Nerams Ltd

Nerams Ltd

Quality Report

Durham Dales Business Centre,
Castle Gardens,
Stanhope,
Weardale,
Bishop Auckland
DL13 2FJ
Tel: 01388317999
Website: www.nerams.org.uk

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Nerams Ltd operate under the same name, Nerams Ltd . At the time of this inspection the service was not carrying out any regulated activity. The service had previously provided a patient transport service transporting dialysis patients to and from appointments from their place of residence for Clinical Commissioning Groups (CCG `s) and hospitals in the North – East region which started in June 2018. The service withdrew from their PTS contracts after 19 days because the volume of transfers exceeded what had been identified in the specifications of the service tender

The service now provides event medical coverage providing first aid cover and/or ambulance support at planned events, site rescue safety, providing a confined space medical rescue team and first aid training. These services are not regulated by the CQC and were therefore not inspected.

The inspection covered current working practices not specific to the services which were not regulated and reviewing evidence from when the provider was carrying out patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried an unannounced visit to the providers headquarters at Stanhope, County Durham and their satellite station at Washington, Tyne and Wear on 13 August 2019.

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

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

We rated it as **Requires improvement** overall because,

- The providers safeguarding lead was not trained to level three safeguarding, however, following the inspection, the provider submitted evidence showing the safeguarding lead had been trained to safeguarding level three.

  The safeguarding reporting guidance in the providers safeguarding policy and staff advice flow chart was not correct and if followed could have delayed a referral being made resulting in further harm to the individual concerned, however, following the inspection, the provider submitted evidence showing the safeguarding policy and flow chart had been amended so referrals were made immediately to the local safeguarding authority or department.
- The provider did not carry out limited infection prevention control audits, following the inspection the provider submitted evidence of a vehicle cleaning audit carried out in September 2019. No other infection prevention control audit evidence was supplied
- Medical gases were not stored in accordance with current legislation, however, following the inspection the provider submitted evidence showing they had taken measures to ensure oxygen and Entonox cylinders were stored securely.
- The service did not have an effective system for the identification, mitigation and monitoring of risk.
- Paper patient record forms at the Washington site were not stored securely or collected regularly so they could be reviewed and audited, however, following the inspection the provider submitted evidence of two PRF audits carried out in September 2019.
- Five of the nine current staff files, and one of the five PTS files of staff no longer working for the provider, were reviewed they did not have references.

Summary of findings

- There were no multinational cue cards for patients whose first language was not English or communication aids for patients with visual or hearing on the vehicles inspected.

However, we found the following areas of good practice:

- The service maintained a comprehensive computer-based training matrix to record levels of staff training compliance and when refresher training courses were due.
- There was evidence of hand hygiene observations being carried out in January, April and August 2019.
- The 14 different consumable items we inspected were all found to be in date.
- Ambulances appeared to be visibly clean and well maintained.
- The 55 policies we reviewed were in date, version controlled, and the date of last review recorded.
- The service had an ethical policy, an anti-bribery policy, a whistleblowing policy, hospitality and gifts policy to support staff culture all were in date.
- The service had a computer-based document control register which ensured all documents and records were created, accessed and managed effectively.

Following this inspection, we told the provider that it should make 9 improvements, even though a regulation had not been breached, to help the service improve Details are at the end of the report.

Name of signatory

Ann Ford

Deputy Chief Inspector of Hospitals (area of responsibility), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)	Requires improvement 	At the time of this inspection the service was not carrying out any regulated activity. The service had previously had a PTS contract for dialysis patients which commenced in June 2018.This contract was cancelled by the service on 19 June 2018. From 1 June to 19 June 2018, 2429 patient transport journeys had been undertaken.

Requires improvement

Nerams Ltd

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Nerams Ltd

Nerams Ltd operates under the same name, Nerams Ltd . The service opened in 2018. It is an independent ambulance service based in Stanhope, County Durham which is an office and the administrative base. There is no operational activity carried out there. The provider had a satellite station in Washington Tyne and Wear where their ambulances operated from.

When service was carrying out regulated activity it primarily served the communities of Tyne and Wear, Durham and Teesside.

At the time of the inspection the manager had been registered with the CQC since June 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in patient transport management. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Facts and data about Nerams Ltd

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

During the inspection, we visited the registered base at Stanhope, Bishop Auckland, County Durham and the satellite station at Washington Tyne and Wear. Due to the fact the service was not carrying out any regulated activity at the time of this inspection we were only able to speak to the Director of Operations. During our inspection, we reviewed nine sets of patient records all relating to patients who had been treated at an event.

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 first inspection since registration with CQC.

Activity (June 2018 - June 2019)

- In the reporting period June 2018 - June 2019 there were 2429 patient transport journeys undertaken, however, this activity ceased on 19 June 2018.

At the time of the inspection the service employed three full time staff, who were, the managing director, director of operations and the logistics director and a training manager employed for one day a week to deliver face to

Detailed findings

face training and monitor on line training compliance. There were 58 staff registered to work for the company who were self-employed bank staff qualified to work in any of the services provided by Nerams Ltd.

Track record on safety

- No Never events
- No clinical incidents with no harm, none with low harm, none with moderate harm, none with severe harm, no deaths
- No serious injuries
- Nine complaints

Our ratings for this service

Our ratings for this service are:

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

Notes

Patient transport services (PTS)

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

Information about the service

Nerams Ltd commenced business in June 2018. It is an independent ambulance service based in Stanhope, County Durham. There was a satellite station in Washington Tyne and Wear where the services ambulances operated from. When the service was carrying out regulated activity in June 2018 it primarily served the communities of Tyne and Wear, Durham and Teesside transporting kidney dialysis patients for treatment.

At the time of this inspection the service was not carrying out any regulated activity.

Summary of findings

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

- The providers safeguarding lead was not trained to level three safeguarding, however, following the inspection, the provider submitted evidence showing the safeguarding lead was trained to safeguarding level three.
- The safeguarding reporting guidance in the providers safeguarding policy and staff advice flow chart was not correct and if followed could have delayed a referral being made resulting in further harm to the individual concerned, however, following the inspection, the provider submitted evidence showing the safeguarding policy and flow chart had been amended so referrals were made immediately to the local safeguarding authority or department.
- Consumable items in the Washington station were stored in open plastic boxes which were not protected against dust or dirt, however, following the inspection, the provider submitted evidence showing consumable items were stored in covered in plastic containers to avoid dust.
- One of the ambulances inspected did not have a clinical waste bag, however, following the inspection, the provider submitted evidence showing all ambulances had clinical waste bags.

Patient transport services (PTS)

- The provider did not carry out infection prevention control audits, following the inspection the provider submitted evidence of a vehicle cleaning audit carried out in September 2019. No other infection prevention control audit evidence was supplied.
- Medical gases were not stored in accordance with current legislation, however, following the inspection the provider submitted evidence showing they had taken measures to ensure oxygen and Entonox cylinders were stored securely.
- The service did not have an effective system for the identification, mitigation and monitoring of risk.
- Paper patient record forms at Washington were not stored securely or collected regularly so they could be reviewed and audited, however, following the inspection the provider submitted evidence of two PRF audits carried out in September 2019 and there was evidence the records were stored securely.
- Five of the nine current staff files and one of the five PTS staff files reviewed did not have references.
- There were no multinational cue cards for patients whose first language was not English or communication aids for patients with visual or hearing on the vehicles inspected.

However, we found the following areas of good practice:

- The service maintained a comprehensive computer-based training matrix to record levels of staff training compliance and when refresher training courses were due.
- There was evidence of hand hygiene observations being carried out in January, April and August 2019 by the director of operations. Staff were provided with feedback from the observation which was recorded
- The 14 different consumable items we inspected were all found to be in date.
- Both ambulances appeared to be visibly clean and well maintained.
- The 55 policies we reviewed were in date, version controlled, and the date of last review recorded.
- The service had an ethical policy, an anti-bribery policy, a whistleblowing policy, hospitality and gifts policy to support staff culture.
- The service had a computer-based document control register which ensured all documents and records were created, accessed and managed effectively.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement

We rated safe as **requires improvement**, because:

- The providers safeguarding lead was not trained to level three safeguarding, however, following the inspection, the provider submitted evidence showing the safeguarding lead was trained to safeguarding level three.
- The safeguarding reporting guidance in the providers safeguarding policy and staff advice flow chart was not correct and could have delayed a referral being made resulting in further harm to the individual concerned, however, following the inspection, the provider submitted evidence showing the safeguarding policy and flow chart had been amended so referrals were made immediately to the local safeguarding authority or department.
- Some consumable items were stored in open plastic boxes which were not protected against dust or dirt, however, following the inspection, the provider submitted evidence showing consumable items were stored in covered in plastic containers to avoid dust.
- One of the ambulances inspected did not have a clinical waste bag, however, following the inspection, the provider submitted evidence showing all ambulances had clinical waste bags.
- The provider did not carry out infection prevention control audits, however, the provider did not carry out limited infection prevention control audits, following the inspection the provider submitted evidence of a vehicle cleaning audit carried out in September 2019. No other infection prevention control audit evidence was supplied.
- Medical gases were not stored in accordance with Health and Safety at Work Act 1974 and NHS estates guidance for pipeline systems HTMO2 guidelines.
- Following the inspection, the provider submitted evidence showing they had taken measures to ensure oxygen and Entonox cylinders were stored securely.

However, we found the following areas of good practice:

- The service maintained a comprehensive computer-based training matrix to record levels of staff compliance and when refresher training courses were due.
- There was evidence of hand hygiene observations being carried out in January, April and August 2019.
- The 14 different consumable items we inspected were all found to be in date.
- Both ambulances appeared to be visibly clean and well maintained.

Incidents

- In the 12 months prior to the inspection the provider had not reported any incidents.
- Due to the fact the service had not carried out any regulated activity in the previous 12 months we could not speak to staff to evidence their understanding of the incident reporting procedure.
- The service had not recorded any never events during the past 12 months. Never events are incidents of serious patient harm that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The provider had an incident reporting policy for staff to follow dated December 2017. There was review date for the policy.
- The policy outlined the aims of incident reporting which included analysing incident trends, root causes and development of appropriate action plans. and to effect change, in practices and procedures.
- The policy explained the roles and responsibilities of staff in incident reporting and definitions as to what should be included in an incident report.
- Due to the fact the provider had not reported any incidents in the 12 months prior to the inspection we were unable to evidence staff adherence to the policy.
- On inspection we reviewed the computer-based system for recording incidents. The process was staff would complete an incident report form, scan it using their work mobile phones, then email it to the main services

email address. The scanned report would then be transferred to a report tracker by the office manager and allocated for investigation. The investigation would be reviewed during the Patient Safety Group meetings.

- The provider had no reports of having had to apply the duty of candour principles.
- The duty of candour places a legal responsibility on every healthcare professional to be open and honest with patients when something that goes wrong with their treatment or care. Or has the potential to cause, harm or distress and to apologise to the patient or, where appropriate, the patient's advocate, carer or family.

Mandatory training

- All staff were required by the service to have completed mandatory training. The service maintained a training matrix to record staff compliance. Aspects such as basic life support and infection prevention and control were delivered face to face. Other modules were completed using an online training platform.
- Staff who had current mandatory training qualifications from their primary employer were required to produce the training certificates as proof of qualification. These were recorded on the training matrix with the refresher date.
- All staff initially completed on line training in relation to data protection/security training which allowed them access to safeguarding, mental health, MCA, and learning disabilities training.
- Consent training was covered as part of induction training where it was required. Consent was also covered in the Mental Capacity Act Training vie e-learning modules.
- At the time of the inspection the company was signing up to The Learning Curve, a fully-funded government initiative to provide online training.
- The company had recently recruited a training manager employed for one day a week to deliver face to face training and monitor on line training compliance.
- We saw evidence of a historic spreadsheet, which had been used when the service was carrying out regulated activity, that showed all PTS staff had been up to date with their statutory and mandatory training.
- At the time of the inspection Duty of Candour was not part of staff mandatory training.
- Due to the fact the provider was not carrying out any regulated activity at the time of the inspection there were no current PTS staff training records to check.

Safeguarding

- In the 12 months prior to the inspection the provider had not made any safeguarding referrals.
- Due to the fact the provider had not reported any safeguarding incidents in the 12 months prior to the inspection we were unable to evidence staff adherence to the policy or reporting procedures.
- On the notice board in the office at Washington there was a safeguarding flow chart for staff to follow who wished to make a referral. The advice was to send the referral to the services safeguarding lead not the local authority safeguarding department.
- The same advice was in the services safeguarding policy. This information if followed could lead to a delay in making a referral to the local safeguarding team resulting in further harm to the individual concerned.
- We saw evidence the provider had a safeguarding report form with advice for staff to contact the local social care department, a telephone contact number was provided. The advice was different to that in the policy and flow chart and could lead to confusion on the part of staff as to what was the correct reporting procedure.
- Following the inspection, the provider submitted evidence showing the safeguarding policy and flow chart had been amended so referrals were made immediately to the local safeguarding authority or department.
- We saw evidence from 2018 training record spreadsheet the self-employed PTS staff who had been carrying out regulated activity had received level two adults and children safeguarding training.
- The provider safeguarding lead was trained to level two adults and children safeguarding training. We saw evidence they were booked on courses to complete level three and four safeguarding training.

- Following the inspection, the provider submitted evidence showing the safeguarding lead was trained to safeguarding level three.
- Safeguarding training was provided by the service and was mandatory for all staff. The training was done online.
- Staff employed by other services or companies, who had safeguarding qualifications, had to produce a copy of their training certificate as proof of their qualification. All contracted staff were required to have received level two training for children and adult safeguarding.
- The provider had a safeguarding children, young people and vulnerable adult's policy dated 1 December 2017. The document review date was held on a computer-based document control register. The information contained in the policy was current and the policy was in date.
- The document outlined the policy on identifying and responding to concerns regarding the safeguarding and protection of children and young people, with a specific section on protection of vulnerable adults.
- The service policy and associated procedures provided guidance for all staff and contractors working for the company who may come across safeguarding concerns.
- The director of operations told us any patients who had any safeguarding related plans in place and were referred to the provider for transporting purposes, those plans were included in the patients notes so staff were aware.

Cleanliness, infection control and hygiene

- We found consumable items, including dressings, steri strips, oxygen masks and eye wash were stored in open plastic boxes which meant they were not protected against dust or dirt.
- Following the inspection, the provider submitted evidence showing consumable items were stored in covered plastic containers to avoid dust.
- There was no evidence as to how the provider could guarantee the levels of cleanliness of the vehicles or equipment after cleaning. The cleaning information on the vehicle deep clean records was generic and not broken down into which areas of the ambulances or which equipment carried on them had been cleaned using which cleaning agent
- One of the ambulances did not have a clinical waste bag, which could mean that clinical waste material not be appropriately disposed of.
- Following the inspection, the provider submitted evidence showing all ambulances had clinical waste bags.
- The director of operations told us no infection prevention control audits had been carried out in the last 12 months, following the inspection the provider submitted evidence of a vehicle cleaning audit carried out in September 2019. No other infection prevention control audit evidence was supplied.
- The company had a service level agreement with an external company to provide cleaning materials, clinical waste disposal, and control of substances hazardous to health (COSHH) information. They also provided a half-day face to face staff training course in relation to cleanliness, infection control and hygiene.
- The office at Stanhope and the station at Washington were both visibly clean and tidy.
- The registered office of the service in Stanhope, County Durham was in a leased building with several other offices used by other businesses. The room was cleaned by an external contractor. The office was solely used for administrative purposes.
- We saw evidence of a detailed provider infection prevention control policy dated January 2018.The policy defined which cleaning materials to use where, operational location variations, shift vehicle cleanliness checks, cleaning responsibilities of staff when they had completed their shift, vehicle cleaning protocols, how to clean equipment and monitors and management of linen.
- In the Washington office in the equipment storeroom there was a cleaning station with a sink and notices above it explaining the colour coding of which areas to clean with which cleaning agents which were stored next to the sink and clearly labelled as to what they contained. There was a supply of single use mop heads to use for cleaning.

- There was an additional locked storage area used for events which was not inspected.
- There were notices displayed to explain to staff as to how to dispose of various kinds of waste. There was a supply of cleaning agents and buckets for staff to use to mix them with water to correct dilution rates.
- External to the building there were two locked cupboards which contained cleaning equipment including a power washer and vacuum cleaner. The same notices which had been displayed next to the internal cleaning station and explained the colour coding of which areas to clean with which cleaning agent were displayed in the cupboards.
- There were cleaning agents in wall mounted containers which delivered the cleaner in the correct levels of dilution.
- In the Washington office on a notice board was information for staff as to how to clean their uniforms which included the minimum wash temperatures to use.
- During inspection we saw the provider maintained a spreadsheet with the dates when vehicle deep cleans had been required and when they had been completed. We reviewed the records from the start of 2019 and saw evidence the two PTS vehicles we inspected had been deep cleaned every month. The deep clean covered 43 different areas of the vehicles and the equipment carried on them.
- There was evidence the director of operations signed off each cleaning check list to confirm the standards of cleanliness had been met. There was one example where additional cleaning was required to meet the required standard but there were no reasons why this was required outlined on the spreadsheet.
- Both PTS ambulances we inspected were visibly clean and tidy. Both contained anti-bacterial sprays, sterile wipes and had a supply of gloves, hand gel and clean disposable linen.
- During inspection we saw evidence of six hand hygiene observations being carried out in 2019 by the director of operations. There were two in January two in April and two in August. No issues were identified.
- In the Washington office there was a folder which contained all the services policies and procedures which included infection, prevention and control. Staff could easily access this if required.
- When the service was carrying out regulated activity the director of operations told us PTS staff would be informed of any potential patient infection risk during the booking process. We were unable to evidence if this had occurred.

Environment and equipment

- The medical gases were not stored in accordance with Health and Safety at Work Act 1974 and NHS estates guidance for medical gas pipeline systems HTMO2 guidelines.
- Medical gases were stored in wooden racks which were colour coded, red for empty and green for full. The medical gases were not in locked in a cage and were therefore not secured to prevent them falling over and the cylinders being damaged.
- Following the inspection, the provider submitted evidence showing they had taken measures to ensure oxygen and Entonox cylinders were stored securely.
- In the store room standing on the floor, not fixed securely, were three fire extinguishers. All three had labels indicating they had been tested. The fire extinguishers were not stored in accordance with the Fire Extinguisher regulations which form part of the Regulatory Reform (Fire Safety) Order 2005 which outlined to prevent fire extinguishers from being moved or damaged, they should be mounted on brackets or in wall cabinets with the carrying handle placed 3-1/2 to 5 feet above the floor.
- The automated external defibrillator pads (AED`s) on both vehicles we inspected were found to be out of date. All other consumable items and equipment on both vehicles were in date.
- There were no paediatric harnesses or chairs carried on the vehicles we inspected.
- The registered office was in Stanhope, County Durham. The office was in a block of offices leased and shared

with other businesses. There was a communal entrance which had separate buzzers for each business to alert the owner or staff who had to physically open the door to allow entry.

- The building was alarmed and covered by closed circuit television. The office itself was one room with work stations and computers and a table for meetings. There were locking filing cabinets for the storage of paper work. The director of operations held the office key.
- The operational station where the services ambulances were based was in a leased unit on an industrial estate in the Washington area of Tyne and Wear.
- There was external signage at the entrance to the industrial estate which identified which business unit Nerams operated from. There was external signage on the unit where Nerams was based.
- There was a small lobby area with a signing in book. This led to an area, split with kitchen/welfare facilities on one side and an operational area for staff on the other. The service operational area contained draws with forms for staff to used and wall mounted letter boxes which were labelled for staff to leave completed forms in. There were notice boards with instructional information for staff to follow in relation to operational activity.
- There was Control of Substances Hazardous to Health Regulations (COSHH) information reference book available for staff in the office.
- The vehicle keys were securely stored.
- In the equipment store we inspected, at random, 14 different consumable items stored in open plastic boxes without lids. All the items were found to be in date.
- There were three spare wheel chairs in the room all had stickers attached indicating the next test was due August 2020.
- Four scoop stretchers were stored securely on a wall, they all had stickers attached indicating the next test was due August 2020.
- There was a poster displayed in the store room which explained to staff about the storage and administration of medical gases, however, there was no policy in place regarding the administration of medical gases.
- We saw evidence the provider had a service and maintenance contract in place with an external company that supplied them with medical devices.
- The contract was in place to ensure that all medical devices were regularly maintained and serviced in accordance with manufacturer's guidelines and where applicable in accordance with current guidance, to ensure that all medical equipment purchased from the provider met with manufacturers guidelines and where appropriate with met current British Standards (BS) standards, and to ensure that if there was a need for devices to be exchanged or replaced due to damage or fault, this would be offered at an agreed cost.
- The provider had a service level agreement in place with the company who they hired their PTS vehicles from this included the vehicle servicing.
- We inspected two PTS ambulances which were parked on land next to the Nerams unit.
- Medical gases on both vehicles were securely stored. Both ambulances we inspected had a warning notice on the rear doors stating medical gases were carried on the vehicles.

Assessing and responding to patient risk

- Due to the fact the service was not carrying out any regulated activity we were unable to obtain any evidence in relation to assessing and responding to patient risk.
- The director of operations told us when the service had carried out regulated activity if a patient had become obviously ill the PTS ambulance would stop and a member of staff would dial 999 for an emergency NHS ambulance to attend.
- The service had a policy in relation to this which was in date.

Staffing

- At the time of the inspection the service employed three full time staff and one part time member of staff, who were, the managing director, director of operations and the logistics director and a training manager employed for one day a week to deliver face to face training and monitor on line training compliance.

Patient transport services (PTS)

- When the provider had the PTS contract, they would inform the self- employed bank staff as to which shifts were available. The staff had access to a company computer-based system where available shifts were identified. Staff would then allocate themselves to which shifts they wished to work.
- The director of operations told us the shifts were allocated on a first come first served basis.
- Due to the fact the provider, at the time of this inspection, did not have any contracts with NHS or independent providers we could not evidence staffing levels or shift patterns.
- At the time of the inspection the service had recruited 58 self-employed bank staff registered to work for Nerams Ltd.
- The service had recruited suitably trained staff in anticipation of obtaining a PTS contract.
- The director of operations told us the 58 self-employed bank staff were qualified to work in all the services currently provided by the company. The sample of staff files we reviewed confirmed this.

Records

- Due to the fact the service was not carrying out any regulated activity at the time of the inspection we were unable to review any patient records, however, we were told these were stored electronically and were safe.
- When the service was carrying out regulated activity they did not have their own patient record forms (PRF`s) but used the patient booking form provided by the service requesting the transport.
- The director of operations told us when the service was carrying out PTS they required a booking sheet to be completed which identified whether protection plans were in place. The allocated crews were made aware of any special requirements and individual needs before attending to collect any patient where a protection plan was in place.

Medicines

- The service did not hold any medicines. If a PTS patient had their own medicines, they would be responsible for carrying them during the patient transfer.
- There was no evidence of a policy in relation to patients carrying their own medicines.
- The PTS vehicles we inspected carried medical gases. Training for medical gas administration was included in staff induction/mandatory training with dates for refresher training included on the training spreadsheet.
- Under the Health and Safety at Work Act 1974 and HTMO2 guidelines Entonox cylinders should be stored at above 10°C for at least 24 hours prior to use. During inspection we did not see evidence of the store room temperatures, where the Entonox was stored, being measured.
- Following the inspection, the provider submitted evidence showing the room had a thermometer which recorded the room temperature, however, there was no evidence submitted as to the recording and monitoring of the temperatures.

Are patient transport services effective?

Not sufficient evidence to rate

We inspected but did not rate effective because there was insufficient information due to the fact the provider was not carrying out any regulated activity at the time of the inspection.

Although we did not rate effective we found the following area where the service could improve,

- Five of the nine current bank staff files did not have references and one of the five PTS staff files of staff who no longer worked for the service did not have references.

Evidence-based care and treatment

- We saw evidence current staff had access to all company policies and protocols online, through a computer system called Share Point. Staff could use Share Point to access forms, such as equipment checking logs for use at events, incident forms and safeguarding forms.
- Completed forms could be scanned by staff and e mailed back to the main office where they would be added to spreadsheets for monitoring purposes.

- The director of operations told us PTS staff would have the same access to all company policies and protocols online if a contract was obtained.

Nutrition and hydration

- When the service was carrying out regulated activity, due to the type of PTS service carried out, there was no requirement to plan the nutrition and hydration of patients.
- On one of the PTS ambulances we inspected there was drinking water available for patients, however, there was no record as to how long it had been on the vehicle.

Response times / Patient outcomes

- The service had carried out performance gathering in the 19 days they had the PTS contract in June 2018.
- In relation to the collection time from patient's residence the service achieved a 99.83% rate. In relation to the patient departure time from hospital the service achieved a 91.32% rate. In relation to getting patients to appointments on time the service achieved a 95.94% rate. In relation to not exceeding 60 minutes patient journey time the service achieved a 96.17% rate
- The provider did not have any internal key performance indicators to measure response times or patient outcomes.

Competent staff

- At the time of the inspection staff who were recruited had a FREC level three qualification, so could be offered other work in all the services provided by Nerams Ltd.
- The company followed a recruitment process which was displayed on a flow chart on the office notice board. The aim of the policy was to deal with the induction of staff in an organised and consistent manner, to enable staff to be introduced into a new post and working environment quickly, so they could contribute effectively as soon as possible.
- Although the service had an induction policy for new staff, due to the fact they were not carrying out any regulated activity at the time of the inspection, we could not speak to PTS staff and obtain their views of the induction procedure.
- The induction policy, associated procedures and guidelines aimed to set out general steps for managers and staff to follow during the induction process.
- The provider had a 12-day PTS training programme for staff covering a wide range of subjects required for the role.
- Staff had to complete phase one e learning covering, medical gas, consent, duty of care, equality, diversity, fire safety, health, safety and welfare, safeguarding adults and children and information governance.
- Staff had to complete the modules within three months of commencing employment.
- Phase two of staff e learning covered, awareness of dementia, awareness of mental health, infection prevention and control, patient moving and handling and conflict resolution.
- Staff had to complete the modules within six months of commencing employment.
- We saw evidence on a spreadsheet from when the service carried out regulated activity all PTS staff were qualified as First Response Emergency Care Level three.
- We saw evidence all drivers within the organisation had been required to undergo driving licence checks every 12 weeks. Full photocopies and downloads of the driving licence counterpart were required for continued authorisation to drive for the company, these were held in company files.
- The director of operations told us this was non-negotiable and non- compliance could render the individual member of staff being taken off driving duties and potentially suspended from duty until verification of driving authority has been received by the company.
- Staff had to complete a driving licence declaration to immediately inform the company of any driving endorsements or penalties that occurred during the period they were registered to be employed by the company. Failing to do so could result in disciplinary action.
- There was evidence the provider had a job description for patient transport drivers which covered the main purpose of the job and the main duties and responsibilities of the role.

Patient transport services (PTS)

- Due to the fact the service was not carrying out any regulated activity at the time of the inspection there were no PTS staff appraisals to review.
- Current staff were recruited according to their skills and experience. Managers were responsible for monitoring this. The operations manager was responsible for events staff, the logistics manager was responsible for site safety and rescue staff, and the director of operations was responsible for PTS staff.
- We saw evidence of a current staff recruitment process where checks were completed on commencement of employment and included schedule three requirements including two references.
- We reviewed 14 staff files, nine were current staff and five were PTS staff who had been employed in June 2018 but no longer worked for the service. Five of the nine current staff files did not have references and one of the five PTS staff files did not have references.
- The company did accept disclosure and barring service (DBS) checks done by other services but specified staff should have DBS checks repeated by Nerams within three months of employment.
- Additional checks included professional registration, if applicable, CV and immunisation records. The service recorded this information in a spreadsheet which was colour-coded to indicate compliance: green have returned all documents, yellow are compliant but awaiting new information/documentation, red are not compliant.
- All new staff received a staff handbook. We reviewed version 1 dated December 2017 of the handbook. This included an introduction to the company including induction and staff development information, a history of the service, and equality, diversity and respect guidance. The handbook gave details of which employee information was required to be submitted to Nerams Ltd and listed Nerams' code of conduct, confidentiality and conflict of interest guidance, and company policies.

Multi-disciplinary working

- Due to the fact the service was not carrying out any regulated activity at the time of the inspection we were unable to evidence multi-disciplinary working.
- We saw evidence the provider had a do not attempt cardiopulmonary resuscitation (DNACPR) procedure flow chart for staff to follow if a patient they were transporting had a DNACPR in place. The flow chart could be used by staff if there was a PTS contract in place.

Health promotion

- The provider did not take part in health promotion with the patients they transported when they were carrying out regulated activity.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a consent to examination, assessment, intervention, treatment and care policy dated 1 December 2017. The document review date was held on a computer-based document control register.
- The policy had links to the providers Mental Capacity Act Policy and Mental Capacity Act Practice Guidance. The document outlined what consent meant, the roles and responsibilities of staff and what documentation to complete in relation to policy.
- We saw evidence on the patient booking form patient risk was considered.

Are patient transport services caring?

Not sufficient evidence to rate

We inspected but did not rate caring because there was insufficient information due to the fact the provider was not carrying out any regulated activity at the time of the inspection.

Compassionate care

- Due to the fact the service was not carrying out any regulated activity at the time of the inspection we could not evidence compassionate care.

Emotional support

- Due to the fact the service was not carrying out any regulated activity at the time of the inspection we could not evidence emotional support.

Patient transport services (PTS)

Understanding and involvement of patients and those close to them

- Due to the fact the service was not carrying out any regulated activity at the time of the inspection we could not evidence understanding and involvement of patients and those close to them.

Are patient transport services responsive to people's needs?

Not sufficient evidence to rate

We inspected but did not rate responsive because there was insufficient information due to the fact the provider was not carrying out any regulated activity at the time of the inspection.

Although we did not rate responsive we did find the following areas where the service could improve,

- On the vehicles there were no multinational cue cards for patients whose first language was not English.
- There was no communication aids for patients with visual or hearing impairment in the vehicles inspected.

Service delivery to meet the needs of local people

- Due to the fact the provider did not have contracts with NHS or independent providers at the time of this inspection we could not evidence if there had been long-term planning of PTS capacity to cope with differing level and nature of demand in different localities.
- When the service had the PTS contract in June 2018 and the demand levels exceed those which had been outlined in the tender, the service recognised it did not have the resources to meet the needs of local people and voluntarily cancelled the contract.
- The director of operations told us the company were in negotiations with an NHS ambulance provider to obtain a PTS contract.

Meeting people's individual needs

- On the vehicles we inspected there were no multinational cue cards for patients whose first language was not English.
- There was no communication aids for patients with visual or hearing impairment in the vehicles we inspected.

Access and flow

- Due to the fact the service was not carrying out any regulated activity at the time of the inspection access and flow could not be evidenced.

Learning from complaints and concerns

- We saw evidence of a complaints process flow chart for staff and managers to follow. The flow chart outlined the various stages of the complaint investigation process and roles and responsibilities of staff and managers.
- The logistics director was responsible for recording of complaints on the company's incident log database and ensuring all complaints were acknowledged within two working dates and responses were available to the complainant within the 20 working days.
- The director of operations had responsibility to assist the complaint process to the satisfactory conclusion of the complainant by ensuring all complaints were allocated to an appropriate manager depending on the grading and seriousness of the complaint.
- An investigator from the management team was responsible for contacting the complainant to establish a single point of contact and to gather the facts and investigate the complaint. They ensured the complaint was investigated within the agreed timescale.
- The finalised investigation was submitted to the managing director who ensured all areas of the complaint have been addressed. They provided feedback from the investigation outcome and any individual lessons learned to the line manager and staff involved in the complaint. If appropriate, any identified wider learning was shared with all the staff via e mail.
- We saw the service had recorded nine complaints when they were carrying out regulated activity. None of the complaints were in relation to the conduct of staff or patient care. All were in relation to waiting times once a patient had finished their treatment and were waiting to go home.

Patient transport services (PTS)

- All the historic complaints were closed as resolved after contact with the complainant. The complaints had been investigated in accordance with the company policy.

Are patient transport services well-led?

Not sufficient evidence to rate

We did not rate well- led as there was insufficient information due to the fact the provider was not carrying out any regulated activity at the time of the inspection.

However, we did find the following areas where the service could improve;

- The service did not have an effective system for the identification, mitigation and monitoring of risk.
- Paper patient record forms at Washington were not stored securely, however, following the inspection the provider submitted evidence showing PRF`s and incident forms were stored securely in a cabinet with a number combination lock.
- Patient record forms were not collected regularly so they could be reviewed and audited, however, following the inspection the provider submitted evidence of two PRF audits carried out in September 2019.

However, we found the following areas of good practice:

- The 55 policies we reviewed were in date, version controlled, and the date of last review recorded.
- The service had an ethical policy which provided information for staff to act in accordance with the rules or standards of conduct and practice relating to the standards of their profession, an anti-bribery policy, a whistleblowing policy, hospitality and gifts policy to support staff culture.
- The service had a computer-based document control register which ensured all documents and records were created, accessed and managed.

Leadership of service

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service was led by a Managing Director. The Director of Operations reported to the Managing Director and supervised the Logistics Director and Training Manager.
- Responsibility for finance, human resources and IT support was outsourced.
- The provider had a fit and proper persons policy for directors dated 9 July 2019. The policy outlined the providers legal requirements to ensure that anyone who is or has been appointed as a director to a position of authority is: “good character” as defined Care Quality Commission guidance to meet Regulation 5, be qualified, competent, sufficiently experienced and,sufficiently healthy to carry out the role, withno personal history of serious misconduct or mismanagement in carrying out a regulated care activity which would make the person ineligible for the role.

Vision and strategy for this service

- The provider had a vision which was, “Aspiring to be better today and even better tomorrow at everything we do”.
- The providers goals were; always caring for patients and work colleagues, striving to improve services, always set high standards and deliver what was promised and leadership and safety being at the core of the patient safety groups.
- The providers core values were; care, teamwork, quality, respect and honesty. Each of the values were underpinned by a mission statement.
- Due to the fact the service was not carrying out any regulated activity at the time of the inspection we were unable to evidence staff understanding of the vision and strategy for the service or evidence if these were present in staff appraisals.

Culture within the service

- The provider had a corporate ethics policy which included; an ethical policy, an anti-bribery policy, a whistleblowing policy and a hospitality and gifts policy dated 1 December 2017. The document review date was held on a computer-based document control register.
- The policy defined what the responsibilities of staff were in relation to the areas outlined.

- Due to the fact the service was not carrying out any regulated activity at the time of the inspection we were unable to evidence staff views about the culture in the company.

Governance

- During inspection we reviewed the minutes of the Patient Safety Group meetings held in April, May and June 2019. The issues discussed did not relate to PTS.
- The meetings were attended by the director of operations, operations manager who was a member of bank staff, logistics director, on one occasion by an office manager.
- The minutes covered the matters arising from the previous meeting but there was no evidence of a set agenda.
- Policies were reviewed annually unless an amendment was required, the renewal due date was recorded online.
- Due to the fact the service was not carrying out any regulated activity at the time of the inspection we were unable to evidence the governance of PTS or levels of PTS staff adherence to the services policies.

Management of risk, issues and performance

- The service did not have an effective system for the identification, mitigation and monitoring of risk.
- The service had an up to date emergency/ major incident response and business continuity plan which outlined the roles and responsibilities of staff. The document provided clearly defined courses of action to take in the event of a major interruption to the operation of the services provided.
- The document had been created on 1 December 2017 and had an author. The document review date was held on a computer-based document control register.
- The providers PTS vehicles were supplied by a national car hire company. We saw evidence of a service level agreement with the car hire company which covered the rental process, servicing and supply and collection of vehicles.
- We saw evidence the provider had a service level agreement with an external company relating to all medical devices including servicing and maintenance.

Information Management

- The provider had achieved a level two status on the NHS digital toolkit for information governance.
- There was evidence the out sourced IT team ran checks on the providers IT systems to ensure all were secure, current and up to date.
- We saw evidence the service had a computer-based document control register. The computer system ensured all documents and records were created, accessed and managed. The Managing Director was the document controller who was responsible for creating and modifying documents.
- When we inspected the Washington office we found the letter box for sensitive information was not locked and when opened a completed form was found inside dated 6 July 2019. This meant that personal patient information could have been accessed by members of the public or none service staff?
- There was a separate letter box for patient information. This was found to be insecure. Although locked we could see forms in clear view in the slot where the forms were inserted. The gap in the letter box was large enough to reach in and extract the forms.
- We extracted nine patient forms, the oldest dating back to 7 July 2019, the most recent 20 July 2019. Two forms had no dates. All the forms related to patients who had received treatment at an event not PTS.
- However, following the inspection the provider submitted evidence showing PRF`s and incident forms were stored securely in a cabinet with a number combination lock.

Public and staff engagement

- The service had carried out a recent staff survey, but the results were not available at the time of this inspection.
- There was no evidence the service had carried out any public engagement.
- When we inspected the Washington office we saw a poster on a notice board which invited staff to attend the monthly patient safety group meeting.

Innovation, improvement and sustainability

Patient transport services (PTS)

- The director of operations told us the company provided a range of different services to generate income and remain sustainable.
- At the time of the inspection there were no contracts in place for PTS for either NHS or independent health care providers.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should ensure multinational cue cards for patients whose first language was not English are carried on their ambulances. This is in relation to Regulation 9: Person-centred care.
- The provider should ensure communication aids for patients with visual or hearing impairment are carried on their ambulances. This is in relation to Regulation 9: Person-centred care.
- The provider should store fire extinguishers in accordance with the Fire Extinguisher regulations which form part of The Regulatory Reform (Fire Safety) Order 2005. This is in relation to Regulation 15: Premises and equipment.
- The provider should measure and monitor the store room temperatures to ensure Entonox cylinders are stored at above 10°C for at least 24 hours prior to use. This is in relation to Regulation 15: Premises and equipment.
- The provider should have a policy regarding the administration of medical gasses. This is in relation to Regulation 17: Good governance.
- The provider should carryout audit activity. This is in relation to Regulation 17: Good governance.
- The provider should have an effective system for the identification, mitigation and monitoring of risk. This is in relation to Regulation 17: Good governance.
- The provider should have a process to collect paper records on a regular basis from the Washington site, so they can be reviewed and audited. This is in relation to Regulation 17: Good governance.
- The provider should have a system in place to ensure all staff recruited to work for the service have two references. This is in relation to Regulation 19: Fit and proper persons employed.