Personal Security Service Limited

Personal Security Service

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 know to CQC and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Personal Security Service is a patient transport service operated by Personal Security Service Ltd.

We carried out an unannounced inspection on 22 June 2017 to follow up on our previous concerns about the service. This report looks specifically at those concerns and so does not cover all of the areas of our comprehensive inspection methodology.

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.

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 had previously carried out an unannounced inspection on 20 February 2017, along with an announced visit to the service on 21 February and 2 March 2017.

During the earlier inspection we identified the following concerns where the provider was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- We found there was no incident reporting system.
- Safeguarding training was not to the recommended level as per national guidance.
- The provider did not operate a safe recruitment process and there were no assurances staff were safe to work with vulnerable patients.
- We were not assured that the mandatory training was sufficient to ensure staff competence.
- There was no auditing of infection prevention and control practice and hand hygiene amongst staff when transporting patients.
- Records of patients and staff were not secured properly.
- There were no records to show vehicles were maintained on a regular basis.
- There was no dedicated training offered around supporting those with dementia or learning difficulties and there was no support for patients with communication difficulties or who did not speak English.

Following the inspection, we urgently suspended the service from carrying out any regulated activities. We told the provider that it must take actions to comply with the regulations. We returned to the service on 19 April 2017 to review what actions had been taken by the provider to respond to CQC's concerns about the governance of the service. As a result of improvements made the suspension of the service ended at midnight on 21 April 2017.

We carried out this unannounced inspection of the service on 22 June 2017 to review progress made in accordance with the action plan which the provider submitted to CQC following the last inspection.

We found that the provider had made significant improvement on the concerns listed above. We also found the following concerns that the service provider needs to improve:

- Incidents were not logged on the electronic incident recording system.
- The auditing process was inconsistent.
- Not all managers had access to the IT system

Summary of findings

As a result of which we issued a warning notice under Regulation 17, (1) (2) (a) (b) (f), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider that they must be compliant with this regulation by 31 July 2017.

Professor Ted Baker
Chief Inspector of Hospitals

Personal Security Service

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Background to Personal Security Service

Personal Security Service is operated by Personal Security Service Limited. The service registered with the CQC in 2013. It is an independent ambulance service with the head office based in London, the service however provides patient transport service across the United Kingdom and abroad.

Personal Security Service provides a secure patient transport service to mental health patients. This includes transporting a patient sectioned under the Mental Health Act 1983. Most journeys involve the transport of a patient from one hospital to another. Depending on patient's needs and associated risks the transport is carried out in low secure or high secure vehicles fitted with a secure area (cage) in the rear section of the vehicle. The service provides a driver, escorts and nurse if requested by hospital staff registered mental health nurse (RMN).

The service has had a registered manager in post since 2013.

Our inspection team

The team that inspected the service comprised two CQC inspectors and a specialist advisor with expertise in mental health. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for North London.

Facts and data about Personal Security Service

The service is registered to provide the following regulated activities:

• Transport services, triage and medical advice provided remotely

During the inspection, we visited Personal Security Service office. We spoke with the managers of the service and reviewed records relating to the governance improvements made since the last inspection. We did not have the opportunity speak with or observe any patients being transported during the course of our inspection.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Personal Security Service is operated by Personal Security Service Limited. The service provides a patient transport service.

We inspected this service to check improvements made in response to our report on the service published in June 2017.

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.

Summary of findings

We do not currently have a legal duty to rate independent ambulance services.

We always ask the following five questions of each service:

Are services safe?

- Incidents identified in the patient record audit were not logged on the electronic incident reporting system.
- The auditing process was inconsistent and was not documented in ways which would assist with monitoring and identifying additional needs in order to make improvements to the service.

Are services effective?

- Staff did not have ready access to policies and procedures when they were out in the field.
- The clinical manager did not have ready access to IT systems.
- The staff supervision electronic record was not updated regularly to reflect the current situation.
- Registered mental health nurses did not have access to clinical supervision.
- Staff were not supervised every 8 weeks in accordance with the provider's supervision policy.

Are services caring?

We did not gather evidence for this as part of this inspection.

Are services responsive?

Patient transport services (PTS)

- There was no support available during journeys for patients with communication difficulties or for those who did not speak English.
- There was no dedicated training offered around supporting those with dementia or learning difficulties.

Are services well-led?

- There was no written vison or strategy for the service.
- There was limited management oversight of how audits were conducted.
- There was limited management oversight of how the incident recording system and the supervision record were maintained and updated.

Are patient transport services safe?

Summary:

We found the following issues that the service provider needs to improve:

- Incidents identified in the patient record audit were not logged on the electronic incident reporting system.
- The auditing process was inconsistent and was not documented in ways which would assist with monitoring and identifying additional needs in order to make improvements to the service.

Incidents

- We reported in our last inspection in February 2017 that the provider had no formal incident reporting system and we found there was under reporting of incidents. Therefore the provider was unable to monitor incidents or identify themes in order to learn, protect patients and develop the service.
- During this inspection, we found that the provider had developed an incident recording system to record, monitor and identify trends from incidents. We were told the system was particularly for recording the use of restraint and handcuffs.
- However, we were not assured that all incidents were reported and recorded in accordance with the provider's incident reporting guidance. This states that staff must complete a restraint record and incident record which will also be recorded on the incident recording system.
- We reviewed a job sheet audit which recorded where restraint or handcuffs were used on at least 7 separate occasions. The provider was unable to show us copies of the required reports and we did not see any entry on the incident reporting system related to these job sheets where restraint or handcuffs were used.
- During our last inspection in February 2017 we reported that there was no apparent sharing of incidents or learning from them. During this inspection, we saw that incidents were placed on the agenda for discussion at team meetings. The service aimed to have one team meeting a month and one team meeting had taken place since our last inspection; the minutes of which included a discussion on guidance for incident reporting. The next meeting was planned for the week following this inspection and we noted that incidents and learning from them was an agenda item. One

member of staff told us they had a greater understanding of the expectations around incident reporting and told us they had experienced a helpful discussion about certain incidents during the last team meeting.

Clinical Quality Dashboard or equivalent

- We found at our last inspection that the provider had no system in place by which to monitor safety and results.
- The provider's action plan included details of an audit system which was put in place following the inspection in February to ensure improvements had been made and were sustainable. The function of this system was to assist in monitoring, identifying additional needs and making required improvements.
- However at this inspection, we found the way in which audits were carried out was unlikely to enable the provider to monitor trends or identify additional needs. For example, an audit of job sheets to monitor the use of restraint and handcuffs was written on a torn piece of paper and we subsequently confirmed that this information was not transferred onto the incident reporting system. We looked at an audit of staff records which was unsigned and undated. This had some brief notes but did not identify how staff records were audited or in what way this information would be maintained in order to assist with monitoring.

Cleanliness, infection control and hygiene

- The Department of Health Code of Practice about the prevention and control of healthcare associated infections Health and Social Care Act 2008 (the Code) states that `all registered providers will need to have adequate systems for infection prevention (including cleanliness)'.
- During our last inspection, we were told by the registered manager that no hygiene audits were carried out and no cleaning schedules were kept.
- We were told on this inspection that each vehicle now had a cleaning schedule which must be strictly adhered to with drivers expected to submit their completed checks on a weekly basis. In addition, a monthly check was done by a manager.
- We saw records of vehicle check forms for five vehicles which included an equipment and cleanliness check by the driver.
- Minutes of a recently held management meeting noted that the provider was 'struggling to get paperwork' from staff. We spoke with the director who confirmed that this was the case. They said staff would be told at the next staff meeting that disciplinary measures would be taken if evidence to confirm that vehicles were clean was not submitted.
- A new procedure was to be initiated following the staff meeting to ensure that responsibility for completion of vehicle checks and accompanying paperwork was clearer. The member of staff who had the vehicle between 09:00am and 12:00pm each Monday was expected to carry out the required duties in relation to that vehicle. The vehicle tracking system meant that office staff would be able to confirm where each vehicle was during that time and ensure the person responsible submitted evidence of the vehicle check.

Environment and equipment

- We did not gather evidence for this as part of the inspection.

Medicines

- We did not gather evidence for this as part of the inspection.

Records

- During the last CQC inspection in February 2017 we found that service users' confidential information was not securely kept. We found paperwork which included confidential patient information was kept in boxes on the office floor which were not secure. We also found that filing cabinets, which contained sensitive staff and patient information, were unlocked.
- The provider had since addressed all of these issues. There was no confidential information on public view and filing cabinets were kept locked. Keys to cabinets with sensitive information were held by the registered manager and director only.
- However, we noted on our arrival that one computer was logged on and unlocked. We were told that it had been left logged on all night. There were e-mails visible on the screen related to transport arrangements.

Safeguarding

- At the last inspection, we were not assured that there was appropriate reporting of safeguarding incidents to

CQC. Whilst the provider told us there had been no safeguarding incidents to be reported since then, they spoke with confidence of their understanding of what should be reported.
- At the time of the last inspection, the registered manager who was the safeguarding lead, did not have the appropriate level 3 training to fulfil this role. Since then, they submitted evidence which confirmed they had successfully completed an online safeguarding adults level 3 course.
- We saw evidence of safeguarding training for staff. This was done as part of a full day face to face classroom training course which covered a range of topics. Included in this training day was safeguarding vulnerable adults (Level 1 & 2) and safeguarding vulnerable children (Level 1 & 2). The staff training record showed that all staff had completed this training.
- There was safeguarding information on display in the office. This included the types of abuse which a member of staff should be aware of. It also included a flow chart for staff to follow where they may have concerns of a safeguarding nature. The flow chart advised staff who they could contact if they were unhappy with how the provider investigated the safeguarding concern. We noted that this did not include any telephone numbers to assist staff with this.

Mandatory training

- We noted during the last CQC inspection in February 2017 that there was no training record maintained to monitor staff training compliance and flag up when refresher training was due.
- During this inspection we saw the provider had developed an electronic record on which all staff training was logged. We saw that all staff were up to date with their training apart from five who required incident reporting training. We were told that this would be addressed as soon as possible.

Assessing and responding to patient risk

- The booking form used at the time of the last CQC inspection included minimal detail about the patients and their requirements.
- This had since been updated and required the booking staff to obtain more in-depth information about the patient. This included known risks, for example absconsion, violence or self-harm and special requirements including dietary or physical.

Staffing

- We were told that there were sufficient staff employed to meet the current demands of the service. We noted there were four registered mental health nurses (RMN) on the staff list. The director told us this was adequate since most services which requested transport of patients detained under the Mental Health Act supplied their own RMN.

Are patient transport services effective?

Summary:

We found the following issues that the service provider needs to improve:

- Staff did not have ready access to policies and procedures when they were out in the field.
- The clinical manager did not have ready access to IT systems.
- The staff supervision electronic record was not updated regularly to reflect the current situation.
- Registered mental health nurses did not have access to clinical supervision.
- Staff were not supervised every 8 weeks in accordance with the provider's supervision policy.

Evidence-based care and treatment

- We did not gather evidence for this as part of the inspection.

Assessment and planning of care

- We did not gather evidence for this as part of the inspection.

Competent staff

- At the previous CQC inspection the provider could only produce 17 staff records out of a total of 47. There were no staff records available for any of the registered mental health nurses (RMN).
- At the last inspection, we found that the service did not have recruitment processes in place to ensure that all staff were appointed following a robust check of their suitability and experience for the role, together with robust pre-employment checks. Disclosure and Barring Services (DBS) checks were not being completed appropriately and there were no assurances staff were safe to work with vulnerable patients.

Patient transport services (PTS)

- Where there were disclosures of past cautions and convictions we found that there was no risk assessment process in place to mitigate any potential risks to service users.
- Since the last inspection the provider had made significant improvements in this area and staff records were readily available to inspectors and contained all relevant information. The registered manager completed a safer recruitment training course and ensured that information in staff records was relevant and checked appropriately.
- We saw that there were risk assessments in the records of staff with previous convictions and the current staff list identified members of staff who had been appointed but were not allowed to work until their DBS was issued. We checked 14 job sheets and confirmed that the names of the staff not yet cleared to work did not appear on any job.
- During the previous inspection, the registered manager told us there was no system in place for the supervision or appraisal of staff. Since then, an electronic recording system had been developed and all staff should receive supervision every 8 weeks.
- However, the manager whose responsibility it was to supervise staff could not access this electronic format; consequently it was not updated to reflect supervision sessions which took place. We were shown their paper records of supervision. We saw from this record that all staff had one supervision session since the last inspection. We looked at four supervision records and noted that they covered a range of points including any concerns about the member of staff's role; training needs and matters related to terms and conditions of their job.
- However, all staff were due their next supervision in May and we saw that just two out of a potential 23 members of staff had been supervised to date. The manager responsible for supervision told us it had proven difficult to arrange supervision times with staff since they were busy with their work. They told us this situation was a matter of concern and one which they were trying to resolve.
- The clinical manager told us there was no provision for clinical supervision in their role or for other RMNs who worked for the provider. They told us this was something they believed to be necessary and had placed it on the agenda for the next management meeting.

Coordination with other providers and multi-disciplinary working

- We did not gather evidence for this as part of the inspection.

Access to information

- We did not gather evidence for this as part of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not gather evidence for this as part of the inspection.

Are patient transport services caring?

We did not gather evidence for this domain as part of this focused inspection.

Compassionate care

- We did not observe any patients being transported during the course of our inspection and so are unable to comment on whether staff offered compassionate care to patients.
- The office manager told us they ensured there was always a same gender escort allocated to the patient, we saw on all job records we saw that this was the case.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection.

Emotional support

- We did not gather evidence for this as part of the inspection.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

Summary:

We found the following issues that the service provider needs to improve:

- There was no support available during journeys for patients with communication difficulties or for those who did not speak English.
- There was no dedicated training offered around supporting those with dementia or learning difficulties.

Service planning and delivery to meet the needs of local people

- We did not gather evidence for this as part of the inspection.

Meeting people's individual needs

- We did not gather evidence for this as part of the inspection.

Access and flow

- We did not gather evidence for this as part of the inspection.

Learning from complaints and concerns

- At the previous inspection, we were unable to clarify how many complaints there had been against the provider in the 12 months prior to the inspection. This was because there was no system in place to monitor complaints and note any recurring themes.
- During this inspection we saw that the provider had set up a folder where any complaints would be filed. There were no complaints to view and the director told us there had been none since 2015.

Are patient transport services well-led?

Summary:

We found the following issues that the service provider needs to improve:

- There was no written vison or strategy for the service.
- There was limited management oversight of how audits were conducted.
- There was limited management oversight of how the incident recording system and the supervision record were maintained and updated.

Leadership / culture of service related to this core service

- The leadership of the service consisted of a nominated individual who was responsible for the operational side of the business, including vehicles and invoicing, and a registered manager who was responsible for staff and responding to complaints. In addition, the provider had recently appointed a clinical manager whose role was to offer support to staff and initiate an auditing process.
- At the previous inspection in February 2017 we found that the nominated individual and registered manager had a significant lack of awareness of their roles and responsibilities. This included limited understanding of their safeguarding roles, unsafe recruitment practices, lack of auditing processes, no risk register to monitor and assess risk and absence of reporting to CQC. We also found there was no senior leadership team and no management meetings took place.
- During this inspection, we found that there had been improvements made in most of these areas. For example, there was now a management team which was made up of the registered manager, the director and the clinical manager. This was recently established and had met twice, the focus of which was to discuss all aspects of the service. We saw minutes of the last meeting which was structured around the action plan which followed the last inspection.
- Other improvements included the introduction of a more robust approach to recruitment and training.
- However, the auditing process was not adequate to enable the provider to understand trends and identify areas of concern. This was especially relevant to the job sheet audit, incidences of use of restraint and the staff record audit.
- The provider developed an incident reporting system and staff meeting minutes recorded that staff were briefed about how to report incidents. The provider's guidance on incident reporting stated that staff must complete a restraint record and incident record which will also be logged on the incident recording system.
- However there was just one historic incident on the reporting system. We saw that an audit of the use of restraint identified at least 7 occasions where restraint was used. None of these were added to the incident reporting system and there were no reports available for us to view on the day of our inspection. Therefore we were not assured that there was an understanding of what constituted an incident and that incidents were reported and investigated according to the provider's incident reporting guidance.

Vision and strategy for this this core service

Patient transport services (PTS)

- The director told us the service was still settling into systems newly introduced following the previous CQC inspection in February 2017. We were told that whilst there was no written vision or strategy, managers understood that the current focus was to re-establish the business and ensure commissioners had confidence in the service provision.
- We were also told that much work was done to embed new practices and procedures with all members of staff through staff meetings and correspondence.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The provider has responded to concerns previously raised by CQC by implementing new governance and risk management processes with the support of an external management consultant.
- The registered manager told us (via telephone) that a spread sheet had been developed onto which any arising risks were added. We saw that there were no recent risks added although an historic risk had been added.
- There was a better understanding of the role of the safeguarding lead and they had completed safeguarding training to the required levels.
- Disclosure and Barring Services (DBS) checks were completed and we saw that staff did not begin work until their DBS certificate was obtained.

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

- At the previous inspection the provider was unable to demonstrate that patient feedback was sought on the quality of the service provided. There was no evidence at this inspection that any patient feedback was actively sought since then. We did note that there was a record of positive feedback from commissioning staff who supported the provider's staff with patient transfers.
- There was no evidence of a staff survey to determine the views of staff at the time of the last inspection.
- At the time of this inspection, the director showed us a copy of a staff questionnaire which was to be introduced to staff during the following team meeting. This asked questions about management support and additional training requirements. The director assured inspectors that staff anonymity was guaranteed for those who completed the form.

Innovation, improvement and sustainability

- We did not gather evidence for this as part of the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to incident recording and reporting, and the governance of the service.
- The provider must ensure that good governance systems and processes are established and operated effectively.
- The provider must ensure there is an understanding of what constitutes an incident and that all incidents are reported, investigated and recorded in accordance with the provider's incident reporting guidance.
- The provider must ensure that registered mental health nurses have access to clinical supervision.

Action the hospital SHOULD take to improve

- The provider should ensure that staff are supervised every eight weeks in accordance with the provider's supervision policy.
- The provider should ensure that the staff supervision electronic record is updated regularly to reflect the current situation.
- The provider should ensure the clinical manager has access to IT systems.