Immediate Care Medical Services Limited

Immediate Care Medical Services

Quality Report

Suite 108
69 Steward Street
Birmingham
B18 7AF
Tel: 01212003086
Website: www.immediatecaremedical.co.uk

Date of inspection visit: 2 February 2018
Date of publication: 24/05/2018

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Immediate Care Medical Services (ICM) is operated by Immediate Care Medical Services Limited. The service is based in Birmingham, West Midlands, and provides patient transport services and event cover across central England and the UK.

Our inspection on 2 February 2018 lasted one day and covered two of the five domains. This was to assess whether the patient transport services provided by ICM were safe and well led. We did not inspect safe and well led domains using all key lines of enquiry.

The provider operated from one location split between two premises. The office was based in an office block in Birmingham. The vehicles, resources and equipment were held in an industrial garage based in Smethwick. We did not inspect the industrial garage or vehicles and equipment contained within. We inspected the office base only as part of this inspection.

Ted Baker

Chief Inspector

Immediate Care Medical Services

Detailed findings

Services we looked at Patient transport services (PTS)

Detailed findings

Contents

Background to Immediate Care Medical Services

Immediate Care Medical Services is operated by Immediate Care Medical Services Limited. The leadership team consisted of three directors and an operational manager. One of the directors was a registered nurse and the registered manager of the service. An operational manager was responsible for all operational aspects and securing patient transfers. The leadership team were supported by an administrator.

Immediate Care Medical Services had no substantive contracts but sub-contracted jobs on a request basis on an ad-hoc basis. The provider had no direct contact with NHS providers or private organisations they sub-contracted work from. The majority of Immediate Care Medical Services work output was event cover. They also provided training courses for external providers. CQC do not regulate either of these activities and therefore is out of CQC's remit to inspect and will not be included in this report.

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) Inspector and was overseen by a CQC Inspection Manager. In addition, the team consisted of a specialist advisor paramedic with a background in ambulance service management.

Patient transport services (PTS)

Safe	
Well-led	
Overall	

Information about the service

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

On 2 February 2018 we carried out a focused unannounced inspection. Previously we had conducted an announced comprehensive inspection of Immediate Care medical services Limited on 6 December 2016. This was as part of our routine inspection programme, during which we identified regulatory breaches. Following this inspection and via engagement and intelligence we had received, we were not assured the provider had taken sufficient action to comply with the regulations. Therefore, we carried out a further focused, unannounced inspection of Immediate Care Medical Services Limited.

We followed our risk based methodology to reach this decision to inspect. During our inspection, we spoke with one executive director, one operational manager, and one administrator. We also reviewed policies and procedures and records, including 14 staff files, incident forms and patient transfer records at the head office.

Following our inspection visit, we spoke with the registered manager.

We did not visit any hospitals and did not accompany any Immediate Care Medical Services personnel on any patient transfers. We did not inspect ambulance vehicles, the premises, equipment and storage of equipment at the ambulance depot.

Track record on safety

There were no reported never events in the 12 months preceding the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event has the potential to cause serious harm or death but neither had happened.

There were no reported clinical incidents or serious injuries in the 12 months preceding the inspection.

There were no formal complaints received by the service in the 12 months preceding the inspection.

Patient transport services (PTS)

Summary of findings

Services we do not rate

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

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

- There were no formal processes, for example, training recording or reviewing systems in place to ensure staff received mandatory training.
- The systems to ensure staff knew and understood policies and processes relating to safeguarding were not robust.
- There was no risk management policy in place to ensure the provider were assessing and managing risk.
- Governance was not embedded. There was no business vision and strategy to help guide the service in setting objectives or future planning.
- Recruitment processes were not sufficient to ensure that staff were appropriately employed with the right checks to ensure competency. To ensure the safety of those who used the service.
- Staff did not always have up to date Disclosure and Barring Service checks and reviews to ensure they were suitable to work in a position of trust.

Are patient transport services safe?

Incidents

- The provider had an incident reporting system, which was in paper form and stored in a folder. We looked through the folder and found the majority of the recorded incidents related to vehicle concerns.
- We identified a number of incidents through our conversations with managers. We had a record of a whistle-blower concern and looking through staff files we identified further incidents. There was no evidence that any of these had been fully investigated or reviewed. There were no documented lessons learned and shared to avoid similar future events taking place.
- A director told us that there were no formal investigation processes. We saw no evidence of any learning from any incidents. Providers must have an effective system for receiving, handling and responding to complaints and incidents from all contributors. All incidents must be considered and any necessary action taken where failures have been identified. This meant there could be a risk of harm to people using the service.
- One employee had three incidents recorded in the incident book about their conduct and competence. We noted a conversation had taken place between a senior member of staff and the sub-contractor. However, the notes of the conversation ran to one sentence. It did not demonstrate that their conduct or competence had been addressed or further assessed. This meant the incident may not have been dealt with to avoid similar future concerns being raised against them or happening again.
- We saw no evidence of incident reporting training for staff or any related policies and procedures to ensure staff were clear about the process for reporting. Managers told us if an incident occurred, the sub-contracted staff member completed an incident form and then returned the forms to the office in Birmingham.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

Patient transport services (PTS)

- Immediate Care Medical Services did not use a quality dashboard or equivalent which meant they had no way to monitor the safety of the service delivered.

Cleanliness, infection control and hygiene

- We did not inspect this area.

Environment and equipment

- We did not inspect this area.

Medicines

- We did not inspect this area.

Records

- We did not inspect this area.

Safeguarding

- Safeguarding systems and processes were not robust to ensure staff and people who used the service were protected against the potential for harm and actual harm. For example, there was a policy but the systems didn't always support it. For example, staff were required to evidence they were trained to work with vulnerable people. There was no evidence of this in staff files.There was a safeguarding policy and a safeguarding booklet. The policy did not clearly set out procedures for staff to follow to protect vulnerable people for example, who to contact at the local authority when a safeguarding concern was identified.
- Thirteen of the14 staff files we looked at had no evidence of safeguarding adults or children training. One of the 14 staff files we looked at had evidence that they had achieved the minimum required standard for safeguarding children. Staff must be trained in safeguarding children to meet the minimum requirements in line with intercollegiate guidance; 'Safeguarding children and young people: roles and competences for health care staff INTERCOLLEGIATE DOCUMENT Third edition: March 2014. This meant that only one of the 14 staff could evidence their competency. This could also mean that staff do not understand how to protect people who might be vulnerable who they come in to contact with through work. The provider must have a system in place to ensure staff meet these requirements and protect people in vulnerable circumstances.
- The safeguarding lead was trained to a 3 which was documented in their file. Safeguarding leads should be trained to level 4 for both adults and children or have access to a level 4 trained professional to support the organisation in ensuring they meet the appropriate standards to protect those who use their services.
- Staff told us there had been no safeguarding concerns raised in the 12 months prior to our inspection. This meant we were unable to assess how the provider dealt with safeguarding concerns.

Mandatory training

- The provider did not offer mandatory training courses. Instead, following recruitment, subcontracted staff were provided with a one day refresher workshop. Staff were expected to evidence their competency by providing certificates of learning from their substantive or previous roles. Staff did not always provide this evidence and this might mean that had not been suitably trained to provide quality care to those using the service.
- Staff who attended the refresher workshop were provided with information relating to a number of relevant topics. Each topic was allocated 30 minutes. These topics included information relating to how to deal with an acid attack. Attendees were also provided with information on how to carry out cardiopulmonary resuscitation, an emergency procedure to manually preserve intact brain function until further measures can be introduced. There were further topics, which included infection control, major incident, manual handling, patient observations, patient report forms and safeguarding. This meant that without evidencing a previous full-length course, 30 minutes updates would not provide sufficient training to ensure staff competency in all topics covered.
- The provider agreed that the one-day workshop was not sufficient if the person had not undertaken the full course previously.
- Staff files did not have an up to date record of proof of attendance at full courses. There were self-declaration forms in most staff files; all staff were required to complete these upon employment. For example, to self-declare they had up to date safeguarding training. This meant that in the absence of up to date certification, Immediate Care Medical Services relied on

honesty when staff self-declared they had been trained to the required standard. This was not a robust system to ensure the competency and suitability of staff as they needed proof of original full course training.

Assessing and responding to patient risk

- We did not inspect this area

Staffing

- The provider told us they had a bank of over 100 subcontracted staff. This meant that there was a bank of staff who could be recruited based on their skills, competency and suitability for the role.

Response to major incidents

- The provider had no arrangements to support business continuity.

Are patient transport services well-led?

Vision and strategy for this this core service

- The provider did not have a formal vision or business strategy in place to help deliver on strategic and operational objectives. This meant we were unclear about the full function of the business, their objectives and what goals were set for the future.

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

- We did not see good governance to ensure delivery of high quality health care to people who used the services.
- There was no risk register for the service. The purpose of a risk register was to record the details of all risks that have been identified along with their analysis and plans for how those risks will be treated. This meant there were no systems to identify, assess, and manage risks.
- There was no policy or analysis in place to support the identification and management of risk. We were told that the provider was in the process of writing a risk policy. Risk management policies, procedures and systems and processes help identify and evaluate risks as a means to reduce injury to patients, staff members, and visitors within the organisation. This meant that at the time of our inspection, managers were not working proactively and reactively to either prevent incident or to minimise the damages following an event, or to identify learning
- Staffing and sub-contractor management was not robust, and education and training was not evidenced.
- There was no recruitment policy or robust systems and processes in place to ensure staff recruited were suitable to work in their role. There were some processes, for example, checklists at the front of some of the staff files, however these were not consistently on file or fully completed. Recruitment processes must be robust and ensure that staff employed have the qualifications, competencies, skills and experience to undertake their roles. This includes any required mandatory training and qualifications. There were no robust systems in place to ensure staff were supported to keep their competencies up to date.
- There was no mandatory training or robust audit of staff files with up to date record of proof of attendance at initial full courses to ensure their competency for their role.
- The provider did not have a system in place to ensure staff and substantive staff met their statutory duty to protect people in vulnerable circumstances. For example, ensuring a robust checking system for safeguarding training or having the required standard for qualified staff to safeguard vulnerable people.
- The company director confirmed that enhanced Disclosure and Barring Service checks that were carried out within a three-year period were accepted. Staff were asked to sign a self-declaration form. This meant managers were reliant on honesty. This was to confirm they had not committed any offences since completion of their Disclosure and Barring Service checks that would make them unsuitable for work. There was no written related policy, risk assessment or rationale to review for this decision.
- We looked at Disclosure and Barring Service checks in 14 staff files. Six staff files had a Disclosure and Barring Service check carried out within 12 months of employment This would provide some assurance that those staff had not committed any offences in that 12 month period.

Patient transport services (PTS)

- One staff file had a standard Disclosure and Barring Service . A standard Disclosure and Barring Service check does not show whether a person was barred from working with children or vulnerable adults. This would not meet the standards required when delivering a regulated activity.
- The remaining seven staff files had either no Disclosure and Barring Service checks at all or the Disclosure and Barring Service checks had been carried out over 12 months prior to employment. Although there is no mandatory requirement stipulating how often to repeat a DBS check, by virtue of the staff group working on a bank basis, this makes them a higher risk group. This would warrant rechecks on a more frequent basis. There was no risk assessment rationale for leaving for three years which was the practice. This system had inherent risks and meant those staff might be unsuitable for working with vulnerable groups.
- All 14 staff files we looked at had an inconsistent approach to references. Six of the 14 staff files had no references. Managers told us that they sometimes employed people who they knew personally and relied on honesty in their applications and declarations. This approach would not be robust enough to ensure staff delivering the service posed no risk to the public.
- Staff received a welcome pack with the policies attached. Staff had to make a declaration that they had read, understood and received the policies. However, we saw that not all policies were sent out, for example, incident reporting, complaints, raising a grievance and safeguarding policy and procedure. This might mean that staff were unaware of company policy to support them in carrying out their role.
- The provider did not have a policy in place to support identification and management of risk. However, a manager told us they were in the process of writing a risk policy. This meant that there were no policies to help manage risks or outline the expectations to those working for your organisation when a risk was identified.

Leadership / culture of service related to this core service

- A team of directors, and an operational manager led the service. The provider was a small family run business. The leaders in the service told us, and we saw in documentation that they sometimes employed people they knew and they sometimes relied on trust and honesty when employing staff in their service. This meant that their systems were not always robust to ensure the safety and quality for those who used the service.

Public and staff engagement

- People who used the service could complete a patient satisfaction survey that staff gave to all patients, including those transported to acute hospital services. However, the provider reported there was very little response to the surveys to inform any development of the service.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The provider did not provide evidence of innovation, improvement and sustainability.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The provider must take action to ensure:

- Recruitment processes are robust and staff employed have the appropriate safety checks (which includes DBS and reference checks), qualifications, competencies, skills and experience to undertake their roles.
- Staff are trained in safeguarding children and adults to meet the minimum requirements in line with intercollegiate guidance.
- There is a policy in place to support identification and management of risk.
- Incidents are managed using an effective reporting, analysis and management system. Staff are managed when there are complaints, competency and conduct issues identified.
- Governance is embedded to facilitate a commitment to maintaining standards, including risk management and assurance processes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— **(a) assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity (including the quality of the experience of service users in receiving those services);** (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The requirements set out in Regulation 17 were not met because: • Recruitment processes were not robust and staff employed did not always evidence that they had the appropriate safety checks (which included DBS and reference checks), qualifications, competencies, skills and experience to undertake their roles. • Staff did not always evidence trained in safeguarding children to meet the minimum requirements in line with intercollegiate guidance. • There was no policies, procedures or systems in place to support identification and management of risk. • Incidents were not managed using an effective reporting, analysis and management system. • Staff complaints, competency and conduct issues that were identified were not managed in an effective way.

This section is primarily information for the provider

Requirement notices

- Governance was not embedded to maintain high quality standards, including risk management and assurance processes.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...