action was taken.

We were not able to speak with staff who worked for the service, so were unable to ascertain from staff what the working culture was and if they felt able to raise concerns or if they felt valued in their roles.

Governance

Leaders did not operate effective governance processes.

The governance arrangements were unclear, and there was a lack of clarity about authority to make decisions and how individuals were held to account. We were told the service held monthly directors' meetings however leaders were unable to provide any minutes or action points. The provider did not hold meetings with the ambulance staff due to the setup of the business and the ad-hoc nature of staff shifts.

The service had a range of policies however most of the copies available to staff had not been ratified. There was no assurance that the version uploaded onto the portal was the correct version that had been signed off.

The service had limited processes for monitoring quality. Leaders told us that they did try to collect patient feedback to understand the quality of care; however, this was not effective. This involved patients who were treated offering feedback after events. Patients used a unique ID code attached to a patient record form, to log onto the providers web site and leave feedback. There was no evidence that patients had provided feedback. The service did not monitor other quality measures such as response times.

Management of risk, issues, and performance

The service did not manage risks and performance effectively. Leaders did not identify and escalate relevant risks and issues and did not identify actions to reduce their impact.

At the time of our inspection the provider's risk register contained generic risks related to some day-to-day operations within the service. The risk register included risk entries referring to potential vehicle concerns and staff sickness. The risk register did not have a date for how long the risk had been on the register for, or who was responsible for mitigating the risk. There was no evidence that the risk register had been reviewed by directors at their meetings as there were no minutes or action points. The risk register did not flag issues that we found on inspection this included the lack of disclosure barring service (DBS) assurance, ensuring staff were competent for the role given the limited assurance following employment. The risk register did not highlight the concern raised at a directors' meeting that the gas cylinder was not being stored appropriately.

The service did not have a programme of audit to monitor the safety, quality and performance of the service. Due to the lack of governance meeting minutes there was limited evidence to demonstrate that managers of the service identified and mitigated all the risks to service users.

The service captured some records, for example, the cleaning of vehicles and servicing of equipment. However, leaders were unable to demonstrate how they audited this information to improve performance or safety over time. The service was unable to provide any up-to-date records of management or staff meetings.

Information Management

The service did not collect reliable data and did not analyse it. Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service had introduced a new computer system. However, this had not been kept up to date for managers to monitor performance. This included as an example staff training and recruitment which had not been linked to staff members meaning that the service was unable to determine its policies on recruitment and training had been met. Leaders were unable to access staff files on the day of the inspection. Some staff files were stored offsite at the registered manager's home, and these were also not available when we requested to see them.

Contracting communications, policies, procedures and secure document storage for the service were maintained within the electronic management system however most policies had not been ratified.

The service did not have embedded quality and improvement processes to collate information and drive improvement. Staff used mobile devices and desk-based computers to access information in relation to the service, these were password protected.

Inadequate

Emergency and urgent care

Engagement

Leaders and staff had limited engagement with people who used the service and the wider community.

There was a limited strategy to engage beyond obtaining patient feedback.

The service did not hold staff meetings and relied upon written communication with staff to provide updates.

The service did not keep records of stakeholder engagement

Learning, continuous improvement and innovation

No formal processes were in place for quality improvement of the service or making change to the service following incidents, complaints, service user feedback or staff feedback.