

Pulseline Ambulance Services Ltd

# Pulseline Ambulance Services Ltd

## 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.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Pulseline Ambulance Services provides patient transport services (PTS) to local NHS trusts and provides privately funded PTS on request.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 5 March 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this service was Events work.

### Services we do not rate

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

We found the following areas of good practice:

- Staff completed mandatory training on induction day and then annually. All PTS staff (100%) had completed mandatory training.
- We saw robust recruitment processes were in place to ensure suitable staff were appointed safely.
- The provider had an effective system in place to ensure vehicles were re-stocked, faulty equipment was brought to their attention, and that staff had clear lines of responsibility for the cleaning of vehicles.
- The provider shared information with local NHS hospitals to ensure plans were in place in the event of a major incident.
- Staff knew how to recognise and respond to signs of abuse, and report a safeguarding disclosure. All staff (100%) had completed safeguarding adults and safeguarding children level 2 and level 3 training.
- The vehicles we inspected were visibly clean and fit for purpose. The provider had processes in place to manage cleanliness and there was evidence of appropriate waste segregation.
- Staff described a positive working culture and a focus on team working. Staff told us they could approach the manager or supervisor at any time to report concerns.
- The provider encouraged staff to seek feedback from patients. The feedback we reviewed was positive including comments about the professionalism of staff. The provider had not received any complaints since they had registered with the commission.
- The provider had some governance processes in place, for example staff appraisal, monitoring staff disclosure and barring service (DBS) compliance, and monitoring staff training.

However, we also found the following issues that the service provider needs to improve:

- We were not assured staff could define an incident or knew when to report them. No incidents had been reported since the provider had registered with the commission.

# Summary of findings

- The provider had some governance processes in place such as the monitoring of staff appraisals, training and competencies. Not all governance processes were in place however, such as environmental audits, infection prevention and control (IPC) audits, and patient transport record audits.
- The provider had policies and procedures in place however, they were not all service specific which meant they did not always direct staff to follow correct processes.
- The provider did not have a documented policy and procedure for staff to follow in the event of a deteriorating patient.
- The provider did not always ensure patient records were stored safely and securely at all times. The provider took immediate action to resolve the concern following our inspection.
- The provider did not have a risk register or a process to review and mitigate presenting risks to the business in a consistent way.
- The provider did not always store chemical products in line with the Control of Substances Hazardous to Health Regulations 2002 (COSHH) requirements. The provider took immediate action to resolve this at the time of our inspection.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

**Heidi Smoult**

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Patient transport services (PTS)

### Rating Why have we given this rating?

We inspected but did not rate this service. The main activity for this service was to attend events work that was not in CQC scope. Patient transport services (PTS) accounted for approximately 8% of the business with an average of five to 10 journeys a month.

We found:

The provider had a robust recruitment process that ensured staff were suitably qualified for their roles. Staff completed comprehensive mandatory training as part of their induction, and this was reviewed annually to support continued professional development. Four of the five vehicles we inspected were fit for purpose and the provider assessed patient needs around mobility, medicines and capacity to ensure the right professionals were allocated to the patient transport journey. Staff followed infection, prevention control processes and there were clear lines of responsibility for the cleansing of vehicles and replacement of stock. The provider did not complete formal audits to contribute to learning and service improvements. The provider had a range of policies and procedures however, these were not always service specific which meant guidance was not always relevant or easy to follow. There was no policy for staff to follow in the event of a deteriorating patient, although staff demonstrated they were knowledgeable to manage concerns. The provider recognised the risks to the business but did not have a process to systematically review and mitigate risks.

Staff described a positive working culture and all were passionate about patient welfare and safe care. The provider encouraged staff to seek feedback from patients and all comments we reviewed were positive. The provider had received no complaints about the service since registering with the commission.

# Pulseline Ambulance Services Ltd

## Detailed findings

### Services we looked at

Patient transport services (PTS)

# Detailed findings

## Contents

### Detailed findings from this inspection

	Page
Background to Pulseline Ambulance Services Ltd	6
Our inspection team	6
How we carried out this inspection	6
Facts and data about Pulseline Ambulance Services Ltd	6
Action we have told the provider to take	22

## Background to Pulseline Ambulance Services Ltd

Pulseline Ambulance Services opened in 2012. It is an independent ambulance service in Bromsgrove, Worcestershire. The service primarily serves the communities of the West Midlands.

The service provider was also the registered manager and has been in post since 2012. This was the first time we had inspected the service.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, one CQC inspector, and a specialist advisor. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspections.

## How we carried out this inspection

We undertook an announced inspection on 05 March 2018. During the inspection we spoke with five staff including; the manager, operations manager, a paramedic, and two technicians. We reviewed seven

patient feedback forms of the service, completed by patients or family members prior to our inspection. We reviewed policies and procedures, nine staff files and inspected five vehicles.

## Facts and data about Pulseline Ambulance Services Ltd

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice remotely
- Treatment of Disease, Disorder, or Injury

The provider offered patient transport services (PTS) 24 hours a day, 365 days a year from its headquarters in Bromsgrove supporting general non-emergency PTS journeys, including hospital discharges and privately funded patient transfers.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

# Detailed findings

## Activity (January 2017 to December 2017)

- In the reporting period January 2017 to October 2017, patient transport journeys accounted for an average of 8% of the provider's business.
- Track record on safety:
- No never events
- No clinical incidents
- No serious injuries
- No complaints

# Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

## Information about the service

The main service provided by this ambulance service was event first aid cover, including sporting events, but this was not in scope of the inspection. Emergency transport journeys made from the events to NHS hospitals was in scope of the inspection. These journeys averaged one to two per month. The provider also provided patient transport services (PTS) that accounted for 8% of the business between January 2017 to October 2017. The provider told us approximately five to 10 planned PTS journeys were completed per month.

The provider employed one member of staff directly; this was the owner who was also the registered manager. The provider employed ten other staff on casual contracts, this included three emergency care assistants (ECAs), four technicians, two paramedics, and an operations manager.

The provider used an external provider on an ad hoc basis to do repairs and servicing on the vehicles.

The provider carried out private patient transfers, for example collecting patients from airports and transporting patients between hospitals. The provider did not hold any PTS NHS contracts.

The provider did not hold any controlled drugs (CDs) or other medication at its location. However, the provider did use medical gases on vehicles and ambulance staff replenished these with a local provider.

## Summary of findings

We found the following areas of good practice:

- Staff completed mandatory training during training and we saw from the nine staff files we reviewed, all (100%) were compliant with mandatory and annual review training.
- Staff knew how to recognise, and respond to the signs of abuse, and report safeguarding disclosures. All eleven staff (100%) had completed safeguarding adults and safeguarding children level 2 and 3 training. The provider and operations manager were the safeguarding leads and had completed safeguarding adults and safeguarding children level 4 training with the local authority.
- The vehicles we inspected were visibly clean and fit for purpose. The provider had processes in place to clean and deep clean vehicles and there was evidence of waste segregation.
- The provider completed a patient booking form over the telephone to assess patient needs around mobility, medicines and capacity to ensure the journey was safe to commence.
- Staff completed mental capacity act training that included the effective management of challenging behaviours, associated with some patients living with dementia. Staff accessed translation services for those patients who did not speak English as a first language via an online portal.

# Patient transport services (PTS)

- Staff described a positive working culture and a focus on team working. Staff told us they could approach the manager or supervisor at any time to report concerns.

The provider encouraged staff to seek feedback from patients. The feedback we reviewed was positive, including comments about the professionalism of staff, and treating patients over and above what was expected. The provider had not received any complaints in the period since registering with the commission.

However, we found the following issues that the service provider needs to improve:

- Staff had never reported an incident and did not always know what would constitute an incident. No incidents had been reported since the provider registered with the CQC.
- Policies and procedures were not always service specific, which meant guidance for staff was not always relevant.
- The safeguarding policy did not include all relevant referral information to assist staff when dealing with a safeguarding concern.
- The provider did not have a documented policy and procedure for staff to follow in the event of a deteriorating patient.
- The provider recognised most risks to the business but did not have a process to systematically review and mitigate risks or a risk register.
- The provider had some governance processes but had not yet fully embedded all governance processes such as auditing and team meetings.
- The provider did not always store patient records safely and securely however, the provider installed a secure file storage unit within the ambulance station within one week of the inspection.
- Cleaning fluid was stored next to bleach, which could present a risk of the wrong fluid being used to clean

areas. An electric plug was stored near water. The provider took action on the day of inspection to ensure the storage of electrical equipment and cleaning fluids was safe.

# Patient transport services (PTS)

## Are patient transport services safe?

### Incidents

- No incidents had been reported since the provider registered with the CQC and we were not assured staff knew what would constitute an incident. Staff had not received training on the reporting of or management of incidents, accidents or near misses. The provider had not been able to analyse or review when things had gone wrong, and no learning could be shared to contribute to service improvements. We spoke with three staff about incident reporting. Each staff member knew the process of how to report an incident however; they told us they had not been required to raise an incident during their employment. Two staff members discussed issues that had arisen during patient journeys so were not clear what constituted an incident. On discussion, staff recognised there was a missed opportunity to review and improve practice to prevent reoccurrence.
- The provider had a policy for incident and accident reporting and management. We reviewed the policy and found it was in date however, it was not service specific. Not all information in the policy was relevant to the service and it referred to senior management personnel not employed by the provider, for example a health and safety lead. The policy stated that any significant risks would be placed on the appropriate risk register however; the provider told us they did not have a risk register. There was conflicting guidance for submitting completed incident forms; in one paragraph the policy stated they must be submitted within 24 hours, and in a second paragraph the policy stated within 48 hours. The provider used a paper-based incident reporting system and we reviewed the form and found it was fit for purpose.
- The provider reported no never events or serious incidents from January 2017 to December 2017. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires

providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. The provider was aware of the regulation but had not needed to apply it however, staff had not received training in the DoC.

- One of the two members of staff we spoke with about the duty of candour regulation had limited knowledge but said they would refer any incidents to the provider.

### Mandatory training

- Staff received mandatory training in safety systems, processes, and practices.
- Mandatory training comprised of a range of subjects and included: health and safety, infection prevention and control (IPC), information governance, moving and handling, basic life support (BLS), capacity and consent, safeguarding adults and children, carry chairs and lifting aids, health and safety (including Control of Substances Hazardous to Health (COSHH) and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).
- The provider ensured mandatory training was reviewed on an annual basis as part of staff's continued professional development (CPD). We observed eight staff files, and observed mandatory and review CPD training was in date. The provider used an online electronic learning system, which staff completed at home.
- The provider completed a training matrix for each staff member that highlighted the type and level of training required for their particular role. The provider did not provide specialty training for paramedics and ambulance technicians as staff were self-employed and completed training in their main employment. Additional training completed by staff was held in staff records. We observed relevant checks were completed by the provider to confirm the scope of each professional's practice.
- The provider checked relevant staff had completed driver assessment and refresher training and we saw certificates were up to date and stored in staff files. The provider carried out an initial driver assessment as part of the staff induction process.

### Safeguarding

# Patient transport services (PTS)

- The provider had some systems, processes, and practices in place to keep people safe from abuse. All staff were trained to recognise and report abuse however, policies did not always provide concise information for staff to follow if they were concerned about a potential safeguarding risk.
- The provider had a combined safeguarding vulnerable adults and children's policy that was reviewed and in date. We reviewed the policy and found the information did not separate adults and children's safeguarding procedures. The policy did not include domestic abuse, psychological abuse, or financial abuse in definitions of abuse or neglect. Most of the information was specific to safeguarding children and was not always relevant to safeguarding vulnerable adults. Referral information at the bottom of the document was not correct as it included one contact number for raising all safeguarding referrals. This number was to make a referral to the adult safeguarding team however; the policy did not clarify this. There was no contact number for staff to raise a referral with the local children's safeguarding team. The policy included contact details for the local police public protection team, the provider's safeguarding leads, and for a domestic abuse helpline.
- The provider and the operations manager had undertaken safeguarding officer's course adults and safeguarding children level four training with a local county council. Refresher level two and three training for adults and children was completed in January 2018. The provider and operations manager were the named safeguarding persons for the service.
- Staff completed on line safeguarding adults and safeguarding children level two and three training which was in line with safeguarding children and young people: roles and competences for health care staff Intercollegiate document, March 2014.
- Data supplied by the provider showed staff achieved 100% compliance with safeguarding adult and children training at level two and three. Staff, on occasion, transported children.
- The provider had not transported any children in the three months prior to our inspection but told us that if they were to transport children the child would have a chaperone in the form of a family member or carer.
- The provider used a specific form for recording adult and child safeguarding incidents as part of the referral process. The provider had not raised any safeguarding concerns with the local authority relating to patient transport services since they registered with the CQC.
- We spoke with three staff about safeguarding, all of them knew how to recognise, and respond to the signs of abuse, and report a safeguarding disclosure. Staff told us they would telephone the provider for immediate advice if necessary and told us they knew where to access local authority safeguarding contact details. We observed safeguarding incident forms were carried in a vehicle on each patient transport journey.

## Cleanliness, infection control, and hygiene

- The provider had a policy for the prevention, protection, and promotion of infection control; this was in date however, was not specific about the tasks required to maintain cleanliness. There was no explanation of what required wiping down or cleaning, and with which cleaning fluid.
- We reviewed the daily cleaning schedules for vehicles and found staff completed routine checks and cleaning schedules. A paper record was signed by a staff member to confirm they had been responsible for, and had completed the vehicle check and cleaning before and after a patient transfer.
- The four vehicles we inspected were mostly clean and fit for purpose. We observed that the cleaning of three vehicle's floors required some improvement as there was some debris from patient's shoes. The provider had processes in place to clean, deep clean and to check daily vehicle schedules had been completed. Spot checks were completed by the provider but they did not complete audits of the cleaning of vehicles, therefore cleaning was not monitored to ensure compliance, performance and to seek improvements.
- Staff cleaned vehicles at the ambulance headquarters, including any deep cleans, using appropriate detergents after every shift. We checked four vehicle's records that included a history of deep cleaning. We saw two of the four vehicles' deep cleans were completed within standard, and two of the four had no record of a deep clean. The provider told us the two vehicles without a deep clean record (4x4s) were mostly used at events,

# Patient transport services (PTS)

which fall out of CQC scope. Two staff described the process they followed to clean and check vehicles and explained they used disinfectant wipes to clean surfaces between patients.

- We alerted the provider to a small rip in the seat used by staff in one of the ambulances. We were concerned the rip compromised the effectiveness of cleaning the seat and could pose a potential infection risk. This had not been reported as an incident. The provider told us they would arrange for the rip to be repaired.
- Staff reported any areas of concern in relation to ambulance cleanliness, or equipment directly to the provider for action if there were issues.
- The provider carried waste bins securely in both ambulances. Staff clearly labelled waste bins for clinical and non-clinical waste. The provider had an established agreement with a private infection clinical waste service that collected and disposed of clinical waste.
- Ambulance staff wore appropriate uniform and were bare below the elbow to reduce the risk of infection. Staff laundered their own uniform following provider guidance. The provider stored some spare uniforms for staff use in the event of soiling.
- Staff had access to personal protective equipment such as goggles, aprons and gloves on ambulances as well as alcohol gel dispensers and disposable antibacterial wipes to promote hand hygiene and infection control.
- The provider had a sink and hot running water in the headquarters along with an alcohol gel dispenser to allow staff to maintain hand hygiene. There were posters to highlight good hand washing practice in staff toilets and in the ambulance station. The provider told us they regularly observed hand hygiene practice however, they did not complete formal hand hygiene audits to ensure compliance and seek improvements.
- The provider held a pest control contract that we observed was in date.
- A steel, electric shutter was locked when the premises were not in use and the provider confirmed a lock was fitted to the office door following our inspection.
- There was CCTV in operation. Ambulances were parked both in the locked garage and outside on the driveway.
- Staff mostly maintained the storage areas to ensure they were visibly clean, tidy, well stocked, and safe from any trip or fall hazards. We found cleaning fluid stored next to bottles of bleach, which could have presented a risk if the wrong fluid was used incorrectly. An electric extension lead was stored next to water. A high shelf contained stock that was not stored safely and could have presented a risk if it fell. We raised these issues with the provider who took immediate action to make the area safe. The provider did not complete environmental audits to monitor safety and drive service improvements.
- We checked the service records in relation to all five vehicles and found the provider had service records and Ministry of Transport certification (MOT) for 100% vehicles in line with specified requirements.
- The provider maintained a contract with an auto recovery service to support any ambulance breakdowns. If staff found any faulty equipment, they reported this to the provider, who recorded the issue and took action to repair or replace the faulty equipment.
- Ambulance staff replenished consumable stock on the ambulances and carried out stock control and rotation regularly. Staff signed a statement to confirm they had re-stocked a vehicle from an outside source or at base and they confirmed the stock count was accurate. We reviewed disposable equipment on four ambulances and found them to be stored appropriately and in date for sterility.

## Environment and equipment

- The ambulance station included an office area, staff room, storage area and an indoor garage, with an outdoor area where vehicles were parked. The entry door was securely locked with deadlocks, and a key was stored in key box, which was accessed with a keypad
- Relevant oxygen equipment, masks and nebulisers for both adults and children was available, and staff maintained stock to ensure it was visibly clean and in safe storage areas within the headquarters.

# Patient transport services (PTS)

- Ambulances carried a spillage kit. These were complete, within date and staff stored these correctly within the ambulances we inspected.
  - We reviewed the firefighting equipment within the headquarters and on the ambulances. We found all equipment was serviced within the required dates and fit for use.
  - The emergency defibrillators were serviced and ready for use.
  - Vehicles carried first aid kits containing a selection of wound dressings plasters, sterile wipes, and triangular bandages. We found all equipment within the first aid kits on the vehicles we inspected to be in date and in good condition. The provider did not complete audits to check if equipment was always in date and maintained.
  - An external company serviced vehicle equipment, for example, lap belts, straps, and clamps. We had no concerns regarding the safety or servicing of equipment.
  - All staff received training in the safe use of lifting aids, the carry chair, and stretcher during their induction to the service. Staff training records kept by the provider confirmed this.
- Medicines**
- The provider did not store medications within the headquarters however, they transported patient's own medicines during patient transport journeys on board ambulances.
  - Paramedics employed by the provider on a casual basis carried their own medicines in line with their professional registration. Patient Group Directions (PGDs) were supplied and administered by paramedics who held the required qualifications to prescribe medicines to pre-defined groups of patients, without a prescription. A PGD is defined by the Human Medicines Regulations (2012) as a 'written direction that relates to the sale, supply and administration of a description or class of medicinal product'. A PGD enables named, authorised, registered health professionals listed in Schedule 16 of The Human Medicines Regulations, which includes paramedics and nurses, to administer a parenteral medicine for which there is not another exemption to a pre-defined group of patients. The provider reviewed records of patients prescribed medicines under a PGD however; they did not have a formal audit process to ensure paramedics worked within the scope of their role.
  - The provider had a medicines policy and procedure, which we reviewed and found was fit for purpose.
  - We reviewed nine staff records and found 100% had received mandatory training in handling medication and reducing drug errors.
  - The provider stored oxygen and nitrous oxide (Entonox, a medical analgesic gas) in cylinders at the headquarters. We saw cylinders were stored in locked cages in ventilated areas.
  - We reviewed the medical gas cylinders on the five vehicles we inspected and found the servicing and calibration of the gas flow meters was in date. Gas cylinders were in good condition, appropriately filled and secured safely on the ambulances using appropriate straps.
  - Staff replenished medical gases with a local provider. Oxygen cylinders remained in the locked ambulances and cylinders were out of sight in line with guidance from the British Compressed Gases Association Medical Oxygen in a Vehicle 2015.

## Records

- Staff accessed appropriate records in relation to patient transport needs. The local NHS trust, private hospital, or other customer gave the provider the details of the patient needs at the time of booking.
- Ambulance staff transported patient medical records with the patient. However, these always remained with the patient and never returned to the headquarters. Staff explained that during transport, they stored patient records out of site, in a locked cupboard within the ambulance to keep the records from public view. Local hospitals usually sealed patient medical records in an envelope; these ensured patient records remained secure and out of site during transfer to another hospital.
- The provider stored transport booking forms and patient records at their home address in locked cabinets. No confidential records were stored within the headquarters for more than 24 hours. The provider told

# Patient transport services (PTS)

us if the headquarters was locked when staff returned from a patient transport journey, the patient records were locked in the ambulance overnight. We raised this during the inspection, as we were not assured records were stored securely at all times.

- Following the inspection, we observed the provider had fitted a locked internal paperwork box on the station wall. This was situated behind an internal locked door. The provider told us no patient records were left on a vehicle since this action was taken within one week of our inspection.
- The provider did not complete an audit of journey times however, staff made them aware if there was a delay and they would inform family or professionals as required.
- We spoke with the staff about the use of do not attempt cardiopulmonary resuscitation (DNACPR) forms. Staff told us that NHS trust staff would inform them if a patient had a DNACPR in place and the relevant paperwork would be with the patient during transportation. Staff said they would support the patient in line with the DNACPR and, should they deteriorate during the journey, make them comfortable and transport them to the nearest emergency department.

## Assessing and responding to patient risk

- The provider did not have a documented procedure for staff to follow in the event of a deteriorating patient. We spoke with three staff about deteriorating patients, all three knew how to respond to a deteriorating patient and escalate their concerns. Staff clearly described the actions they would take including providing first aid and diverting to the nearest accident and emergency unit, or by requesting emergency ambulance services as required. A list of emergency department addresses was available in each patient transport vehicle.
- The provider completed a patient booking form over the telephone with the customer booking the service to assess patient needs around mobility, medication needs and mental capacity. In all cases, ambulance staff would carry out an assessment of the journey and the patient needs to ensure the journey was safe to commence.

- PTS staff carried out their own pre transport observations of the patient to ensure the patient was safe and fit to travel before agreeing to transport them.
- For privately funded patient journeys, the provider risk assessed the patient and the journey in advance using information taken from the patient or family member at the time of booking. For example, how mobile they were, what medications they took, and if they had capacity. This ensured the appropriate grade of ambulance staff were allocated to complete the journey.
- Medical cover plans and risk assessments were agreed with contractors in advance of events work. The plans outlined the scope of work completed by the provider during events, and the roles and responsibilities of staff when completing emergency transfer work. A skills matrix confirmed the grade of staff who would accompany patients during transfer to a local NHS hospital should an emergency transport journey be required. Staff were allocated according to the assessed level of patient risk.

## Staffing

- The provider was the registered manager and employed ten other staff on casual, self-employed contracts. The staff included the operations manager, three emergency care assistant (ECAs), four ambulance and two paramedics.
- The provider also employed agency staff on an ad hoc basis if required. The provider completed necessary checks with the agency to confirm staff had the required competencies, documents and qualifications for the roles.
- The provider offered patient transport services 24 hours a day, 365 days a year including evening and weekends.
- The provider had oversight of the PTS bookings and booked casual staff onto shifts based on demand a month at a time.
- The provider aligned staff to PTS bookings based on the patient acuity and the skills and experience of the staff member.
- At the time of our inspection, the provider explained they had no issues with staff sickness or retention, due to the casual nature of the work. The provider requested

# Patient transport services (PTS)

staff availability for a month in advance, which allowed them to create a rota and plan cover for any sickness absence and ensure staff were available to cover any bookings received.

## Anticipated resource and capacity risks

- The patient transfer services (PTS) formed a small proportion of the business. We asked the provider for details of the number of planned PTS journeys completed each month from March 2017 and March 2018. The only information provided by the registered manager confirmed six planned PTS journeys were completed in April 2017, and seven planned PTS journeys were completed in August 2017. This represented 4% and 2% of business respectively, with the remaining work attributed to events, medical repatriations and sports meetings. The majority of work was out of CQC scope however, emergency transfers from events were in scope. During April and August 2017, one unplanned emergency patient transfer journey was completed in each month. From January to October 2017, PTS planned journeys accounted for an average of 8% of the provider's overall business. This was not the main source of income or demand for the service.
- The provider did not hold contractual agreements with a local NHS trust for PTS and the service took bookings on a regular and ad hoc basis.
- The provider recognised loss of income was the biggest risk to the service and planned to grow the business gradually to minimise risks. There was no written plan however; the provider had an informal verbal plan that included the purchase of new vehicles to develop services.
- The service had no anticipated resource and capacity risks as all PTS staff were on zero hour contracts. The service planned journeys in line with staff availability.

## Response to major incidents

- The provider had no agreements with the local NHS trust to provide any emergency cover in the case of a major incident.
- Detailed medical cover plans, informed by risk assessment, were provided to contractors for work carried out at events. We observed one plan, which set out clear processes and procedures to be followed in

the event of a major incident or mass casualty. The plan outlined the provider's roles and responsibilities in relation to supporting a local NHS trust with emergency transport journeys. The provider informed the local NHS of their attendance at large events.

- We observed the fire safety risk assessment was detailed and reviewed annually and was last reviewed in January 2018.

## Are patient transport services effective?

### Evidence-based care and treatment

- The service provided patient care in line with current legislation and best practice guidelines.
- The service had policies and procedures that referred to national guidance and best practice, such as guidance issued by the Department of Health. However, most policies were not service specific, which meant some guidance was not easy to follow. The conflict of interest policy, procedure for the prevention of occupational exposure to blood, capacity to consent, and risk identification policies referred to personnel such as senior managers, divisional managers and supervisors, and executive directors who were not employed by the service. The infection prevention and control policy did not clearly describe the process to follow to clean surfaces and with which cleaning product.
- The provider did not have a policy to set out time frames for the review of policies however, we saw policies were version controlled, contained the date of issue, and the date of review on the front cover.
- Staff signed a form to confirm they had read and understood policies. The policies were stored in paper format in a file in the ambulance headquarters, and also in a secure electronic portal meaning staff could access them at all times.

### Assessment and planning of care

- The provider carried out assessment of patient care, based on information provided over the telephone and ambulance staff would re-assess the patients' needs at the point of collecting patients.

# Patient transport services (PTS)

- If staff had any concerns in relation to meeting patients' needs, they told us they would contact the provider for guidance.
- The provider used a comprehensive booking form for private patient transfers. The booking form covered patient mobility, capacity, and medication requirements, and do not attempt cardiopulmonary resuscitation (DNACPR) status. This meant the provider was aware of patient needs before the journey and could plan for the journey and staff appropriately.
- The provider carried fresh bottled water on its vehicles, to support patient hydration when it was safe to do so. Staff told us that patients often brought their own drinks. The provider would factor in regular comfort and meal breaks for those private patients travelling significant distances.
- Staff told us before they returned patients to their homes, they checked at the time of booking that they had something to eat and drink before they collected them.
- We reviewed induction records for eight members of staff and saw all records contained certificates of disclosure and barring (DBS) clearance, driving licenses and qualifications. The provider ensured all staff received subsequent DBS checks every year.
- The provider checked the staff driving licences on joining the service, and then every three months throughout the staff members' employment, to ensure they had not received any penalty notices for driving offences, and were still eligible to drive.
- The provider requested staff completed first aid, medicines or ECG questionnaires appropriate to their role at the time of interview. This enabled the operations manager to identify where learning or refresher training was required to support continued professional development. (CPD). We observed completed questionnaires in staff files and reviewed during appraisal.
- Drivers completed an initial driver assessment with the provider during the induction to the service. The registered manager and operations manager observed staff driving skills when they were part of the ambulance crew, and fed back verbally to staff on their driving standards.
- The provider checked with an agency that staff were competent for their roles before employing them for work. They checked the Health and Care Professionals Council (HCPC) register to ensure paramedics were authorised to practice and ensured competencies had been verified by the agency.

## Response times and patient outcomes

- Due to the nature of the service, staff often only transported patients once and as a result did not keep records in relation to the outcomes of patient care and treatment.
- Ambulance staff kept detailed records of response times during the patient journey, this included the vehicle call time, arrival time and departure time. The provider was made aware of the reasons for delays in journey times and ensured patients, their families, and service providers were kept informed to ensure the service was meeting the needs of the contract and the patient.

## Competent staff

- We reviewed nine staff files, which showed that staff had received an appraisal within the last 12 months. The provider kept a paper spreadsheet to record the date staff had received an appraisal and the date the next one was due.
- All staff entering the service completed a comprehensive induction process, including orientation within the ambulance station, key health and safety details, and specific training, for example safeguarding adults and children.

## Coordination with other providers

- The provider accepted ad hoc patient transfer journeys with the local NHS trusts, private hospitals, companies, and individuals and communicated with them as required to agree the scope of work.
- The provider communicated by telephone with contractors to assess patient needs before transporting them.
- PTS staff communicated with staff caring for the patient at the pick up location before transporting patients.
- The provider used booking forms from patient carers and family to assess patient needs before transporting them.

# Patient transport services (PTS)

## Multi-disciplinary working

- The provider's ambulance staff team liaised with contractors, for example the operations director, to deliver patient journeys appropriately. Staff contacted professionals at the patient's destination to inform them of any change to arrival time to support a co-ordinated approach to the delivery of care.
- The provider's ambulance staff team worked with staff at the patient pick up location to discuss patient needs and effectively plan the patient journeys to meet individual needs.
- Staff recorded details of the patient's journey in patient care plans as a record for their carers when returning patients to their homes. For example, if they had eaten or taken any medicines.
- The provider engaged with local NHS hospitals and ambulance providers when arranging events cover. This alerted the local hospital that a large event was taking place and that the provider was on site to support communication should an emergency situation arise.
- The provider had an up to date MCA and DoLs policy and all staff completed training in mental capacity and consent, during induction and annual refresher training. Data supplied by the provider showed 100% staff compliance was achieved during 2017/8.
- We spoke with two members of staff regarding the mental capacity act and both staff knew how to support patients to make day-to-day decisions.
- The service had an up to date policy on consent that included definitions and guidance on assessing capacity and specific situations where consent may be more complex, such as in the case of patients presenting with disturbed behaviour. Staff we spoke with had not experienced a situation when a patient refused to give consent for either treatment or a patient transport journey. If consent was declined, staff would not transport the patient but would inform the contracting service and registered manager immediately.
- Staff sought verbal consent from patients who required emergency treatment and transport from an event to a hospital. When children were assessed by a healthcare professional as having sufficient understanding of what was involved in a transfer, direct consent from the child was sought.

## Access to information

- Staff maintained contact with the provider by designated work mobile telephones, and ambulances had on board satellite navigation systems.
- Staff received patient details from family members or carers at the time of booking a private patient journey. We reviewed one patient booking form and found it to be comprehensive, including the patient mobility, mental capacity and medication needs.
- The provider communicated with staff via text, email or a group social media forum however, no staff meetings were held to share regular information. The provider and operations manager frequently worked alongside staff members during patient transport journeys and at events. Staff were updated with new company information as required to deliver safe patient care.
- The provider told us staff received patient information via an encrypted text message system on work mobile phones only, and staff deleted text messages immediately after reading to protect patient confidentiality.

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

## Are patient transport services caring?

### Compassionate care

- We did not observe the provider carrying out any episodes of patient care or interaction.
- PTS staff spoke with hospital staff, carers and family members, and other providers about patient needs before transporting them.
- We reviewed seven sets of written patient feedback in the provider's complaints and compliments file. Comments from patients included, "Friendly and very professional," and "Thank you for your dedication and commitment for a smooth transfer." One relative wrote "Thank you for a fantastic service ...you instilled calm and confidence in us both and made a traumatic situation easy to bear." Four sets of feedback stated that they found the service over and above what was expected.

# Patient transport services (PTS)

- Most vehicles were fitted with blackout windows that ensured the privacy of patients' being transported.
- One staff member told us they used additional blankets stored in the vehicles for patients who were being transported by stretcher to ensure their privacy and dignity.

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

- PTS staff told us they were dedicated to providing a service that involved the patients at all times. Staff involved patients in planning stops on longer journeys and ensured they understood their location and plans at all times.
- The provider ensured specific patient requirements were recorded at the time of booking and shared with PTS staff to meet their needs.

## Emotional support

- We were unable to observe staff interactions in relation to emotional care, but staff told us they would provide emotional care if this was required.
- We spoke with PTS crews who showed a respectful understanding of the impact a patient's care, treatment or condition had on their wellbeing and on those close to them.

## Supporting people to manage their own health

- Staff would support patients on long journeys to take their own medication when required.
- The provider explained if patients or family members asked for advice or guidance during the journey, staff would advise them to speak to hospital or medical staff.

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

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

- The provider planned and delivered patient transport services to meet the needs of local people. The service provided PTS ambulances with wheelchairs, high dependency ambulances, and full emergency ambulances to intensive treatment standards. The

vehicles were also incubator capable with integrated electrical systems and pipeline air. This meant the service could transport and treat babies in an incubator within a safe environment.

- All drivers were trained to Institute of Health Care Development (IHCD) blue light standards, meaning they could respond to patients who required transport in an emergency.
- All staff were trained to support patients with mental health needs and the staff skills mix meant the provider could meet the needs of all NHS and private patients.
- The facilities and premises were appropriate for the services delivered.
- At the time of our inspection, the provider was planning to increase the fleet of vehicles to grow the PTS side of the business.

## Meeting people's individual needs

- The provider did not have access to a translation service but staff used IT applications to access word translation services.
- As part of induction process, staff received training on how to recognise and effectively manage any challenging behaviours, and in reducing the use of restraint.
- Some vehicles had ramp access for patients who used a wheel chair or were on a stretcher. The vehicles did not have specific equipment to transport bariatric patients.
- The provider told us at the time of booking, they would prompt services to review if a patient required anti-emetic (anti-sickness) medicine when a long patient journey was required.
- Staff told us they would record on the booking form the preferred name a person liked to be called, and ensure PTS staff were made aware.
- Two PTS staff told us they make sure that patients using services are able to find further information about their care and treatment by liaising with NHS trust or private hospital staff on their behalf.

## Access and flow

# Patient transport services (PTS)

- The provider had oversight of the private bookings allocated to them. The provider only took bookings for days when they had staff and vehicles available to fulfil the needs of a booking.
- Private patients made bookings for PTS over the telephone and the provider told us they would signpost to another service if they did not have capacity to meet the booking. However, the provider told us they could provide a service for most bookings and used agency staff when required.
- Patients could access the service at times that suited them 24 hours a day, 365 days of the year. The business had staff of all grades, which meant patients with different health needs could access the service.
- Ambulance staff kept records of response times during the patient journey, this included the arrival time at the ward and departure time. The provider used these times to ensure the service was meeting the needs of each contract and to ensure patient journeys provided patients with a positive experience.
- The provider told us the work was variable and some days were busier than others. Agency staff were employed as required to meet service demand.

## Learning from complaints and concerns

- The provider had a complaints policy. The service had not received any complaints since it registered with the CQC.
- We saw information about how to make a complaint available in the vehicles we inspected.
- We spoke with two staff during our inspection; both of them knew what would constitute a complaint, the provider's complaints process including how to deal with complaints, and the importance of escalating complaints to the provider.

## Are patient transport services well-led?

### Leadership of service

- The registered manager led and managed the service with the support of the operations manager. The two roles coordinated the business delivery as well as managed staff whilst ensuring quality checks, training and effective staff deployment took place.

- The registered manager spoke with staff at the start or end of every shift. In the registered manager's absence the operations manager fulfilled this role. Staff we spoke with told us the registered manager was supportive and visible and that they frequently worked alongside them.

### Vision and strategy for this core service

- The registered manager and operations manager told us they had a vision to grow the business in a carefully planned and methodical way. The vision was underpinned by the provider's values that aimed to provide a passionate, personal and safe service at all times. The longer-term strategy included engagement with NHS PTS contracts, alongside an increased fleet of vehicles, although there was no written strategy.
- We spoke with the registered manager about their core values and they explained they expected staff to treat patients with dignity, respect, and high quality care. The provider was passionate about patient safety and welfare, and written organisational values of quality, experience and commitment were in place. The operations manager told us they were proud of the company's reputation that was built on from the values they held.
- All the staff we spoke with said they wanted to ensure they provided patients with a good experience during their journey. Staff were aware of the provider's values and told us they aimed to provide high quality care at all times.

### Governance, risk management and quality measurement

- The provider had variable governance processes in place, for example there were systems to monitor staff appraisal, staff disclosure and barring service (DBS) compliance, and staff training. However, there was a lack of systems and process to implement service specific policies for example, with ensuring all policies referred to the correct organisational structure and processes to be followed. The safeguarding children and vulnerable adult's policy did not provide concise referral information. The provider did not have a deteriorating patient policy in place.

# Patient transport services (PTS)

- The incident reporting policy was not service specific and we were not assured staff recognised what constituted an incident or reported incidents when required.
- There was no system in place to manage the audit process or action plans to develop service improvements. The provider did not complete monthly audits for example infection, prevention and control (IPC), vehicle cleanliness or environmental cleaning, to monitor or improve the quality of the service.
- There were no formal staff meetings to raise and discuss governance issues however, the registered manager and operations manager shared information verbally during working shifts. The provider and operations manager often worked alongside staff and regularly communicated with them to share information and to observe practice to contribute to service developments. They fed back verbally to staff during or at the end of a shift and reviewed staff progress within the appraisal process.
- The provider did not have a formal risk register in place however, they were able to articulate the risks to the business, such as vehicles being off the road, staff sickness, or in the event of the registered manager and operations manager becoming unwell. We were not assured however, the provider had a process in place to systematically review and mitigate all risks.
- Recruitment procedures were in place to ensure that all staff were appointed following a robust check of the suitability and experience for the role, together with pre-employment checks having been carried out.
- The provider had a robust system in place to ensure vehicles were re-stocked, faulty equipment was brought to their attention, and that staff were held accountable for the cleaning of vehicles.

## **Culture within the service**

- Staff described a positive working culture and a focus on team working, saying they could approach the manager or supervisor at any time to report concerns.
- Staff we spoke with during our inspection described the service as a positive place to work. Staff described a culture focused on meeting patients' needs and ensuring they completed their work to a high standard.

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

- The provider had no formal process for staff engagement. However, the provider encouraged staff to feedback on the quality of the service. Staff told us they would inform the registered manager if a patient transport journey did not run smoothly to support service improvement.
- Two staff members told us they fed back to the manager at face-to-face meetings before or after a shift, and during appraisal.
- The provider encouraged staff to seek feedback from patients. We reviewed seven sets of patient feedback and found the feedback to be positive including the professionalism of staff.

## **Innovation, improvement and sustainability**

- During the previous 12 months the provider had employed a trainee ambulance technician who completed their training and was now a self-employed technician. This increased the number of PTS technicians to four.
- The provider was in the process of creating a business plan to increase the size of the ambulance fleet and to work towards having PTS NHS contracts.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital **MUST** take to improve

- The provider must ensure staff understand what constitutes an incident and that all incidents are reported, analysed and learning is shared.
- The provider must develop governance processes to complete audits and analyse the outcomes to contribute to service developments.
- The provider must ensure there is a system in place to review and mitigate all business risks.
- The provider must ensure systems and processes are in place to ensure policies are service specific, contain accurate guidelines, and that staff have understood and read them.

- The provider must ensure the safeguarding children's and vulnerable adult's policy includes accurate referral information.
- The provider must ensure staff have a documented policy and procedure to follow in the event of a deteriorating patient.

### Action the hospital **SHOULD** take to improve

- The provider should ensure all confidential information and patient records are stored safely and securely at all times.
- The provider should consider holding staff meetings to share information.
- The provider should ensure cleaning fluids and electrical items are stored safely.

## 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  Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>How the regulation was not being met:</b></p> <ul style="list-style-type: none"><li>• The service did not have systems and processes in place for comprehensive local audit schedule to assess, monitor and improve different quality and safety aspects. There were no individual audits around IPC and vehicles.</li><li>• The service had no methods of recording, reviewing or managing risks.</li><li>• The service did not ensure staff understood what constituted an incident. No incidents had been reported since registering with the commission. There were no opportunities to identify themes and trends in incidents in order to effectively monitor and reduce incidents.</li><li>• The provider did not ensure policies and procedures were service specific. Most policies referred to a different organisational structure and were not easy to follow.</li><li>• The provider did not ensure the safeguarding policy contained all relevant referral information.</li></ul>