Salop Medical Services (UK) Ltd

SMS Base

Quality Report

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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.

Ratings

Overall rating for this ambulance location	Inadequate
Patient transport services (PTS)	**Inadequate**

Summary of findings

Letter from the Chief Inspector of Hospitals

SMS Base is operated by Salop Medical Services (UK) Ltd . The service is registered to provide a patient transport service. People who used the service were supported by staff during transportation between services such as; their own homes, hospitals and care homes.

During our inspection we identified that the service was also providing treatment of disease, disorder or injury in the form of emergency and urgent care during transportation from events to emergency departments. The service was not registered to do this and was therefore carrying on a regulated activity unlawfully. We informed the provider of this and requested that they stopped providing this part of their service until they were registered with us correctly.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 9 July 2019.

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 staff told us, what records showed and how the provider understood and complied with the Mental Capacity Act 2005. Due to the type of service, we were unable to observe patient care or speak with people who had used the service.

This was the service's first comprehensive inspection. We rated it as **Inadequate** overall.

We found areas of practice that were inadequate:

- The service did not ensure staff completed mandatory training in key skills to enable them to safely carry out their roles. This meant we could not be assured that staff knew how to care for patients safely and protect them from harm.
- Staff did not have the required level of training on how to recognise and report abuse. Staff did not always understand how to protect patients from abuse. Safety systems and processes did not keep people safe.
- Effective systems were not in place to ensure people were protected from the risk of infection. Suitable equipment and control measures to protect patients, themselves and others from infection were not in place on the ambulances. We could not be assured that ambulances were cleaned in accordance with best practice guidance.
- The vehicles used to transport patients and the equipment within them were not safe or adequately maintained. This placed people who used the service at risk of harm. We could not be assured that staff and visitors to the service's registered premises were protected from the risks associated with fire.
- Staff did not complete risk assessments for patients. Therefore, we were not assured that risks to patients and staff were removed or minimised risks.
- Staff identified patients who were clinically deteriorating. However, we could not be assured that appropriate action was taken to ensure the safety and wellbeing of deteriorating patients.
- The provider could not evidence that the service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not keep detailed records of patients' care and treatment. Records that were maintained were not clear. This meant we could not be assured that patients had received safe care.
- We could not be assured that staff gave administered medicines in line with national guidance. This placed people at risk of harm.

Summary of findings

- The service did not manage patient safety incidents well. Staff did not always recognise incidents and near misses and they did not always report them appropriately. There was limited evidence to show that the registered manager investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations.
- The service could not evidence that care and treatment was based on national guidance and evidence-based practice, meaning that patients could receive ineffective care.
- Staff could not show that they assessed patients' food and drink requirements to meet their needs during a journey. This placed patients at risk of receiving inappropriate and unsafe support with regards to their nutrition and hydration needs.
- The service did not monitor any agreed response times so that they could facilitate good outcomes for patients.
- The service did not make sure that staff were competent in their roles, placing patients at risk of receiving ineffective care. The registered manager did not appraise the staff's work performance and did not hold supervision meetings with them to provide support and development.
- We were unable to establish if the staff worked effectively with other agencies to provide good care.
- We were unable to establish if staff gave patients practical support and advice to lead healthier lives.
- There were no records to evidence that national guidance was followed to gain patients' consent. Staff did not receive the training required to ensure they knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. This placed patients at risk of receiving care in an unlawful manner.
- The service did not plan and provide care in a way that met the needs of local people and the communities served.
- The service did not take into account the individual needs and preferences of patients, meaning that people may not be able to access the care they need.
- Accessible systems were not in place to ensure people could give feedback and raise concerns about care received. People and their families were not invited to express their views on the care and support provided by the service.
- At the time of inspection, the registered manager/provider did not have the knowledge and skills required to manage the service and staff safely and effectively, therefore we were not assured that they had the capacity to deliver high-quality, sustainable care. However, they were visible to the staff.
- There was no current strategy in place that detailed realistic objectives and plans for high-quality and sustainable delivery of care. The service had no statement of vision or values in place for staff to strive to achieve.
- Systems were not in place to ensure the service had an open and honest culture.
- Effective governance processes were not in place to assess, monitor and improve the safety and quality of care.
- Systems were not in place to manage performance effectively. Risks were not identified and action was not taken to reduce their impact. This placed patients and staff at risk of harm.
- Information that staff required to provide safe, effective care was not available, placing patients and staff at risk of harm.
- The provider did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. This meant systems were not in place to respond to what patients and staff think about the quality and safety of care.
- Effective systems were not in place to encourage learning, innovation and improvement at the service.

Summary of findings

- We were unable to establish if people could access the service when they needed it.
- We were unable to establish if staff treated patients with compassion and kindness. Systems were not in place to ensure patients were consistently treated with dignity and the service could not evidence that they considered patients' individual needs.
- We were unable to establish if staff provided emotional support to patients, families and carers to minimise their distress. Systems were not in place to ensure staff understood patients' personal and cultural needs.
- We were unable to establish if staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

However, we found the following areas of good practice:

- Staffing levels were assessed and planned for to ensure the right number of staff were available.
- The registered manager/provider was visible to the staff and worked alongside them delivering patient care.

Following this inspection, we took urgent action and suspended the provider's registration to prevent them from transporting patients. We told the provider that it **must** take some actions to comply with the regulations. We also issued the provider with a requirement notice to address a less urgent concern. Details of regulatory breaches can be found at the end of the report.

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)	Inadequate 	The main service provided was non-emergency patient transport. Therefore, we used our patient transport services core framework to inspect the service. The service also provided first aid and medical cover for events which is not within our scope of registration. However, on occasions, the service transports patients from an event site to hospital in the event of emergency treatment being required. This falls under our scope of regulation. However, the service was not registered with us to do this, so we told them to stop providing this part of their service until they were correctly registered to do so. We rated the service as inadequate in the safe, effective, responsive and well-led domains and were unable to rate the caring domain as we could not observe or gain direct feedback about patient care. This led to an overall rating of inadequate.

SMS Base

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to SMS Base

SMS Base is operated by Salop Medical Services (UK) Ltd . The service registered with us in April 2018. It is an independent ambulance service in Telford, Shropshire. The service primarily serves the communities of the Shropshire, but also facilitates the transfers of adults and children transfers out of the county.

The service has had a registered manager in post since it registered with us. The registered manager is also the provider/company director.

The service is registered to provide a patient transport service. People who used the service were supported by staff during transportation between services such as; their own homes, hospitals and care homes. The service had completed 129 patient transport jobs from 1 January 2019 to 8 July 2019. The provider had two ambulances that were used for this purpose.

At the time of this inspection seven staff were contracted by the provider to carry out patient transport work.

This was the service's first comprehensive inspection.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and a specialist advisor who was a registered paramedic.The inspection team was overseen by Victoria Watkins, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the registered location where we spoke with the registered manager/provider. We also spoke with three staff members by phone in the week following the inspection.

We viewed the staff files relating to (where appropriate) the training and recruitment records of the registered manager and four staff members. We also viewed the records of six people who had been transported by the service.

We did not speak with people who used the service as no patients were receiving patient transfer services care at the time of our inspection. No patient feedback was available to us to review.

Detailed findings

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Not rated	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not rated	Inadequate	Inadequate	Inadequate

Patient transport services (PTS)

Safe	Inadequate
Effective	Inadequate
Caring	Not sufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

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Summary of findings

We rated the service as inadequate in the safe, effective, responsive and well-led domains and were unable to rate the caring domain as we could not observe or gain direct feedback about patient care. This led to an overall rating of inadequate.

Systems were not in place to ensure staff were suitably skilled or experienced to provide safe care. Risks to patients and staff were not assessed and planned for. The vehicles used to transport patients were not adequately maintained or monitored to ensure they were safe for use.

The service could not evidence that care and treatment was based on national guidance and evidence-based practice, meaning that patients could receive ineffective care.The registered manager did not appraise the staff's work performance and did not hold supervision meetings with them to provide support and development.

There were no records to evidence that national guidance was followed to gain patients' consent. Staff did not receive the training required to ensure they knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. This placed patients at risk of receiving care in an unlawful manner.

Patient transport services (PTS)

The service did not take into account the individual needs and preferences of patients, meaning that people may not be able to access the care they need. Accessible systems were not in place to ensure people could give feedback and raise concerns about care received.

Effective systems were not in place to ensure the safety and quality of the service was consistently assessed and monitored to improvements to safety and quality could be made.

Are patient transport services safe?

Inadequate

We rated safe as **inadequate.**

Mandatory training

The service did not ensure staff completed mandatory training in key skills to enable them to safely carry out their roles. This meant we could not be assured that staff knew how to care for patients safely and protect them from harm.

- We were unable to establish which training the provider deemed mandatory for the staff who worked at the service. No training matrix was maintained to show the training the staff required or the staffs' compliance with training.
- The registered manager did not ensure that staff completed training. The registered manger showed us a mandatory training workbook that staff should complete online. However, they informed us no staff had completed this workbook as required.
- We could not be assured that staff had up to date knowledge and skills to enable them to safely assist people to mobilise and transfer from their pick-up location to the ambulance and from the ambulance to their drop off location. The staff we spoke with told us they had not completed moving and positioning training at the service and staff files contained no evidence to show they had completed moving and positioning training. The only exception to this was one staff member's file that contained evidence of moving and positioning training in 2013.
- We could not be assured that all staff who worked on the ambulances had completed training to enable them to use blue lights safely. Evidence to show this training had been completed was only available for two of the seven members of staff.

Safeguarding

Patient transport services (PTS)

Staff did not have the required level of training on how to recognise and report abuse. Staff did not always understand how to protect patients from abuse. Safety systems and processes did not keep people safe.

- We could not be assured that staff would identify potential safeguarding concerns or follow best practice in safeguarding children and adults. The staff we spoke with told us they had not completed any safeguarding training at the service. Six of the seven staff working at the service had not completed adult safeguarding training or level three children's safeguarding training as required in accordance with national guidance.
- We could not be assured that the registered manager, who was also the service's named safeguarding lead would consistently identify and appropriately act upon potential safeguarding concerns due to their lack of appropriate training. They had not completed the required level four children's safeguarding training in accordance with national guidance. The registered manager told us they believed they only required level two training, although evidence of this training was not found in their staff record.
- One of the staff members we spoke with told us they would escalate any safeguarding concerns to the service's safeguarding lead. However, the service's safeguarding lead had not been trained in the skills required to enable them to effectively act as a safeguarding lead. The registered manager who was the safeguarding lead for the service had not completed level four children's safeguarding training as required in accordance with national guidance. The registered manager told us they believed they only required level two training, although evidence of this training was not found in their staff record. The registered manager was able to tell us how they would escalate a safeguarding concern. However, we could not be assured that they would consistently identify potential safeguarding concerns due to their lack of appropriate training.
- We could not be assured that all the staff who worked at the service were of suitable character to work with vulnerable adults and children. Evidence of DBS checks (checks of criminal records) were only available for four of the eight staff. One DBS check recorded a significant criminal caution. No risk assessment had been recorded to show how the risks associated with this caution had been assessed and planned for to safeguard the people who used the service.

Cleanliness, infection control and hygiene

Systems were not in place to ensure people were protected from the risk of infection. Suitable equipment and control measures to protect patients, themselves and others from infection were not in place on the ambulances. We could not be assured that ambulances were cleaned in accordance with best practice guidance.

- The staff we spoke with told us they had not received training from the service in infection prevention and control and the staff files we viewed contained no evidence of up to date training in infection control and prevention. The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance, recommends that all staff providing care should receive suitable and sufficient information on, and training and supervision in the measures required to prevent and control the risks of infection.
- Guidance based on best practice was not available for staff to follow to ensure they and the patients they cared for were protected from the risks associated with infections. The service's infection prevention and control policy did not meet the recommended requirements of the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance. For example, this policy did not describe safe processes for the management of linen, infectious patients and decontamination.
- We could not be assured that ambulances were cleaned in accordance with best practice. No guidance was contained in the policy detailing how a deep clean of the ambulance would be completed. Cleaning logs records were kept. However, we could not be assured that the quality of cleaning was sufficient. For example, the cleaning logs recorded that all equipment had been wiped with antibacterial wipes and the saloon floor and surfaces had been cleaned. However, there did appear to be large amounts of dust and dirt on items within the rear saloon of one of the ambulances.

Patient transport services (PTS)

- We found no evidence to show that information about patients' infection status or risks were assessed and planned for. Staff told us they would refer to the booking information on patient records to identify any infection risks. However, booking information was only available for six of the 129 patient transport jobs completed in 2019. Booking forms did not contain any reference to infection status and associated risks.
- We found that personal protective equipment was not available on both ambulances. Both ambulances contained a range of non-latex gloves. However, only one ambulance had aprons, masks and goggles on board. Neither ambulance held a bodily fluid spill kit. These are designed to safely absorb such as blood, urine and vomit.
- Clinical waste bins were located in both ambulances. However, these were not secured which meant there was a risk that their contents could be spilled during transportation. Clinical waste bins were also located at the service's premises and arrangements were in place for the safe collection of clinical waste.

Environment and equipment

The vehicles used to transport patients and the equipment within them were not safe or adequately maintained. This placed people who used the service at risk of harm. We could not be assured that staff and visitors to the service's registered premises were protected from the risks associated with fire.

- Appropriate equipment was not available to ensure that patients were adequately protected from the risk of harm during transportation on stretchers. Only horizontal straps were in use in both ambulances, meaning patients were only protected against the risk of moving from side to side. No harnesses were in place to prevent movement up and down the stretchers.
- Appropriate equipment was not available to ensure that children were transported safely in the ambulances. No paediatric harnesses or straps were available.
- Patients were not protected from the risk of harm caused by potential projectiles on one of the ambulances. Projectiles included; the Automated External Defibrillator/ electrocardiogram machine, a clock, a sharps box, a clinical waste bin and an oxygen cylinder. Following our inspection, the registered manager informed us some of the projectiles had been secured or removed, but we were not assured that all potential projectiles had been made safe.
- Patients and staff were at risk of harm in the event of a sudden breakdown or safety incident. The hazard lights on one of the ambulances was not working correctly. There was a five-minute delay from pressing the lights button to the lights coming on, suggesting an electrical fault. The provider contacted us following our inspection, to inform us they had booked the ambulance in to get the hazard lights fixed. However, the systems were not in place to ensure the same fault would not be identified again. This was because none of the vehicle check forms that were used by staff included the checking of hazard lights.
- We were not assured that the ambulances were adequately maintained and in good working order. We found that ambulances were not serviced on a regular basis. One of the ambulances was due a service in June 2019, but this had not been completed at the time of our inspection. The other ambulance had exposed electrical wiring in the front and back. In the front the wiring was feeding through the door sill, placing it at risk of damage, meaning there was a risk of electrical fire.
- Emergency equipment on the ambulances was not always available, safe or suitable to use. There were no, suitable adult automated external defibrillator pads on one of the ambulances which meant if a patient deteriorated during PTS work, the automated external defibrillator could not be used. We also found multiple items of equipment on the ambulances that was not safe to use they had passed their expiry date. This included paediatric automated external defibrillator pads which expired in 2016.
- We could not be assured that the risks associated with fire at the registered premises had been assessed and planned for. We asked the registered manager for a copy of the fire risk assessment. They told us they did not directly employ staff. However, it is best practice to ensure the risks associated with fire are assessed, recorded and mitigated in order to protect contracted staff who visit the location.

Assessing and responding to patient risk

Patient transport services (PTS)

Staff did not complete risk assessments for patients. Therefore, we were not assured that risks to patients and staff were removed or minimised.

Staff identified patients who were clinically deteriorating. However, we could not be assured that appropriate action was taken to ensure the safety and wellbeing of deteriorating patients.

- We could not be assured that patients' risk such as risks associated with; mobility and transfers, infection status, medical conditions and communication needs were being assessed and planned for to ensure these risks were mitigated or removed. We found that for the 129 patient transport jobs completed in 2019, only six had booking forms and these only detailed basic information about the patient, such as; a name, address, medical history and if there were steps at the property. Information relating to the risks listed above were not recorded.
- Risks to staff and patients that were associated with the environment, such as; access to properties were not recorded. Therefore, we could not be assured that these risks were being assessed and planned for. There were no records to show that any environmental risks had been assessed or planned for, for 123 of the 129 patients.
- All six booking forms contained a risk assessment form. However, none of the six risk assessment forms were completed to show risks had been assessed and planned for.
- We could not be assured that appropriate action was taken to ensure the safety and wellbeing of deteriorating patients. One patient record contained clinical observations which included oxygen saturation levels (oxygen saturation levels show how well oxygen is being circulated around the body) as the patient had complained of feeling short of breath. Records showed that a staff member gave the patient oxygen which somewhat improved their oxygen saturation levels. However, these levels remained lower than the recommended acceptable range. Records showed this patient had been transported to their home as requested by the provider. However, we were not assured that this was safe as the records did not show that the patient's clinical deterioration had been communicated to a medical professional.
- The provider could not evidence the qualifications that all staff held to ensure they had the skills to manage deteriorating patients as training records were not maintained for all staff.

Staffing

The provider could not evidence that the service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, staffing levels were assessed and planned for to ensure the right number of staff were available.

- We could not be assured that staff had the right knowledge, skills and experience to work at the service. The staff files we viewed contained no evidence to support staff had been interviewed to ensure they were suitable to work at the service. Staff files also contained no evidence to show references had been sought to explore staffs' suitability and experience in relation to their work at the service.
- The registered manager told us that patient transport jobs were only accepted when there were enough staff members available to fulfil the requests of other providers who requested the service. During these jobs' ambulances were always staffed by two members of staff.

Records

Staff did not keep detailed records of patients' care and treatment. Records that were maintained were not clear. This meant we could not be assured that patients had received safe care.

- Accurate, complete and contemporaneous patient records, including a record of the care and treatment provided to each patient and decisions taken in relation to the care and treatment provided were not kept or maintained.
- We were unable to establish what care and support had been provided to patients during transportation. For example, the method of transfer used and if they travelled on a stretcher or seat. Records for patient transport work only contained patients' initials, the pick-up and drop off location and time and the mileage covered.

- Records were not always clear and did not provide staff with the guidance needed to provide safe care and support. Six of the 129 patient transport jobs had booking forms that detailed basic information about the patient. This included the patients' mobility status. However, we found that the mobility status of these patients were not always clear as four of the six forms contained contradictory information.

Medicines

We could not be assured that staff gave administered medicines in line with national guidance. This placed patients at risk of harm.

- We could not be assured that medicines used by staff during patient transport were obtained, prescribed, administered and stored safely. The only medicines available to staff during patient transfer work were oxygen and a pain reliving gas. The registered manger gave us examples of when these two medicines had been offered or administered to patients during patient transfer work. The service's medicines policy did not cover the procedures in place for the ordering, storage and administration of these medicines. Therefore, we were unable to establish if safe systems were in place to ensure people were protected from the risks associated with these medicines. This did not comply with national guidance such as Royal Pharmaceutical Society (RPS) and Royal College of Nursing (RCN) – Professional Guidance on the Administration of Medication in Healthcare Settings January 2019).
- The risks associated with the storage of medicines had not been assessed and planned for. Small gas cylinders were stored securely outside the registered premises. However, no risk assessment was in place for this gas storage area meaning that concerns regarding ventilation & vehicles accidentally reversing into the storage box were not assessed and planned for.

Incidents

The service did not manage patient safety incidents well which placed patients and staff at risk of harm. Staff did not always recognise incidents and near misses and they did not always report them appropriately. There was limited evidence to show that the registered manager investigated incidents and shared lessons learned with the whole team.

- There was no incident policy in place which meant staff did not have access to guidance required to support them to identify safety incidents. We found examples where incidents had occurred but had not been identified or reported as an incident. Therefore, no learning was completed to prevent future incidents from occurring. Records showed that a patient who was transported by the service from hospital to their home had deteriorated on their journey home and oxygen had been supplied during transport by one of the staff members on the ambulance. This was not identified or reported as in incident even though it was not normal practice to administer oxygen for patient transport work. The records for this patient also did not offer any assurances that they were clinically stable to be left at home. Therefore we were not assured that incidents had been identified, managed and any lessons had been learnt to improve patient safety.
- We could not be assured that blue lights ambulance journeys were completed safely and appropriately. Blue lights ambulance journeys should only be completed when responding to an emergency, at the scene of an emergency, when wanting to let people know you are there or wanting to let people know that there is a hazard on the road. The registered manager informed us that a blue lights ambulance journey had been completed during a patient transfer from hospital to hospital in June 2019. The patient's records did not record the rationale for the use of blue lights. However, the registered manager told us the reason for transfer and this reason did not meet the criteria of an emergency, therefore it was inappropriate to use blue lights. The use of blue lights in this instance had not been reported as an incident despite it being out of the 'norm' for patient transport services. Therefore, no analysis of the incident had been completed to identify if the use of blue lights was safe and appropriate.
- We could not be assured that all reported incidents were investigated and acted upon to reduce the risk of further incidents from occurring. Only two incidents had been reported between January 2018 and July 2019. One of these incident forms did not contain any information to show action had been taken in response to the incident. The registered manager told us they had reported the concern to the relevant ambulance control room (as it related to a delay in getting 999 treatment). This action had not been recorded for us to confirm this.

Patient transport services (PTS)

Are patient transport services effective?

Inadequate

We rated effective as **inadequate.**

Evidence-based care and treatment

The service could not evidence that care and treatment was based on national guidance and evidence-based practice, meaning that patients could receive ineffective or unsafe care.

- There were no clinical policies in place to review, such as policies that incorporated The National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. Therefore, we could not be assured that staff had access to the most recent guidance required to ensure their care and support was based on up to date evidence.
- We could not be assured that oxygen was administered effectively and safely in accordance with RRCALC and the British Thoracic Society (BTS) Guideline for Oxygen Use in Adults in Healthcare and Emergency Settings. No policy was in place to ensure staff followed best practice guidance for oxygen administration.
- We could not be assured that patients were supported to move and transfer in line with best practice guidance. No policy was in place that specified which moving and positioning techniques the staff were trained and authorised to use to effectively assist and support people to move in a safe and approved manner.
- Effective systems were not in place to ensure staff met patient's mental health needs in line with evidence-based practice. For example, no policy was in place to support staff on how to meet the needs of patients who were living with dementia and staff told us and staff files showed that staff had not completed dementia awareness training at the service.

Nutrition and hydration

Staff could not show that they assessed patients' food and drink requirements to meet their needs during a journey. This placed patients at risk of receiving inappropriate and unsafe support with regards to their nutrition and hydration needs.

- Patient records did not evidence that their nutrition and hydration needs were assessed and planned for. This included lengthy journey's that were expected to take over two hours. The registered manager told us, and we saw that bottled water was carried on the ambulances. However, we were not assured that patients who had difficulties swallowing fluids would be identified due to the lack of assessment systems in place. This meant there was a risk that a patient who was unable to swallow water safely may be offered and provided with water placing them at risk of choking and/or aspiration (aspiration is when a person inhales a foreign object, such as water into their windpipe and lungs).
- The registered manager told us that where long journeys were expected, where possible they asked staff at the patient's pick-up location to prepare and provide suitable food for the patient to consume during their journey. This ensured that in these circumstances the patient's food was provided by staff who were aware of their nutrient needs. However, the registered manager told us of occasions where they had stopped on a journey and offered to purchase a patient food to eat. Again, we were not assured that patients who had difficulties swallowing food would be identified due to the lack of assessment systems in place. This meant there was a risk that a patient who was unable to swallow food safely may be offered and provided with unsuitable food placing them at risk of choking and/or aspiration.

Response times

The service did not monitor any agreed response times so that they could facilitate good outcomes for patients.

- The service did not monitor their performance in relation to if patients were transported at the agreed time. Therefore, we could not establish if the service facilitated good outcomes for patients.

Competent staff

Patient transport services (PTS)

The service did not make sure that staff were competent in their roles, placing patients at risk of receiving ineffective care. The registered manager did not appraise the staff's work performance and did not hold supervision meetings with them to provide support and development.

- The development needs of the staff were not assessed, monitored or planned for. The registered manager told us none of the seven staff employed for patient transfer work had received appraisals or supervision.
- Staffs' competencies were not formally assessed and monitored. Therefore, the provider could not assure us that the staff were competent to work in their roles. The registered manager told us that no competency frameworks were in place to enable formal competency assessments to take place.
- We were not assured that staff were supported to familiarise themselves with the service's policies and procedures. Staff we spoke with told us they had not completed a formal induction at the service and staff files contained no evidence of induction.

Multi-disciplinary working

We were unable to establish if the staff worked effectively with other agencies to provide good care.

- Patient records did not evidence that staff worked effectively with other agencies to identify individual patient's needs and risks. Only six of the 129 patient transport jobs completed in 2019 evidenced that basic information about patients' needs and risks had been requested and recorded.
- We could not be assured that information about a patients' journey was shared with relevant people, such as care staff or family members. Patient records did not evidence that a handover was given to any carers or family members who were present at patient's drop off locations.
- When a patient's records showed they had clinically deteriorated during their journey from hospital to home. Records did not show, and the registered manager could not evidence that this clinical deterioration was escalated appropriately to a medical professional.

Health promotion

We were unable to establish if staff gave patients practical support and advice to lead healthier lives.

- No guidance was available to staff to give health promotion support and advice and no records of any support and advice were kept and maintained.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

There were no records to evidence that national guidance was followed to gain patients' consent. Staff did not receive the training required to ensure they knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. This placed patients at risk of receiving care in an unlawful manner.

- Patient records contained no evidence to show that consent to care and transport was sought or obtained. However, staff we spoke with told us consent was sought and obtained verbally.
- We could not be assured that staff would support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with the legal requirements of the Mental Capacity Act 2005 (MCA). The staff we spoke with and staff files showed that training in the MCA had not been completed at the service.
- We were unable to establish if patients who lacked capacity to make their own decisions were supported in line with the MCA. Patient records did not contain evidence to show that patients' capacity to consent to their care had been assessed, planned for and recorded. The staff we spoke with told us that some patients who they supported displayed symptoms of dementia which may have affected their ability to consent to their care. This meant we were unable to establish if any of the 129 patients who were transported by the service in 2019 lacked the capacity to consent to their care.

Are patient transport services caring?

Not sufficient evidence to rate

We inspected but did not rate caring

Compassionate care

Patient transport services (PTS)

We were unable to establish if staff treated patients with compassion and kindness. Systems were not in place to ensure patients were consistently treated with dignity and the service could not evidence that they considered patients' individual needs.

- No patients were receiving transport services at the time of our inspection. Therefore, we were unable to observe patient care to establish if patients were treated with compassion and kindness.
- The service did not gather feedback form patients about their experiences of care.
- One of the ambulances did not contain privacy blinds which meant the privacy and dignity of patients travelling in that ambulance was not promoted. However, staff we spoke with told us they would cover patient's with linen and blankets to promote their dignity.
- We could not be assured that the comfort needs of individual patients were assessed and planned for. Patient records contained no evidence to show that patients' individual needs were considered and planned for. Only six of the 129 patient transport records for 2019 contained basic information about the patients' individual needs. The staff we spoke with told us they would enquire about individual patients' needs on arrival at the pick-up location. This meant staff then had limited time and resources to plan how to meet specific comfort needs during the journey such as; pain management and positioning.

Emotional support

We were unable to establish if staff provided emotional support to patients, families and carers to minimise their distress. Systems were not in place to ensure staff understood patients' personal and cultural needs.

- No patients were receiving transport services at the time of our inspection. Therefore, we were unable to observe patient care to establish if staff provided emotional support to patients, families and carers.
- We could not be assured that the personal and cultural needs of individual patients were assessed and planned for. Personal and cultural needs could include mental health needs such as anxiety, travel sickness and preferences for receiving gender specific care and support. Patient records contained no evidence to show that this information was considered and planned for. However, the staff we spoke with told us they would offer reassurance and support to any patients who displayed signs of anxiety and agitation during their journey.

Understanding and involvement of patients and those close to them

We were unable to establish if staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

- Due to the type of service provided, we were unable to observe patient care to establish if staff involved patients, families and carers to make decisions about their care.
- We were not assured that staff would be able to communicate with patients who had communication challenges, for example, if English was not a patients' first language or if a patient had dysphasia (difficultly in understanding and/or expressing language). We asked the registered manager how staff communicated with patients who had communication challenges. They showed us a translation book that could be used to facilitate communication in multiple languages. However, this book was kept at the service's registered location rather than in the ambulances. Because information about patients' communication needs was not gathered during the booking process, we could not be assured that staff would know they needed to collect this book in order to use it with patients during a journey.

Are patient transport services responsive to people's needs?

Inadequate 

We rated responsive as **inadequate.**

Service delivery to meet the needs of local people

Patient transport services (PTS)

The service did not plan and provide care in a way that met the needs of local people and the communities served.

- The service did not have an agreed criteria that defined the type of patients that they could support safely and effectively. This meant information about the patient groups that the service could and could not safely support was not available for the providers and agencies who commissioned care. For example, the service did not have the resources required to safely transport bariatric patients.
- We could not be assured that the service worked effectively and responsively with other provider's and agencies to ensure capacity met demand during times of escalation. The registered manager told us that patient transfer work significantly increased over the winter period due to winter pressures within local hospitals and the local authorities. However, no business plan was in place to ensure the service had effective systems in place to enable them to work responsively during times of escalation.

Meeting people's individual needs

The service did not take into account the individual needs and preferences of patients, meaning that people may not be able to access the care they need.

- Patient records did not evidence that individuals' needs and preferences were assessed and planned for. Of the 129 patient transport jobs completed in 2019, only six of the associated records showed that patients' basic needs were recorded. However, these needs were not always recorded in a clear manner for staff to follow. For example, guidance was not always clearly recorded to inform staff how to safely assist a person to mobilise and transfer. This meant we could not be assured that staff consistently requested information about patients' needs and preferences, therefore we could not be assured that patients' needs and preferences were being met.
- We could not be assured that staff had the knowledge and skills required to meet specific needs relating to dementia, sensory impairments and other additional needs. The service was registered to provide care and support to 'the whole population'. This meant it was registered to provide care and support to people of all ages and abilities, including; people living with dementia, a sensory impairment and people with learning disabilities. Patient records did not evidence that specific needs relating to dementia and sensory impairments were considered and the staff we spoke told us and staff files showed that training in these additional needs had been completed.
- Records showed that the service transported children when required. However, equipment needed to safely transport children, such as children's safety restraints and emergency equipment to manage any clinical deterioration in children was not available. Therefore we were not assured that children would be transported safely

Access and flow

We were unable to establish if people could access the service when they needed it.

- The service did not keep records of any patient transport work that they could not accept or accommodate. There was also no monitoring of response times to enable the provider to identify if the service transported patients at the agreed times. This meant we were unable to establish if people could access the service when they needed it.

Learning from complaints and concerns

Accessible systems were not in place to ensure people could give feedback and raise concerns about care received. People and their families were not invited to express their views on the care and support provided by the service.

- The service had a complaints procedure. However, this was not accessible to patient's, carers and family members. The complaints procedure was not displayed on either ambulance or the service's website.
- The registered manager told us that no complaints had been received in relation to the service. Therefore, we were unable to identify if the complaints were managed in accordance with this procedure.
- The registered manager told us they gave patients a feedback card from a third-party organisation. However, they had received no feedback from this organisation about these cards. Healthwatch is a statutory body whose purpose is to understand the needs, experiences

and concerns of people who use health and social care services and to speak out on their behalf. We could not be assured that these feedback cards were being given to patients as planned as patient records contained no evidence to support this.

Are patient transport services well-led?

Inadequate

We rated well-led as **inadequate.**

Leadership of service

At the time of inspection, the registered manager/ provider did not have the knowledge and skills required to manage the service and staff safely and effectively, therefore we were not assured that they had the capacity to deliver high-quality, sustainable care. However, they were visible to the staff.

- The registered manager did not have the knowledge required to ensure patients were protected from the risk of abuse. They told us they were unaware of the requirements around the levels of children's safeguarding training that they and the staff required. This meant the registered manager had not ensured that they and their staff had completed the training required to provide them with the knowledge and skills to safeguard children.
- The registered manager had not established suitable and effective policies and procedures to fulfil the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). For example, polices were not in place, risk assessments were not carried out and documentation was not completed correctly.
- The registered manager did not demonstrate the capability to follow safe recruitment systems to ensure staff were suitable to work at the service. For example, references had not been sought for any staff and no staff files were kept for the staff who worked as paramedics at the service.
- The registered manager did not assess, monitor and manage the staffs' development needs to ensure they were competent and able to provide high quality care. This was because appraisals and supervision were not completed.
- Staff we spoke with told us the registered manager was visible and approachable as they worked alongside the staff providing care and support to patients.

Vision and strategy for this service

There was no current strategy in place that detailed realistic objectives and plans for high-quality and sustainable delivery of care. The service had no statement of vision or values in place for staff to strive to achieve.

- The provider had not worked with patients, staff and stakeholders to devise a strategy that reflected the needs of the local health economy and the community that it served.
- Staff had no vision or values to base their delivery of care on. This placed patients at risk of receiving care that was delivered in an inconsistent manner.
- Having no strategy and values meant the provider could not monitor, review and develop its progress in its effectiveness in providing high quality and sustainable care.

Culture within the service

Systems were not in place to ensure the service had an open and honest culture.

- Systems were not in place to promote openness and challenge. Staff did not receive supervision sessions to enable them and the registered manager to have open and honest discussions in a safe and supportive environment.
- The provider had no systems in place to assess and monitor the levels of staff satisfaction, stress and workload as no staff survey, supervision sessions or appraisals were completed.
- Staff we spoke with told us they were able to approach the registered manager if they had concerns about safety and quality. However, since the service registered with us, we had been contacted by two whistleblowers

who told us they felt unable to effectively raise concerns with the registered manager. A whistleblower is a member of staff who shares concerns about a service/ provider.

Governance

Effective governance processes were not in place to assess, monitor and improve the safety and quality of care.

- There were no governance systems in place to ensure key areas such as; the service's strategy, values, objectives and business plan were clearly set and monitored to promote the delivery of high quality, sustainable care.
- Arrangements for governance and performance management were not in place. There was a lack of a robust governance framework to support the delivery of quality patient care. There was no clear oversight of the day to day working of the service. For example, the service failed to identify risks associated with safe and effective transportation of patients and they were unable to evidence how they followed national guidance.
- There was a lack of systematic performance management of individual staff, or appropriate use of incentives or sanctions. For example, when staff had not completed their mandatory training workbooks as required, no action had been taken by the registered manager to address this. Staff also did not receive appraisals and assessments of competencies.
- We were not assured that action was taken in response to concerns identified through audits. Where audits had been completed, there was no evidence to confirm that planned actions to address concerns had been completed. For example, when the registered manager had recorded they would speak to staff to remind them of the importance of completing paperwork, there was no evidence in place to show staff had been reminded.

Management of risk, issues and performance

Systems were not in place to manage performance effectively. Risks were not identified and action was not taken to reduce their impact. This placed patients and staff at risk of harm.

- The performance of the service was not monitored. For example, response times were not being monitored to ensure care was consistently provided to the right people at the right time.
- The registered manger was unable to evidence that they assessed, monitored and mitigated risks associated with the running of the service. The service did not keep a risk register and no evidence was shared by the registered manager to show that any risks associated with patient transport work, patient safety or staff safety had been assessed and mitigated.
- The audit systems in place were not managed effectively. Audits we viewed had not been effective in identifying and addressing concerns with the safety and quality of care. Vehicle check lists were not robust enough to identify the urgent concerns we identified with the ambulances. For example, the vehicle checklist did not include checking of hazard lights and checks to identify potential projectiles.
- Audits were not always carried out in accordance to policies and management oversight had failed to identify and address this. The provider's infection prevention and control policy referred to hand hygiene audits. However, we found no evidence that hand hygiene audits were being completed in accordance with this policy. The registered manager confirmed that these audits had not been completed.

Information Management

Information that staff required to provide safe, effective care was not available, placing patients and staff at risk of harm.

- The provider's policies were not robust enough to provide staff with the information they needed to provide safe, effective care. The service's infection prevention and control policy did not meet the recommended requirements of the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance. For example, this policy did not describe safe processes for the management of linen, infectious patients and decontamination. The service's medicines policy did not cover the procedures in place for the ordering, storage and administration of oxygen and Entonox.

- Detailed patient records were not kept and maintained. Most patient transport records only contained patients initials. This meant in the event of a safeguarding concern, the registered manager would be unable to access the information required to make a safeguarding referral to the local authority. In these circumstances, the local authority would require details including the patient's full name, address and/or date of birth in order to identify the correct patient.

Public and staff engagement

The provider did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. This meant systems were not in place to respond to what patients and staff think about the quality and safety of care.

- The registered manager told us they did not have service led systems in place to obtain feedback from patients about the quality of care or the planning of the service.
- No staff survey was completed to gain feedback from staff about the delivery of care and the management of the service.

Innovation, improvement and sustainability

Effective systems were not in place to encourage learning, innovation and improvement at the service.

- The registered manager was unable to evidence any plans and structures in place to promote innovation and improvement. There was no strategy in place to show how the service aimed to develop.
- Staff we spoke with told us that learning and reflective practice was not promoted at the service and staff files we viewed confirmed this.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the provider MUST take to meet the regulations:

The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to safeguarding, incident recording and reporting, and the governance of the service.

- The provider must follow safe recruitment procedures to ensure staff are suitable and experienced to work at the service. Regulation 19 (1)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2014.
- The provider must ensure all staff complete the required and appropriate levels of children's safeguarding training. Regulation 13 (1)(2) HSCA 2008 (Regulated Activities) Regulations 2014.
- The provider must identify appropriate mandatory training for all staff and ensure all staff complete this training. Regulation 18 (1)(2)(a) (Regulated Activities) Regulations 2014.
- The provider must ensure their infection prevention and control policy meets the requirements of the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance. Regulation 12 (1)(2) (h) (Regulated Activities) Regulations 2014.
- The provider must ensure their medicines policy clearly states how medicines used are ordered, stored, maintained and administered in accordance with best practice guidance. Regulation 12 (1)(2)(g) (Regulated Activities) Regulations 2014.
- The provider must ensure that the risks and needs of each patient are assessed and planned for. Regulation 12 (1)(2)(a)(b) (Regulated Activities) Regulations 2014.
- The provider must ensure that both ambulances are consistently in safe working order and that the risks associated with their use are assessed and planned for. Regulation 12 (1)(2)(e) (Regulated Activities) Regulations 2014.
- The provider must ensure that equipment on both ambulances is consistently available and safe to use. Regulation 12 (1)(2)(e) (Regulated Activities) Regulations 2014.
- The provider must provide staff with guidance on how to identify and report safety incidents and near misses and effective systems must be in place to ensure all incidents are investigated with lessons learnt being shared with all staff. Regulation 17 (1)(2)(b) (Regulated Activities) Regulations 2014.
- The provider must keep accurate and contemporaneous records for all patients and staff. Regulation 17 (1)(2)(d) (Regulated Activities) Regulations 2014.
- The provider should regularly assess and monitor the staffs' competencies and development needs. Regulation 18 (1)(2)(a) (Regulated Activities) Regulations 2014.
- The provider must clearly display their complaints process for patients to see and refer to. Regulation 16 (2) (Regulated Activities) Regulations 2014.
- The provider must ensure that effective systems are in place to assess, monitor and improve the safely and quality of care at the service. Regulation 17 (1)(2)(a)(b) (Regulated Activities) Regulations 2014.
- The provider must identify, monitor and mitigate all risks associated with the running of the service. Regulation 17 (1)(2)(b) (Regulated Activities) Regulations 2014.
- The provider must implement an effective system to gain feedback from patients about the quality of the service. Regulation 17 (1)(2)(e) (Regulated Activities) Regulations 2014.

Action the hospital SHOULD take to improve

Action the provider SHOULD take to meet the regulations:

- The provider should ensure clinical polices are in place to ensure staff provide care and support that is based on best practice guidance.

Outstanding practice and areas for improvement

- The provider should monitor response times to ensure the service is providing the right care at the right time.
- The provider should ensure handover's to staff, carers, family members and other health and social professionals are recorded.
- The provider should ensure staff have access to health promotion advice to provide to patients as required.
- The provider should ensure that where appropriate patient records show that patients' consent has been gained and/or the requirements of the Mental Capacity Act 2005 have been followed.
- The provider should ensure that patients privacy needs are consistently met in the ambulances.
- The provider should ensure that the communication needs and individual preferences of all patients are assessed and planned for.
- The provider should devise and implement a criteria that describes which patient groups they can safely and effectively support.
- The provider should devise a business plan that outlines the service's values and goals.
- The provider should gain feedback from staff about the quality of care and the management of the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The service's complaints procedure was not accessible to patient's carers and family members. It was not displayed on the ambulances or on the service's website. Regulation 16 (2)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to the health and safety of patients, including risks associated with infections and medicines were not assessed and planned for. The provider did not ensure that all staff working with patients had the required qualifications and skills to do so. The provider could not evidence that the registered location was safe. Effective systems were not in place to ensure equipment and vehicles were safe to be used. Regulation 12 (1)(2)(a)(b)(c)(d)(e)(f)(g)(h)

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 Effective systems were not in place to ensure patients were protected from the risk of abuse. Regulation 13 (1)(2)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the safety and quality of care.

This section is primarily information for the provider

Enforcement actions

Effective systems were not in place to ensure risks associated with the running of the service were identified and mitigated.

Accurate and contemporaneous patient and staff records were not maintained.

Feedback from patients was not sought and acted upon.

Regulation 17 (1)(2)(a)(b)(c)(d)(e)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing Effective systems were not in place to ensure the staff were continuously suitably skilled to carry out their roles. Regulation 18 (1)(2)(a)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Safe recruitment systems were not in place to ensure staff were of suitable character and experience to work at the service. Regulation 19 (1)(a)(b)