# The Limes Training Centre

## Quality Report

Deacon Road
Lincoln
LN2 4JB
Tel: 01522531112
Website: www.nigel@singleton-associates.org

Date of inspection visit: 4 November 2019
Date of publication: 16/01/2020

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

## Ratings

| | |
|---|---|
| Overall rating for this location | Requires improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Requires improvement |
| Are services caring? | Not sufficient evidence to rate |
| Are services responsive? | Not sufficient evidence to rate |
| Are services well-led? | Requires improvement |

### Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Limes Training Centre is operated by Mr. Nigel Owen Singleton. The service mainly provides care and treatment within the confines of public event site cover which is not a regulated activity. However, the provider does occasionally transport patients off site to other local healthcare providers and as such requires registration with the Care Quality Commission. This regulated activity is reported under emergency and urgent care services.

The service has had a registered manager in post since registration in 2015.

We inspected this service using our comprehensive inspection methodology. We carried out the announced inspection on 4 November 2019. We were unable to observe delivery of the regulated activity during our inspection.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? We were unable to rate caring as we didn't see any regulated activities being carried out and was not able to see feedback related to regulated activity.

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

This is the first time we have rated this service. We rated it as **Requires improvement** overall.

- The provider did not ensure all staff completed mandatory training. The safeguarding systems and processes within the service did not reflect up to date legislation and guidance. Recruitment practice within the service did not consistently meet the provider's policy. Equipment checks were not carried out consistently. Staff did not always have effective systems to assess risks to patients fully and act on them. Storage of medicines, including gases, was not always in line with current legislation. Understanding of what constituted an incident was not understood by all staff.
- Audits into clinical care, patient report forms, hand hygiene and medicine management had not been undertaken. Policies did not have clear document control with updated review dates. Many were past their documented review date. The service did not always make sure staff were competent for their roles. Managers appraised some staff's work performance to provide support and development. The provider did not provide training on the Mental Capacity Act 2005 or the Mental Health Act 1983. However, all staff we spoke with told us how they would support a patient suffering from a metal health crisis.
- The service did not have systems and processes to manage all risks and performance issues. Leaders operated governance processes but there were not always effective. All staff were committed to continually learning and improving services but there was no evidence to support this. The service did not have a vision for what it wanted to achieve.

However, we found the following areas of good practice

- Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean. The design, maintenance and use of facilities, premises and vehicles kept people safe most of the time. Staff managed clinical waste well. 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 kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

# Summary of findings

- The service provided care and treatment based on national guidance and evidence-based practice. Staff assessed and monitored patients regularly to see if they were in pain. All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders had the skills and abilities to run the service. They were visible and approachable in the service for staff. They supported staff to develop their skills and take on more senior roles. Leaders actively and openly engaged with patients and staff to plan and manage services. The culture was described as open and honest and the registered manager was approachable, supportive and visible. A whistle-blowing policy was in place to support staff to raise concerns without fear of retribution. The provider had started a social media group which had 28 members at the time of inspection from different services to communicate in the event of a major incident or issue locally.

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. We also issued the provider with three requirement notices that affected urgent and emergency care. Details are at the end of the report.

**Heidi Smoult**

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

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Emergency and urgent care** | Requires improvement  | The Limes independent ambulance service provides first aid cover for events and transfer from site to another provider if ongoing care is required. First aid cover at events was not inspected as this aspect of care is not currently inspected as part of the CQC regulation. Care of patients during transfer to other healthcare providers was inspected as part of urgent and emergency services. The service carried out one urgent and emergency care patient journey from September 2018 to September 2019.<br>We have rated this service as requires improvement overall. The provider did not ensure that all governance and risk management processes and procedures were in place to meet the needs of patients and make improvements to the service. |

# Summary of findings

## Contents

Requires improvement

# The Limes Training Centre

**Services we looked at Emergency and urgent care**

# Summary of this inspection

## Background to The Limes Training Centre

The Limes Training Centre is operated by Mr. Nigel Owen Singleton. The service has been providing event medical services for approximately eight years. The service registered with the Care Quality Commission (CQC) in 2015. It is an independent ambulance service in Lincoln, Lincolnshire. The service primarily serves the communities of Lincolnshire and provides services across England, Scotland and Wales.

The Limes Training centre has one employed member of staff, who was the registered manager and owner of the service. Other staff working in the service are either self-employed sub-contractors or salaried staff who are employed within the provider's second business. All staff work in an as required ad hoc way.

Throughout the report when staff are referred to, it means both salaried and sub contracted self-employed staff unless otherwise stated.

The service has had a registered manager in post since 2015 when it was required to register with the CQC.

## Our inspection team

The team that inspected the service comprised of a CQC lead inspector,one other CQC inspector and a specialist advisor, with experience as a paramedic. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

## Information about The Limes Training Centre

During the inspection, we visited The Limes Training Centre. We spoke with five staff including, emergency medical technicians, first aiders and the registered manager.

The service mostly covers non-regulated events providing first aid services.

Due to the limited amount of regulated activity taking place at this service we were unable to speak with patients and/or relatives. During our inspection, we reviewed the one set of patient records that were within the regulated activity and inspected four vehicles.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's second inspection since registration with CQC.

Staff are either subcontracted from the providers training business or are self-employed contractors.

We have inspected the location once previously in January 2018, at that point we regulated independent ambulances but did not rate them as part of our regulatory process. At the last inspection we issued two requirement notices, which were:

- The provider must take prompt action to ensure all self-employed staff has a valid Disclosure and Barring Service (DBS) check
- The provider must take prompt action to ensure all sub-contracted staff, employed by the service, have two references provided in line with the provider's recruitment policy.

The providers recruitment practices had improved at the inspection in November 2019, however the recruitment policy was still not applied consistently.

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

# Summary of this inspection

- Treatment of disease, disorder or injury.

With the exception of the registered manager there were no staff directly employed by the service.

**Activity**

The activity for the service between September 2018 and September 2019 as:

- one emergency and urgent care patient journey.

**Track record on safety**

The track record on safety for the service between September 2018 and September 2019 was:

- Zero Never events.
- Zero patient safety incidents and zero vehicle incident.
- Zero serious injuries.
- Zero complaint.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Are services safe?** | **Requires improvement** |
| **Are services effective?** | **Requires improvement** |
| **Are services caring?** | **Not sufficient evidence to rate** |
| **Are services responsive?** | **Not sufficient evidence to rate** |
| **Are services well-led?** | **Requires improvement** |

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Emergency and urgent care** | Requires improvement | Requires improvement | Not rated | Not rated | Requires improvement | Requires improvement |
| **Overall** | Requires improvement | Requires improvement | Not rated | Not rated | Requires improvement | Requires improvement |

Requires improvement

# Emergency and urgent care

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Requires improvement |
| Caring | Not sufficient evidence to rate |
| Responsive | Not sufficient evidence to rate |
| Well-led | Requires improvement |

## Are emergency and urgent care services safe?

Requires improvement

This is the first time we had rated this service. We rated it as **requires improvement**.

**Mandatory training**

**The service provided mandatory training in key skills including the appropriate level of life support training to all staff. However, they did not ensure everyone completed it.**

Mandatory training was delivered at weekly training sessions with subjects identified for a whole year. During our inspection, we saw the mandatory training schedule which included identified training sessions until December 2019. Staff who needed to update were allocated a session to attend. However, self-employed staff attended voluntary as they were not paid. All training sessions were also available on the staff section of the company's website for staff to access at any time.

The registered manager advised they would accept mandatory training if received by staff at their substantive employer or a recognised provider. However, they were required to bring in certificates of attendance at the training to the registered manager, so they could be placed in personal files as proof of training. We did not see any evidence of this within the files that we reviewed. The providers processes for checking evidence of training was ineffective.

The mandatory training was comprehensive and met the needs of patients and staff. The providers mandatory training programme related to eight modules in essential safe subjects. It included health & safety, manual handling, infection prevention and control, safeguarding, mental health, basic life support, automated external defibrillator (AED) use, and clinical manual handling. The frequency of training varied from annually to three years dependent on the subject. For example, life support, use of AED and infection prevention and control was scheduled annually. Training on clinical manual handling was scheduled to be completed every three years.

Managers monitored mandatory training. Mandatory training was monitored using a spreadsheet which was updated manually, this showed that not all staff had completed appropriate mandatory training. During our inspection we reviewed five staff personal files and four showed staff were not up to date with mandatory training.

The provider did not have a target for completion of mandatory training and did not formally monitor uptake of training or take action if it was not completed.

The training available covered a wide range of subjects and included scenarios. For example, the training included how to deal with specific medical conditions and emergencies, general data protection rights (GDPR), clinical observations training, breakaway training, mass casualty exercise, child exploitation and counter terrorism. Multimedia presentations for each training session were uploaded to the service's website for all staff to view.

Not all drivers had undertaken a driving assessment. During the last inspection in 2018, competency of staff

driving for the provider was not assessed. Since then we have seen improvements. We reviewed 18 staff records and saw nine staff had completed a drivers' assessment carried out by the registered manager. The completion of the drivers' assessment was ongoing.

Emergency response ambulance driving using a blue light was not provided or undertaken by the staff. If an urgent transfer of a patient was required staff told us they would call the NHS ambulance service.

**Safeguarding**

**Training undertaken by staff and the policies did not reflect up-to-date legislation. Staff received training on how to recognise and report abuse and understood how to protect patients from abuse.**

The safeguarding training provided to staff was not up to date and referred to out of date authorities. For example, training slides advised that a concern should be reported to the Independent Safeguarding Authority, which was replaced by the Disclosure and Baring Authority in 2012 and did not refer to the guidance 'Safeguarding Children and Young People: roles and competencies for health care staff intercollegiate document 2019" (intercollegiate guidance).

The provider told us that they would not undertake regulated activity for children and young people and would contact the NHS to carry out transfers if required. Staff were trained to the appropriate level as advised by the intercollegiate guidance at level two if transfer of children and young people were not undertaken.

The service had a safeguarding policy issued in 2019 which was accessible to staff through the provider's intranet site. However, the policy was not comprehensive. For example, it did not refer to intercollegiate guidance or define what level of training staff required.

The service had a child protection policy separate from the safeguarding policy which was issued in 2019 but there was no review date. The policy included types of abuse, how to recognise and how to report it. It detailed how to deal with allegations of abuse, who to report it abuse to and contained relevant contact details.

Staff received provider led training in safeguarding during their induction, when they started working with the service and when receiving updated mandatory training. All staff we spoke with understood what abuse consisted of and had knowledge of female genital mutilation, child exploitation and modern-day slavery.

Staff had a clear understanding about what constituted abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and told us how they would work with other agencies to protect them.

Staff told us they would contact the event organisers safeguarding lead and the provider if they believed a patient was at risk. If they believed there was immediate danger, they would contact the police.

The service had a lost children or vulnerable adult policy, which was issued in 2018 but it had no review date. The policy outlined the process to be undertaken in the event of a lost child or vulnerable adult telling them they were lost or someone reporting they have lost someone who was with them.

The service had not reported any safeguarding incidents when attending patients being conveyed to hospital from an event.

The registered manager was the lead for safeguarding within the organisation and was trained to level three. The intercollegiate guidance states the safeguarding lead should be trained to level four in safeguarding. However, the service would be unlikely to require the expertise that is acquired at level four training and level three training was sufficient to ensure a safeguarding referral was made appropriately.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were clear on the requirements to report safeguarding concerns to the relevant local authority and said they would always escalate to the registered manager. Staff gave examples of how they had managed a safeguarding referral in the past.

The recruitment policy required all staff to have a clear enhanced disclosure and baring service (DBS) check and two references before they started working with the service. During our inspection we reviewed six staff recruitment records, four of which complied with the policy. One member of staff had one reference in the file

and one member of staff was awaiting a DBS check to be completed. The registered manager told us there was no risk assessment completed to ensure the member of staff, with no current DBS, was working safely.

The provider's ongoing checks for staff DBS checks were not robust. The provider's safeguarding policy states the company will complete DBS checks every three years for staff. However, the provider told us only two of the staff were now registered on the DBS update service that allowed applicants to keep their DBS up to date.

**Cleanliness, infection control and hygiene**

**The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.**

The provider had an infection control policy which was issued in 2018 but there was no review date. The policy gave guidance to staff about how to reduce the risk of cross infection and included national guidelines. For example, the policy included the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working in health care environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients.

We didn't see any care delivered to patients during our inspection. However, staff we spoke with told us how they followed infection control principles including the use of personal protective equipment (PPE). All staff completed infection prevention and control training when they started with the service and was included in their annual mandatory training. However, records showed not all staff were up to date with the annual mandatory infection prevention and control training.

Staff we spoke with could explain the infection control principles and when they would wash their hands and use PPE. This was in line with the provider's infection control and prevention policy. However, we do not know whether staff had been consistently compliant with policy as the service had not completed any hand hygiene audits.

Cleaning schedules which indicated how to clean ambulances and kit bags were available. However, cleaning records confirming cleaning that had been undertaken were not completed fully. During our inspection, we saw the service had carried out two six monthly infection control audits in January and June 2019. The audit included the ambulance station premise, vehicles, waste and sharps management and issues identified. We saw evidence actions had been taken to address the issues.

We inspected four ambulances during our inspection. All areas, including the cab, were visibly clean and tidy. Reusable equipment on the vehicle appeared visibly clean. Decontamination wipes, PPE and hand hygiene gel was available in all ambulances.

Initial cleaning of the ambulance and equipment with detergent wipes was carried out by staff immediately after a patient was treated. The ambulance was then deemed out of service until a more thorough clean was undertaken by a dedicated employee. A notice was placed in the windscreen stating the vehicle was out of use which was removed once it had been cleaned.

The provider had two mops, one for the toilets inside the ambulance station and one for the ambulances. Following our inspection, we were told that the mop heads were cleaned and disinfected after each use. However, we did not see recorded evidence of this or a replacement schedule.

The ambulances contained spill kits for body fluids with guidance on their use. Staff used decontamination wipes to keep the ambulance and equipment clean.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and vehicles kept people safe most of the time. Staff were trained to use them. Staff managed clinical waste well. However, not all equipment had been checked in line with policy.**

Ambulances and providers kit bags were restocked by a dedicated member of staff before each event using a checklist which identified requirements. Staff checked kit bags provided by the service to ensure all the equipment needed to deliver safe care was in place before each event.

However, the provider did not ensure consistency regarding first aid equipment. Staff could use their own

first aid kit if they wished too which included equipment they chose. This meant the provider did not always know what staff included in their first aid kit and therefore could not be assured they had the necessary equipment to provide safe care and treatment.

Observation kit checks were undertaken by the staff who used the equipment. This included checks of the blood glucose monitoring machine, pulse oximeter (to measure oxygen levels in a patient blood), thermometer and pen torch. However, during our inspection we saw routine tests had not been carried out on all equipment. For example, we saw checks that were due to be completed in July 2019 on a thermometer and pulse oximeter had not been undertaken. This was raised with the registered manager who dealt with the issue.

The provider did not have a record of blood glucose monitoring equipment checks to confirm the readings of a machine were accurate. The blood glucose testing strips were out of date with one machine. We told the registered manager about this and it was rectified immediately.

During our inspection, we saw a suction machine that had not been checked in line with policy. The provider told us the machine was out of use but there was no label or segregation of the equipment to indicate that. Therefore, we were not assured the machine could not mistakenly be used by staff.

Defibrillators were maintained according to the manufacturer's instructions. They were calibrated by the provider annually with appropriate calibration testing equipment. A safety check was also carried out prior to each event.

Consumables were stored on shelves in the store room and all equipment was kept off the floor. However, the top shelf was too high to reach without steps. The provider did have steps, but these were kept outside so not readily available. All consumables were stored appropriately in both the store room and on the ambulances. Following our inspection, the provider told us that stock on the top shelf is the least used to minimise manual handling.

The service had a record for the annual routine inspection of portable appliance (PAT) to check electric equipment safety. However, this was not up to date with items not tested within the appropriate time scale and included items of equipment that had not been in use since 2014. Following our inspection, the provider told us this had been rectified and the record had been updated, however we did not see evidence of this.

The service had enough suitable equipment to help them to safely care for patients.

The service had seven vehicles in use and each had been taxed, ministry of transport (MOT) tested and had appropriate insurance. Each ambulance had an individual file which included up to date records of maintenance, MOT testing and insurance. The provider confirmed that MOTs were booked a year in advance with a local garage. We saw evidence of bookings in the calendar.

The provider informed us any faults identified, either before or during an event, were reported immediately. If urgent or on the driver's vehicle log actions taken to rectify this were taken as soon as practicably possible. This included vehicle defects, problems with equipment and vehicle damage.

An ambulance crash and breakdown policy was in place which was issued in 2018. It did not have a review date. The policy was clear and informed staff of actions to be taken in the event of an accident or breakdown. It also contained contact details of those who needed to be called.

Each ambulance was equipped with a ligature cutter and a break glass hammer. Ligature cutters are specifically designed to safely cut a ligature attached to a person.

Staff stored vehicle keys securely when they were not in use. Keys were stored in cupboard in a locked room with only two people having keys to the locked room.

On inspecting the vehicles, most the consumable items were in date. We spoke with the registered manager about the small number of items out of date and the issues were resolved immediately.

A child harness was not available within the service, the provider told us they have never transported a child. Staff confirmed they would not transport a child and would contact the local NHS ambulance service to carry this out.

A mobile satellite navigation system was available in all ambulances. We were told the system was updated every six months. Staff also used an on-line tracking system available on a smart phone, so staff could be located.

The provider did not have a contract for removal of clinical waste. There was an informal agreement with a healthcare provider that the service could use their clinical waste service for the disposal of the small amount of waste generated. We were also informed in most cases the sharps and clinical waste were taken to the local NHS acute hospital and disposed of there. However, each ambulance had appropriate waste bags and sharps bins for staff to use. Sharps boxes were available for use in each ambulance which were dated, labelled and not overfilled.

**Assessing and responding to patient risk**

**Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments.**

Staff completed risk assessments for each patient on arrival and updated them when necessary and used recognised tools. Staff assessed patients against protocols laid down in the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical guidance. We saw evidence of this on the patient report form reviewed.

The service gathered information about patients, including any previous medical history and input the information on the patient report form (PRF). This included their name, age, known medical conditions, current medication, presenting problem and risk assessments. For example, pain score was undertaken to measure a patient's pain intensity and a Glasgow coma scale was completed to measure a patient's level of consciousness.

Staff knew about and dealt with any specific risk issues. Appropriate procedures were followed to assess and respond to patient risk, including appropriate responses to vehicle breakdown. Staff understood the need to call for assistance from the local NHS ambulance trust if a patients' weight was above a certain level to ensure appropriate equipment was available to provide safe care.

Staff shared key information to keep patients safe when handing over their care to others. A copy of the patients individual PRF was given to third party healthcare providers when handing over care to them. Handover confirmation details were included on the PRF, with a signature and date.

Crews can access specialist advice when on scene or in transit. Staff used the provider's website, which has a comprehensive range of clinical protocols available for staff to access remotely. Staff we spoke with also told us they would contact and liaise with the local NHS ambulance service if required.

The provider did not use a national early warning score (NEWS) to identify a deteriorating patient. NEWS involves taking a series of physiological observations, such as blood pressure, heart rate, temperature and level of consciousness to determine the degree of illness of a patient and prompt any intervention that is required. Therefore, we could not be assured staff would recognise and respond appropriately when there was a rapid deterioration in the health of a patient.

**Staffing**

**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. Managers regularly reviewed and adjusted staffing levels and skill mix.**

The service consisted of the registered manager as the only permanent member of staff. There were 21 staff who were either self-employed on an ad hoc basis depending on demand or sub-contracted from the provider's training business.

Staffing levels for events were decided by the event organiser at booking stage. The skill set, and level of resource provided by The Limes was requested by the organisers of events, having conducted their own risk assessment following Health and Safety Executive (HSE) guidelines. The level of requested resource cover could be challenged by the provider if necessary, but overall responsibility was with the event provider, as referenced

in the HSE guidance for medical event provision. The provider ensured that cover was sufficient to allow staff to convey patients safely from an event to a third-party provider if required.

The service had enough staff and support staff to keep patients safe. The provider had reduced the number of events covered to ensure they had enough staff to provide safe care. If the service was unable to staff an event appropriately they would decline to provide services for it.

The service did not use bank or agency staff. In the event of staff sickness, the service provided cover by booking another member of the self-employed staff.

**Records**

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

Patient notes were comprehensive, and all staff could access them easily. During our inspection, we reviewed one patient report form (PRF) as the service had only transported one patient within scope of their regulated CQC activity in the last 12 months. The PRF was clear, accurate, legible, up-to-date, comprehensive and complete. All staff could access them during the transfer to a new care provider.

Staff completed a PRF for each patient they attended. The record we looked at included full patient details, staff details, times of arrival at scene, observations undertaken, hospital transported to and who the member of staff transferring the patient was.

When patients transferred to a new team, there were no delays in staff accessing their records. A carbonated copy of the PRF was taken to the hospital with the patient when transporting them to an emergency department and given to the receiving clinician.

The provider had not undertaken any audits of the PRFs to check for compliance and quality at the time of our inspection as there had only been one record related to regulated activity.

Records were stored securely. Patients' PRFs were all scanned onto the computer system as soon as practicable following an event and paper records destroyed using a cross shredder.

**Medicines**

**The service used systems and processes to prescribe, record and administer medicines. However, storage of medicines was not always in line with current legislation.**

The service had a medicines' management policy, issued in 2018 but had no review date, however, there were elements which did not apply to the service. The policy made references to medicine legislation but did not make clear how those applied to the service in how they safely managed medicines. The medicines policy included reference to patient transport staff (PTS). The Limes are not providers of a PTS service. Therefore, this does not represent the service delivered by the provider. We spoke with the registered manager about this during our inspection and we saw evidence that the reference to the PTS service was removed.

The medicines policy was supported by administration policies for drugs, which had been completed with input from the clinical lead for medicines, who was a local GP. We saw evidence of the GPs General Medical Council registration number.

We found ambulance technicians were making the decision to treat patients with non-parenteral prescription only medicines. Whilst this practice is not supported by current legislation, an appropriate governance process was in place to assess and manage ongoing risk. Staff had undertaken appropriate training and were assessed as competent. This ensured people had timely access to safe treatment.

The service had a technician medication error reporting form in use. It was issued in 2018 but the provider told us there had never been any errors to report.

The service had a safe system for receipt of medications. Medications were issued to the appropriate staff by the registered manager. Supplies of medicines were issued to each technician and a receipt form was competed, which included name of receiver, batch number of drugs and

quantity received and returned. We saw evidence of a completed form. The technicians were responsible for their own drug stock and new supplies were issued once a drug had been used.

Over the counter medicines within the ambulance station were stored securely. Medicines were stored in a locked safe in a general store room. The building was alarmed and monitored by CCTV. The registered manager was the only person with a set of keys for the safe which were kept on their person at all times. A spare set of keys were stored securely off site.

Over the counter medicines, carried on board ambulances, were stored in a plastic box for use. Medicines remained on the ambulance indefinitely and were not removed overnight. However, the ambulances were stored in a secure compound when not in use.

Stock checks were not routinely carried out of medicines in the ambulance station safe on the three days it was staffed. We saw a medicine record book that showed when medicine had been issued and returned, this included the date and the details of the member of staff. The medicines record did not include the need for a signature or stock levels of medication in the safe. However, the provider did know what drugs and how many were in the safe at the time of our inspection.

The service had not carried out any audits around medicines management, storage, prescribing practice or administration.

Staff followed current national practice to check patients had the correct medicines. Staff we spoke with told us they followed the WHAM questions before administering any medications. The WHAM approach is a mnemonic (memory aid) for the questions asked if a patient requested an over the counter medicine at a pharmacy. The questions clarified who the medicine was for, how long symptoms had been present, allergies suffered by the patient and medication currently being taken.

The service had a stock control system for medical gases. The registered manager told us they ordered new supplies if they felt stock of full cannisters was low. This was on an ad hoc basis with no process to review requirements on a regular basis. However, the use of medical gases was minimal within the service and they had never had a problem with supply.

The medical gas cylinders were not stored in line with the Health and Safety at Work Act 1974 HTMO2 guidelines. They were stored in the general stock room, full and empty canisters were stored together, different gasses were not segregated, oxygen cylinders were stored with other equipment without ventilation at the top and bottom. The manufactures guidelines stated oxygen cylinders could be stored in suitable bag which the provider had interpreted to mean kit bags.

**Incidents**

**The service had a policy in place to manage patient safety incidents. No incidents had been reported. However, during our inspection we saw documentation relating to issues that constituted an incident that had not been reported as such.**

An incident reporting procedure was in place and had been issued in 2018 but it had no review date. The procedure identified what constituted an incident or a near miss, the reporting processes and paper reporting forms. A near miss is an event that might have resulted in harm, but the problem did not because of timely intervention by healthcare providers. However, the procedure did not include arrangements for feedback to staff, timescales and any process to be undertaken if an investigation was required. The provider told us if an incident occurred it would be discussed with individual staff, at the weekly meetings and details put on the secure staff website.

Each ambulance had a driver log which staff used to record issues encountered with the vehicle. There was no record of actions taken to resolve issues. During our inspection, we saw issues recorded including doors not closing on a vehicle and problems with the gears. However, the provider did not deem these reportable incidents. Therefore, we were not assured that all incidents were reported appropriately. This had not improved since our last inspection in 2018.

An incident report form was available in each ambulance and an online version was on the provider's website for staff to record, in detail, incidents involving patients, staff, equipment, drugs and 'near-misses'.

The members of staff we spoke with knew how to report an incident but told us they had not needed to report any.

Requires improvement

# Emergency and urgent care

No incidents had been reported in the 12 months prior to our inspection.

Staff understood the duty of candour. Staff we spoke with told us they would report anything that went wrong to the manager immediately and told us they would be open and honest if things went wrong.

The provider delivered training on duty of candour policy. The duty of candour is a regulatory duty that relates to openness and transparency. It 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 manager had a good understanding of the duty of candour regulation and what to do if something went wrong in the service.

## Are emergency and urgent care services effective?

(for example, treatment is effective)

Requires improvement

This is the first time we had rated this service. We rated it as **requires improvement.**

**Evidence-based care and treatment**

**The service provided care and treatment based on national guidance and evidence-based practice**

Staff followed policies to plan and deliver high quality care for some of the conditions most likely to occur at events according to best practice and national guidance. Staff used the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical guidance to inform clinical decisions and safe administration of pre-hospital medicines for pain relief.

Protocols for provisions of care most likely to be required were in place. For example, these included head injury, concussion and trauma. However, the provider did not have protocols for a patient who had a stroke or a heart attack.

Policies and protocols had been developed to reflect current best practice. There was not always a date in place to review and update policies as a matter of course or when practice changed. The policies had a date when first issued and some included a statement that they would be reviewed annually. Following our inspection, the provider told us all policies were reviewed in March 2019 and would be reviewed annually. However, we did not see any evidence of this.

The registered manager told us there was a system in place to ensure staff had relevant details for each event covered. This included the closest hospital with an emergency department to ensure timely access to acute services and the event organisers contact details.

Staff had access to guidelines and protocols using the secure staff section of the provider's web page, when working remotely.

The service did not transport any patients detained under the Mental Health Act,1983.

The provider had not undertaken any clinical audit to monitor care or prescribing practice. Only one patient had been transported to hospital in the previous year.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The patient report forms (PRF) included a section for recording a patient's initial pain score and subsequent reviews. A pain score was measured using a scale of one to ten, one being mild pain up to ten being severe pain.

Drugs for pain relief were limited to over the counter medicines. This included paracetamol and ibuprofen. All were utilised in accordance with the indications listed within the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical guidance.

The service did not have any analgesia available for the treatment of severe pain. Any patient experiencing such pain would be referred immediately to the local NHS ambulance service via a 999 call.

The service had processes to assess and manage pain when people had difficulties in communicating. For

example, a multi-language book was in use if English was not the patients first language and each ambulance had a pictorial prompt card available for patients unable to communicate by speaking.

**Response times/Patient outcomes.**

**In the 12 months before our inspection the service had only transferred one patient from an event to an emergency department.**

The registered manager stored the PRF for the patient transferred to other care providers with all relevant details included on line.

The provider did not monitor response times or have any targets to meet or participate in national audits or accreditation processes.

There were no formal service level agreements at the time of the inspection other than the contracts with event organisers.

Due to provider not having any formal arrangements with other organisations, they were therefore not required to collect or analyse patient outcome data. As the provider did not collect this data it was difficult to demonstrate their effectiveness at achieving positive patient outcomes.

**Competent staff**

**The service did not always make sure staff were competent for their roles. Managers appraised some staff's work performance to provide support and development.**

Following our inspection, we received evidence that a range of competency-based assessments were in place for the most likely emergencies. These included cardio – pulmonary resuscitation, chocking, allergic reactions and the correct positioning of a patient in the recovery position. However, following review of five staff records, we saw no evidence of completed competency assessments in personnel files.

Self-employed staff did not receive an appraisal or development review and we saw no evidence the provider sought copies from any primary employers. The service had systems to manage staff recruitment, however the processes were not always followed.

Managers supported salaried staff to develop through yearly appraisals of their work. The seven salaried staff had received an appraisal and staff we spoke with confirmed the appraisal had been constructive and supported their development.

The service had a process in place to ensure staff were in possession of a full driving licence and to annually assess driving skills. We saw evidence in staff files the annual driving assessments were underway but only 50% of staff had completed it. This was an improvement from our last inspection in 2018.

Managers gave all new staff a full induction tailored to their role before they started work. The service had an induction checklist for all new starters to complete. It included confirmation of essential training being undertaken and essential documents being reviewed. Evidence of completed checklists was present in the staff files we reviewed.

All new starters within the service had a probation period according to job role and experience. New starters worked alongside a more experienced member of staff for the period of their probation to support their learning. The probationary period was individualised for each new member of staff depending on experience and training requirements. However, there was no competency-based assessment of skills and knowledge undertaken to determine ability and safety at the end of the probationary period.

Competency based assessments had not been undertaken in all elements of care for staff working within the service. Staff could attend training at the weekly meeting and the provider confirmed this training had an element of practical work but did not assess competence. However, an annual assessment of basic life support was undertaken using a computerised mannequin, which analysed the effect of the intervention and identified any training needs.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings were scheduled at three monthly intervals for the year. They took place at the as part of the weekly meeting. Staff we spoke with confirmed that if they could not attend the team meeting the minutes were on the provider's private social media page.

Managers identified the training needs of staff and gave them the time and opportunity to develop their skills and knowledge. Staff we spoke with confirmed training was supported by the provider and opportunities were available to develop their skills and knowledge. For example, staff we spoke with, who were self-employed, told us how they had progressed within the company to become a trained emergency medical technician and how they planned to undertake the training in the near future.

The service had recently introduced self-mapping to salaried staff which enabled identification of individual training needs. To support this, the provider had joined skills for health. Skills for health is a nationally recognised online organisation that provides training to the healthcare sector.

Managers made sure staff received specialist training for their role. This included medical gas training, breakaway training, major incident and clinical training for a range of conditions. The training provided included scenarios and major incident practical training. Staff told us about training in major incidents that had been delivered.

The provider ensured paramedics, working within the service, had maintained professional registration by checking this annually. During our inspection, we saw records confirming the checks had been completed.

**Multidisciplinary working**

**All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.**

Staff transporting a patient were not able to pre-alert the receiving hospital in an emergency as the registered manager had no access to the direct numbers of hospitals but instead were able to ring 999 to tell the emergency services they were en-route and the condition of the patient.

We were not able to review the hand over process of a patient to an emergency department (ED) as we did not attend an event as part of the inspection process. However, staff told us the patient report form (PRF) would always be given to either the NHS ambulance service or the ED department when care was transferred to ensure safe care.

**Health promotion**

The service did not have any information available for patients to support health promotion.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

Whilst the service did not directly delivery training on The Mental Capacity Act 2005 or the Mental Health Act 1983, staff we spoke told us how they would support a patient suffering from a mental health crisis. Following our inspection, the provider told us that training on the Mental Capacity Act was planned for February 2020.

The service had a consent policy which was issued in 2018 but it had no review date. The members of staff we spoke with were able to evidence they understood the policy and how it related to their work.

Staff gained consent from patients for their care and treatment in line with some legislation and guidance. Staff we spoke with could explain how they would obtain consent verbally and reaffirm consent throughout any treatment.

Staff clearly recorded consent in patients' records. The PRF included a section to confirm consent had been gained. We saw evidence this was completed and staff we spoke with told us they would record consent in this way.

Staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care. The services consent policy included information about patient assessment for capacity and staff we spoke with told us what they would do if a patient lacked capacity. For example, they could describe what they would do if a patient was unconscious.

Requires improvement

# Emergency and urgent care

## Are emergency and urgent care services caring?

Not sufficient evidence to rate

We did not observe any care given to patients during our inspection. We were not able to speak to any patients who had received care as part of regulated activity from the service. Due to the limited evidence for caring we have not rated it.

**Compassionate care**

**Staff spoke about patients with compassion and kindness, showing they respected their privacy and dignity, and took account of their individual needs. However, we did not see any care given or speak to any patients.**

Staff spoke about patients with compassion and could show understanding of the personal, cultural, social and religious needs of patients and how they may relate to care needs.

**Emotional Support**

**Staff told us how they would provide emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

Staff spoke about how they would support patients to minimise their distress and how they would ensure cultural needs were met.

**Understanding and Involvement of patients and those close to them**

**Staff told us how they would support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff spoke about how they would involve patients and families to understand their conditions and make choices about their care.

## Are emergency and urgent care services responsive to people's needs?

(for example, to feedback?)

Not sufficient evidence to rate

We did not observe any care given to patients during our inspection and the service had only carried out one episode of regulated activity between September 2019 and September 2019. Due to the limited evidence for responsive we have not rated it.

**Service delivery to meet the needs of local people**

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

We were told the service offered a UK wide service to accommodate the needs of patients who required transfer from an event, for example a motocross event, to a local emergency department.

Delivery of the service operated on an ad-hoc basis. The registered manager arranged care delivery for events dependent upon need, risk assessment and discussion with the event's organisers.

Facilities and premises were appropriate for the services being delivered. The ambulances were able to convey patients who needed to travel on a stretcher and in a wheelchair.

**Meeting people's individual needs**

**The service told us how they would be inclusive and take account of patients' individual needs and preferences and make reasonable adjustments to help patients access services.**

All ambulances within the service were adapted to transport patients with physical disability or mobility problems. All ambulances were fitted with a ramp and could accommodate a wheelchair.

Staff we spoke with told us they would call the NHS ambulance service if they needed to transfer patients with bariatric needs. This ensured these patients were transferred safely using specialised equipment.

We were told that patients were able to carry personal belongings with them and these would be secured during the journey.

Requires improvement

# Emergency and urgent care

The provider told us that patients could be accompanied by a relative or friend when this was appropriate when being transferred to another care provider.

The manager made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. The service had a language book available in the most common languages spoken by the patients and local community. The language book was produced by a national organisation and included 36 different languages for use in an emergency. There were also details of how to access a telephone interpreting service if required.

Staff had access to communication aids to help patients become partners in their care and treatment. The service had a laminated picture board to aid communication on all ambulances for patients unable to communicate by speaking. Training had been provided to all staff in how to assist a patient experiencing a mental health crisis at the weekly training sessions. Staff we spoke with could explain how they would support a patient and get assistance from the NHS if required.

**Access and flow**

**We were told people could access the service when they needed it. However we saw no evidence of this during inspection.**

The service did not monitor response times and there are no targets to meet on access times. The provider told us staff were always available with the skills required depending on the type and size of events being covered to allow patients access to staff with appropriate skills in a timely way.

**Learning from complaints and concerns**

**It was easy for people to give feedback and raise concerns about care received.**

We did not speak to any patients, relatives and carers to confirm that they knew how to complain or raise concerns. However, the service gave out business cards to patients with a unique code which if scanned took people to the feedback page of the provider's website.

There were separate standard forms available for patients to make complaints about the service. Patient complaint forms were present on all ambulances.

The service clearly displayed information about how to raise a concern on the company's website. A complaint form was available by a dedicated link which was available to print off and return to the provider.

The provider reported it had not received any complaints since our last inspection in 2017. We were therefore not able to explore how complaints had been managed or assess any patient complaint themes.

The service had a complaints policy in place that was issued in 2018 but it did not have a review date. The policy set out the timescales for acknowledging receipt of a complaint, which was two working days, and providing a final response which was within 25 working days. However, we were unable to review if the timescales set out in the policy were met as no complaints had been received.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with told us they would support a patient or relative if they wished to make a complaint. They confirmed they would give them a form, a business card with a unique code or advise them to visit the company's website.

## Are emergency and urgent care services well-led?

Requires improvement

This is the first time we had rated this service. We rated it as **requires improvement.**

**Leadership**

**The leader had the skills and abilities to run the service. They were visible and approachable in the service for staff. They supported staff to develop their skills and take on more senior roles.**

The registered manager led the service and was also the only director of the organisation. They had significant experience of pre-hospital care with relevant training undertaken in the management of appropriate conditions. For example, we saw evidence of completion of sepsis awareness, safe administration of lifesaving medicines and first response emergency care.

The registered manager had been in post since the service was registered with the CQC in 2015.

The registered manager held the lead roles for the organisation for human resource, safeguarding, operations, corporate assurance, health and safety and clinical issues.

Staff members we spoke with told us the registered manager was approachable and knowledgeable. Staff felt able to raise concerns and told us any issues highlighted were discussed either with the staff personally or at the weekly meeting. We saw evidence of discussions on agendas and meeting notes.

**Vision and strategy**

**The service did not have a vision for what it wanted to achieve.**

There was no formal recorded vision and strategy for the service. However, the statement of purpose provided to the CQC when registering to provide a regulated activity described a patient focused approach to care for any patient who required assistance at an event.

A patient's charter was in place within the service. The charter included statements to ensure privacy, dignity and informed consent were a priority.

The service had a patient treatment policy which included putting the patient first, the need for compassion and safety for service users. The documented aim was to allow the service to continue to improve.

Staff we spoke with were aware of the patients' charter and the patient treatment policy.

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

All staff we spoke with told us they felt supported, respected and valued. They had confidence in their manager and felt able to raise concerns with them. They wanted to make a difference to patients and were passionate about performing their role to a high standard. They described being proud to work with the service.

Equality and diversity were promoted within the organisation and the service had an equality and diversity policy which was issued in 2018. Staff told us they had opportunities to develop their skills and enhance their career. One member of staff described how they had recently become an emergency medical technician after they felt they could achieve more than being a first aider.

The culture encouraged openness and honesty at all levels. Leaders and staff understood the importance of being able to raise concerns without fear of retribution. The was a clear whistle blowing policy which was issued in 2018 to support staff to raise concerns without fear of retribution**.** Staff we spoke with confirmed they understood the whistleblowing policy and support would be available if they raised concerns.

The registered manager was identified as the whistle blowing lead. Staff confirmed they would go to a senior colleague for assistance if concerns related to the registered manager.

Salaried staff could access confidential support from the company's website through a portal as part of the providers human resources provision. However, this was not available for self-employed staff.

**Governance**

**The leader operated governance processes but there were not always effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

Policies and procedures did not stipulate a review date, but an annual review requirement was identified in some policies. Information provided after our inspection stated all policies had been reviewed in March 2019, but this was not reflected within all policies we saw. For example, the health and safety policy was dated 2017.

In addition, policies did not always reflect processes within the organisation. For example, the complaints policy stated customer care training was mandatory and the risk register would be reviewed. However, the

provider did not offer customer care training or have a risk register. The provider told us after the inspection the reference to the risk register had been removed from the policy.

We were informed all staff were made aware of policies and policy changes at the weekly meeting and advised to review them. Staff we spoke with confirmed this, we saw registers signed by some staff to confirm they had read documents.

We reviewed minutes from meetings with staff to reflect an open and inclusive attitude to governance processes. The meeting minutes included training, human resource update, any risks and a good ideas section for staff to contribute. However, attendance was not monitored

The registered manager told us there was a system in place to ensure staff had relevant details for each event covered. This included the closest hospital with an emergency department to ensure timely access to acute services and the event organisers contact details.

Any issues were dealt with by the manager as they arose. This was reflected by the staff we spoke with.

There was a good range of policies, protocols and procedures covering key issues such as complaints, consent and whistleblowing and infection prevention and control.

**Management of risks, issues and performance**

**The service did not have systems and processes to manage all risks and performance issues. However, there was a major incident plan.**

The service did not have a risk register. However, the provider could describe some of the risks to the service. For example, they described the availability of staff and the age of the ambulance fleet as the main challenges. The provider had plans to manage the risks. For example, there had recently been a successful recruitment open day.

During our inspection we observed additional risks which were not identified as such by the provider. For example; items of equipment which had passed their expiry dates, storage of medical gases, lack of formal clinical waste and sharps contract, lack of calibration records on blood glucose monitoring machines, no review dates on policies and a lack of auditing processes concerning medicines management and clinical care.

The service did not have business continuity plans to ensure continuity of priority functions in the event of an unexpected event. The provider confirmed if unexpected weather occurred then the event would be cancelled by the event organiser. However, there were no plans if extreme weather conditions occurred while an event was underway, blockages of exit of the ambulance, radio breakdown, loss of internet access, staff sickness.

The service had a major incident response policy which was issued in 2017. The policy contained information on what procedures to follow to manage a major incident and the casualties safely. For example, it included how to organise the scene, safety for the staff and how to appropriately triage any casualties.

The registered manager told us they organised an annual major incident practical event, with scenario and role play involved. Staff we spoke with confirmed they had attended classroom teaching and practical role playing training events.

The service had not carried out the testing of the major incident policy with other agencies at the time of our inspection. The registered manager told us they had requested this in the past but other agencies had not been able to support.

The provider had started a social media group; Medical Emergency Digital and Incident Combines Service. This had 28 members at the time of inspection from different services to communicate in the event of a major incident or issue locally.

**Information management**

**The information systems used by the service were secure and patient information was handled in line with data standards.**

The provider had an information governance policy which was issued in 2018. It was due to be reviewed in 2020. It applied to all staff and stated the registered manager had overall responsibility for information management.

The service used paper records which were destroyed as soon as they were uploaded onto the company's secure IT system.

All computers were password protected and we saw them locked when not in use.

Patient information was managed in line with data security standards. Staff we spoke with were aware of how to handle patient identifiable information.

**Public and staff engagement**

**Leaders actively and openly engaged with patients and staff to plan and manage services.**

The service had its own website accessible to the public which described the service, its back ground and contact details.

The provider had developed a business card with a QR code to allow patient to give feedback using their smart phones and had an area for feedback on the company website.

The members of staff we spoke with said they felt listened to and the manager was very approachable. All staff confirmed they attended the weekly meetings and found them useful for discussion about changes, issues, receipt of training and meeting with the other staff. One member of staff told us they found the meeting enjoyable and it was part of their social life as well as a learning event.

Staff met regularly on a weekly basis and we saw evidence in meeting minutes that part of the meeting was dedicated to "good ides" where staff could put forward ideas for change in the service. The patient report form layout had been improved following a suggestion from staff.

**Innovation, improvement and sustainability**

**All staff told us they were committed to continually learning and improving services but there was no evidence to support this.**

The service had not been involved in any research projects or recognised accreditation schemes at the time of our inspection.

The service had not had any internal or external reviews in the year preceding our inspection.

All staff we spoke with told us they were committed to improving patient care and told us of plans to complete further training to increase their knowledge and understanding.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

The provider must take prompt action to address the concerns regarding safeguarding training, policies and updating DBS checks. Regulation 13 (2): Safeguarding service users from abuse and improper treatment.

The provider must take prompt action to address significant concerns around the storage of medical gases and ensure storage meets current legislation. Regulation 15: Premises and equipment.

The provider must ensure their recruitment policy is applied consistently to all staff working within the organisation. Regulation 19 :Fit and proper persons employed.

### Action the provider SHOULD take to improve

The provider should ensure the medicines management policy is reviewed, updated and reflects the services provided. Regulation 12: Safe Care and Treatment

The provider should ensure they review the process for assuring staffs skills and competence. Regulation 12: Safe Care and Treatment

The provider should ensure that they review the provision of protocols for treatment of patients suffering from a suspected heart attack and stroke. Regulation 12: Safe care and treatment

The provider should ensure an audit program is implemented to monitor performance and improve care. Regulation 17: Good governance

The provider should ensure how to appropriately identify, assess, manage, mitigate and update risks within the service. Reg 17: Good Governance.

The provider should ensure appropriate mandatory training is delivered, monitored and completed by staff. The service should complete assessments of all drivers' skills within the service. Regulation 18: Staffing

The provider should consider how equipment checks are carried out consistently and documented appropriately to ensure safe practice.

The provider should consider more formal contract arrangements for the disposal of clinical waste or sharps.

The provider should consider reviewing the incident reporting processes to ensure all staff understand what constitutes an incident.

The provider should consider how policies and procedures are managed appropriately, reviewed in date with standardised document control processes and reflect the services provided.

The provider should consider how support mechanisms for self-employed staff could be improved.

The provider should consider introducing an early warning scoring system to identify patients at risk of deterioration.

The provider should consider developing a vision for the future 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 legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding Regulation 13 (2): Safeguarding service users from abuse and improper treatment.**<br><br>**Systems and processes must be established and operated effectively to prevent abuse of service users.** |

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Regulation 15: (1)(d) Premises and equipment.**<br><br>**Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained.** |

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><br>**Regulation 19 HSCA 2014 (Regulated Activities) Regulations 2014 Regulation 19 (2): Fit and proper persons employed** |

This section is primarily information for the provider

# Requirement notices

Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in (a) paragraph (1).

Providers must have effective recruitment and selection procedures that comply with the requirements of this regulation and ensure that they make appropriate checks for both employees and directors.

Information about candidates set out in Schedule 3 of the regulations must be confirmed before they are employed.