Transsecure NW Ltd

Transsecure NW Ltd

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Transsecure NW Ltd opened in August 2019. It is an independent ambulance service based in Blackburn. The service provides patient transport services for local, regional and national acute NHS hospital trusts, local authorities and independent hospitals, 24 hours a day, 365 days a year.

The service provides patient transport services for adults; the service does not transport children. The service transports patients with mental health needs and those detained under the Mental Health Act 1983. The majority of work undertaken by the service is inter hospital transfers; however, the service also transports patients with mental health needs to and from home addresses when required.

We carried out a short notice announced focused inspection of the service on 27 November 2020. We inspected the providers services to check on the provider's progress towards addressing the concerns and action we took following our previous inspection in October 2020. We did not rate the service.

We found the found the following areas that still required improvement:

- We were not assured that there were systems or processes in place to safeguard patients from abuse and neglect. The safeguarding policy did not guide staff in relation to certain aspects of abuse and it was unclear when a concern would be reported to the local authority. The provider was unable to evidence who they would contact should additional advice be required from a safeguarding lead who had a higher level of competencies and experience until they were trained to that level.
- We were not assured there were robust systems and processes in place to ensure the safe management, prevention and control the spread of infection. The provider's infection prevention and control policy did not include information about how to manage risks related to the COVID pandemic. The coronavirus risk assessments for the service and staff had not been completed and the patient coronavirus risk assessment was not reflective of the service being provided.
- We were not assured that effective systems were in place to ensure the safety of the care and support provided was regularly assessed and monitored to ensure it was being delivered safely. There were no completed risk assessments of the ambulance vehicle. The ambulance risk assessment policy did not define how the levels of risk used were derived, nor did it set out the need for a formal risk assessment and how these should be reviewed.
- We were not assured that care was provided in a way to reduce the risk of avoidable harm to patients. It was unclear who staff should contact should a patient deteriorate and there was a lack of clarity on which procedure staff should be following to manage patients. Although the provider had purchased equipment to monitor vital observations staff had not received training in the use of the equipment.
- The exclusion criteria had been updated but was not adequately defined to ensure the clinical safety of people being transported and there was a lack of clarity around definition of certain conditions being excluded. Also, there was no clear policy or process to determine how many staff were needed to safely care for patients during transportation.
- We were not assured there were systems and process in place to safely manage the risks to patients being transported while sedated. For example, the guidance has been based on sedation levels used in the pre-operating environment not in the environment that would transport patient who had been detained under the Mental Health Act. It was unclear which policy staff should be following as there was no cross reference to the medication policy which was still available for staff which did not contain any guidance for staff on transporting patients who had been sedated.

Summary of findings

- The recruitment, selection and retention policy in place at the last inspection stated that driving assessments under test conditions will be required for all staff who drive vehicles. However, these had not been completed. At this inspection this requirement had been omitted from the policy as well as driving checks. These are vital assessments to ensure patients would be transported safely.
- We were not assured that patient risk assessments would be completed properly or documented as required as there was no supporting policy or procedure.
- We were not assured that restraint would only be used as the least restrictive option or that there were sufficient policies and procedures to support staff in the application of the Mental Capacity Act. The provider's policies and procedures for the use of restraint were not clear and did not always reflect best practice guidance and did not include guidance on the use of mechanical restraint. The provider did not have a clear policy and procedure to support staff in seeking patients' consent, to act in their best interests, or when undertaking a mental capacity assessment. Neither were we assured that the necessary observations and procedures would be undertaken after restraint was used to maintain patient safety.
- We were not assured the provider had robust processes to ensure that directors who had responsibility for the quality and safety of care and for meeting the fundamental standards of care were fit and proper to carry out the role. The provider had not undertaken important checks bankruptcy and insolvency checks on the appointment of its new director. The fit and proper person requirements had not been included in the provider's recruitment policy and there was no other policy outlining these requirements. We were also not assured that the provider had robust process in place to ensure that all staff had the required checks undertaken prior to commencing in their role.
- We were not assured there were effective systems for governance and risk management to ensure patients received safe care and treatment. There was no policy and procedure to support staff in carrying out patient monitoring audits to improve services provided were needed and it was not clear which elements of staff training were mandatory. A number of the provider's policies and procedures contained information that was not reflective of the service provided and it was unclear if the policies were the final version for staff to follow.

However, the provider had made the following improvements since our last inspection:

- The overarching medication policy had been amended to reflect the service provided and outlined clearly that staff would not administer or support patients with medication.
- All staff had competed additional first aid training in addition to basic life support training and staff had undergone additional training in the use of personal protective equipment to help manage the risk of transmission of infections.
- Exposed metal parts of one of the vehicles which was a risk to patient safety had been rectified and the vehicle inventory lists had been updated and implemented for both vehicles.

We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inspected but not rated 	• We were not assured that there were systems or processes in place to safeguard patients from abuse and neglect. • We were not assured there were robust systems and processes in place to ensure the safe management, prevention and control the spread of infection. • We were not assured that effective systems were in place to ensure the safety of the care and support provided was regularly assessed and monitored to ensure it was being delivered safely. • We were not assured that care was provided in a way to reduce the risk of avoidable harm to patients. • We were not assured there were systems and process in place to safely manage the risks to patients being transported while sedated. • We were not assured that restraint would only be used as the least restrictive option or that there were sufficient policies and procedures to support staff in the application of the *Mental Capacity Act*. • We were not assured the provider had robust processes to ensure that directors who had responsibility for the quality and safety of care and for meeting the fundamental standards of care were fit and proper to carry out the role. • We were not assured there were effective systems for governance and risk management to ensure patients received safe care and treatment. However, the provider had made the following improvements since our last inspection • The medication policy had been amended to reflect the service provided and staff had completed additional first aid training. Staff had also received training in the use of personal protective equipment.

Summary of findings

- Vehicle inventory lists were now available for both vehicles and exposed metal parts of one of the vehicles had been rectified.

Summary of findings

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Summary of this inspection

Background to Transsecure NW Ltd

Transsecure NW Ltd opened in August 2019. It is an independent ambulance service based in Blackburn. The service provides patient transport services for local, regional and national acute NHS hospital trusts, local authorities and independent hospitals, 24 hours a day, 365 days a year.

The service provides patient transport services for adults; the service does not transport children. The service transports patients with mental health needs and those detained under the Mental Health Act 1983. The majority of work undertaken by the service is inter hospital transfers; however, the service also transports patients with mental health needs to and from home addresses when required.

Transsecure NW Ltd is registered to deliver the following regulated activity:

- Transport services, triage and medical advice provided remotely

At the time of the inspection, Transsecure was in the process of identifying an individual to undertake the role of registered manager and had put in place a new nominated individual.

This location has been inspected twice previously since it was registered in August 2019. The previous inspections were carried out in July and October 2020. We took urgent enforcement action to suspend delivery of regulated activities by the provider following these inspections.

The current focused inspection was undertaken to assess if the provider had made sufficient improvements. Although we saw some improvements, we identified that there were still areas that posed a potential risk to patients and we took immediate action with the provider.

How we carried out this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Outstanding practice

We did not identify any areas of outstanding practice.

Areas for improvement

Action the provider must take to improve

Action the provider MUST take is necessary to comply with its legal obligations.

The provider must ensure that:

Summary of this inspection

- It meets the requirements set out in Schedule 3 and Schedule 4, part 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 6)
- It meets the requirements set out in Schedule 3 and Schedule 4, part 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 5)
- It meets the requirements set out in Schedule 3 and Schedule 4, part 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 19)
- The use of the secure cell is included in the risk assessment form and only used when appropriate and deemed the least restrictive option. (Regulation 11)
- There is clear policy or procedure which supports staff in seeking consent, acting in a patients's best interests or undertaking a mental capacity assessment. (Regulation 11)
- There is an effective process to manage deteriorating patients in terms of physical or mental health conditions in the event their behavior deteriorated and became uncontrolled. (Regulation 12(1)(2))
- There is a clear policy to support staff in managing patients who had received sedative medication. (Regulation 12(1)(2))
- It reviews its restraint policy and procedures to include appropriate information, best practice and guidance to keep patients safe, and to remove inappropriate references. (Regulation 12(1)(2))
- It reviews its patient booking exclusion criteria in relation to patients who are to be excluded (Regulation 12(1)(2))
- It has a clear policy or process to support staff to determine how many staff members were needed to safely care for patients during transportation. (Regulation 12(1)(2))
- It reviews its infection prevention control policy to include relevant information about infection control precautions in line with current guidance around the transmission of COVID-19. It also reviews the risk assessments to be completed for COVID-19 (Regulation 12(1)(2))
- It reviews its safeguarding adults' policy and its children's and young people's safeguarding policy to supporting staff in recognising safeguarding concerns and to clarify when a safeguarding concern would be reported to the local authority. (Regulation 13(1)(2)(3)(4))
- It obtains and records evidence that its external healthcare professional safeguarding lead has the required skills and competence to undertake this role, and that is has a formal agreement in place to support the role. (Regulation 13)
- It reviews its risk assessment processes to demonstrate how any associated risks have been assessed and planned for by the service. (Regulation 17 (1)(2)
- Its ambulance risk assessment policy defines how the three risk assessment levels of risk are derived and clarifies when a formal risk assessment is required and should be reviewed. (Regulation 17(1)(2))
- It develops and implements an audit programme to undertake and record any patient quality monitoring or audits in relation to key processes. (Regulation 17(1)(2))
- It reviews its patient risk assessment process to ensure it has a policy and process to support staff in the correct application and completion of the risk assessments. (Regulation 12(1)(2))
- It has a policy or process that clearly defines which elements of training are determined as mandatory. (Regulation 17(1)(2))
- It reviews its policies and procedures to remove elements that are not reflective of the service it provides. (Regulation 17(1)(2))
- It has a clear process to determine how the restraint register and incident forms would be reviewed to identify potential failures in care or whether improvements were needed. (Regulation 17(1)(2))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated

Inspected but not rated

Patient transport services

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Are Patient transport services safe?

Inspected but not rated

Safeguarding

We were not assured that there were systems or processes in place to safeguard patients from abuse and neglect.

At the last inspection staff had not completed training for safeguarding adults and children level three, this had not been done in line with the intercollegiate document as face to face training had not been provided. During this inspection, we continued to have concerns. The safeguarding lead for the organisation had been trained to level three for adults and children but this had been on-line training and not face to face training as outlined in national guidance.

Also, at the last inspection there was no formal agreement with an external healthcare professional who was safeguarding level four trained who would be available for additional advice as outline in best practice guidance. During this inspection, the provider indicated that this healthcare professional was no longer contracted by the service. The provider had made no other arrangements to make sure that access to a level four trained member of staff was available in case advice was needed. This meant there was a risk that support would not always be available when needed or dealt with appropriately.

On reviewing the safeguarding policies and procedures it was unclear when a safeguarding concern would be reported to the local authority. We were told that that referrals would be made to the commissioning service and only to the local authority if the commissioning service was not available. There was no process in place for the service to be assured that any concerns raised with the commissioning service had been referred appropriately to the local authority. This meant that there was an increased risk that safeguarding referrals would not always be made appropriately when needed. We found that this was the same on the last inspection.

The term ‘best interests’ was used throughout the transfer and booking policy, but there was no reference to assessment of capacity relating to this or making best interest decisions as outlined by the Mental Capacity Act. There was reference to best interests of the patient and the staff. Staff best interests are not part of the Mental Capacity Act. Best interest decisions are decisions that are made for and on behalf of a person who lacks capacity to make their own decisions.

As in the previous inspection we found that the safeguarding adult policy included definitions of an adult at risk and listed types of abuse and safeguarding risks and provided examples of signs and indicators of abuse. Although it listed female genital mutilation as a potential form of abuse, it did not provide any definition or understanding of this within

the body of the document. The Safeguarding Adult Procedure document, in section 6.1, appeared to continue to conflate employee concerns, that would normally form part of a HR, whistleblowing or lone-working policy with safeguarding concerns. There continued to be inappropriate references to sport or sport organisations within the Safeguarding Adults Policy.

Neither the Safeguarding Adults Policy or the procedure document made reference to the *Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018* and the level of training required for all staff was not documented within the policy or procedure.

Although the provider did not transport children, at the last inspection we found that neither the safeguarding adults policy or procedure included any reference in the body of the documents to support staff to understand and recognise when they may come across situations where they may need to safeguard a child and there was no safeguarding children referral form available for staff.

At this inspection we found that the provider had put in place a Children and Young People's Safeguarding Policy and Procedure which was an improvement. However, we had concerns that in the policy it stated that the safeguarding lead was the operations manager and we were told on inspection that the safeguarding lead for the organisation was the nominated individual. This meant that staff may not fully understand who to go to for additional support. We also noted that section four and section six did not appear to have been fully completed.

Neither the Safeguarding Children and Young People's Policy or the procedure document made reference to the *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Fourth edition: January 2019* and the level of training required for all staff was not documented within the policy or procedure.

Within the Safeguarding Children and Young People's Safeguarding Procedure, there was a section on reporting concerns about 'yourself' if experiencing harm within Transsecure. This would not be applicable as the service only employs adults and does not transport children.

In response to our concerns we took immediate action with the provider.

Infection prevention and control

We were not assured there were robust systems and processes in place to ensure the safe management, prevention and control the spread of infection.

At the previous inspection we continued to have concerns about the robustness of the provider's infection prevention and control measures. Although the provider had implemented personal protective equipment such as face masks and visors in response to the COVID pandemic, the provider's infection prevention control policy did not outline any information about this, meaning that it was unclear if the provider had considered and had kept up to date with the most recent national guidance regarding the pandemic. We found on this inspection this was still the same. There was no policy in place in relation to the management of infection, prevention and control measures in relation to the COVID pandemic.

The Infection Control Policy and Procedure dated 25 November 2020, stated that COVID 19 policy and risk assessments were to be used in conjunction with the policy.

Patient transport services

The provider produced as evidence a number of coronavirus risk assessments. However, these had not been completed for the business or staff and there were concerns that they were not reflective of the service provided. For example, the business COVID risk assessment did not mention vehicles as outlined in the infection prevention and control policy. This was an example risk assessment from a different company as stated at the bottom of the form. The patient COVID risk assessment was around the likelihood or risk of getting COVID 19 and there was no section to identify appropriate measures that should be put in place where patients were COVID positive.

In relation to the cleaning of vehicles in between each transfer the infection control policy and procedure stated that vehicles are appropriately cleaned in between each transfer as per COVID 19 policy despite no policy being available. It also stated no transfer will take place unless the vehicle daily check sheet has been completed and this has been documented; implying that the cleaning of the vehicle will be included on this daily checklist. However, it is not included (TS-OMF-24 B1 daily inspection log/vehicle inspection log). There was also no reference around cleaning vehicles down in between patients especially if they were transporting COVID 19 positive patients.

Accordingly, there was a risk that patients will or may be exposed to the risk of harm as the provider did not have appropriate processes in place to be followed where COVID-19 positive patients were being transported to prevent the transmission of the virus.

Further, the policy also referred to management of clinical sharps (implements that break the skin such as needles or catheters), which would not be expected in the type of service offered by the provider, and which would be excluded by the requirements of the overarching medication policy and procedure for staff not to administer medicines.

Since the last inspection staff had undergone additional training in the use of personal protective equipment.

In response to our concerns we took immediate action with the provider.

Environment and equipment

We were not assured that effective systems were in place to ensure the safety of the care and support provided was regularly assessed and monitored to ensure it was being delivered safely.

At the last inspection, we had concerns that the provider was unable to provide evidence that there was equipment available to monitor patients if they had been sedated. At this inspection

we found that although the service had purchased equipment so that patients could be monitored safely and in line with good practice guidance, we were told that staff had not received training to use this equipment or how to interpret the findings. We were told this had been planned for the 17 December 2020. However, on reviewing the evidence of the training booked for 17 December 2020 this indicated that this was not included.

During out previous inspection, we were not assured that the provider had effective systems in place to regularly assess and monitor the safety of care and support delivered. This was because we found no evidence of completed risk assessments for the ambulance vehicle.

As at the last inspection there was an ambulance risk assessment policy, but we found on this inspection that it had not been amended to reflect our previous concerns. The ambulance risk assessment policy and procedure outlined some key operational and patient safety risks including self-harm. The purpose of this document was to identify and evaluate potential hazards; it stated that there were three levels of risk and identified some of the potential hazards including risk

level and mitigating controls. However, there was no indication on how the level of risk was derived. It did not set out the need for a formal risk assessment outlining any actions required to mitigate risks and for these risk assessments to be regularly reviewed. Risk assessments should be reviewed regularly to ensure that the risks to staff and patients being harmed has not changed and that no further control measures are needed.

At this inspection we found there were no completed risk assessments for the vehicle or other health and safety risk assessments such as of the environment. For example, the conditions staff were working in when visiting hospitals and other providers of care. This would be to ensure there were adequate measures in place to minimise the risk to patients and staff.

There was an equipment risk register in place which outlined the equipment, descriptor, date, risk level, controls, risk after controls, risk owner. It is not clear if any other actions need to be recorded to lower the risk further. However, there is an outline of what action to take dependent on the risk level. For example, high – must eliminate or reduce, medium, risk must be controlled so far as reasonably practicable. This had not been completed for the equipment already owned by the provider.

We found there were daily inspection logs available for vehicle checks and equipment checks. The equipment checks included; blood pressure monitor and pulse oximeter checks, thermometer checks and metal detector checks.

During our previous inspection we found that although the provider had amended the vehicle inventory list to reflect what equipment was needed on the main vehicle that was used following our first inspection, the inventory had not been updated and implemented on the spare vehicle. On this inspection we found that there was an updated inventory list for the spare vehicle.

At the last inspection we had concerns that one of the ambulances was not safe for use. We found there were metal parts of the vehicle which were exposed in the middle saloon which patients had access to and posed a potential risk to patient safety. At this inspection we found that the provided had rectified this.

In response to our concerns we took immediate action with the provider.

Assessing and responding to patient risk

We were not assured that care was provided in a way to reduce the risk of avoidable harm to patients.

Following our concerns at previous inspections regarding the restraint policy and procedure, we found that a transfer and booking policy had been put in place which contained information regarding the use of restraint. However, it was not clear if this had superseded other policies which were no longer to be followed by staff or whether it was to be read in conjunction with other policies. For example, the restraint policy and procedure had not been amended to address the concerns that were identified in our previous inspection and remained available to staff.

We found concerns around the management of restraint as the restraint section of the transfer and booking policy did not have a clear process for a post restraint debrief to be undertaken as outlined in good practice; nor did it make reference to the maximum time that restraint should be used or outline that vitals should be undertaken post restraint.

There was no specific guidance to support the use of handcuffs and there was other information that was not specific to the service currently being provided. The terminology used for some sections was not in keeping with best practice

guidance, including repeated in paragraphs that the use of restraint was “inevitable”. The policy also referred to restraint being part of “the duty of care of the transferring hospital, transferring service and receiving hospital”, meaning there was a risk of restraint being pre-planned prior to transfer and not based on individual assessment but a decision made by staff from other providers on the booking form.

Within the transfer and booking policy the description of training required in relation to restraint did not include team restraint techniques and staff training was listed as “de-escalation techniques, the concept and use of “minimum force” and “approved and acceptable break away techniques”. Although staff currently working at the service had received the correct level of training the policy did not support this going forward. This put patients at risk of serious injury from restraint by staff who had not been trained appropriately.

As a result, we could not be assured that restraint would be used proportionately and in accordance with recommended timeframes. Neither were we assured that the necessary observations and procedures would be undertaken after restraint was used to ensure there was early response to any deterioration and any immediate action required.

As in the previous inspection we found limited assurance that there was an effective process in place to manage deteriorating patients in terms of their physical and mental health conditions. We found the deteriorating patient procedure stated the emergency services should be called or the commissioner must be informed. It was unclear which policy staff should be following as there were no references to other policies around the deteriorating patient or if other policies had been superseded by the transfer and booking policy which contained some information on managing the deteriorating patient.

We were told that patients could be safely transferred in the cell of the vehicle when sedated, without measures in place to prevent them from the risk of harm if there was, for example, an accident as were told that patients could be in the cell of the vehicle but with the internal door open during transportation; there had been no consideration of using other parts of the vehicle which had seatbelts to transport patients on occasions when the cell of the vehicle was not required.

On reviewing the transfer and booking policy we found it did not provide enough information or guidance for staff. There were a number of occasions within this policy where it stated that the responsibility for aspects of transferring patients was identified as the transferring site or referrer. This included decisions about the appropriateness of the transfer, hydration and nutrition, observations and monitoring and need for restraint and other restrictive interventions. This potentially meant that Transsecure staff were not responsible for the safe management of patients as these decisions or any resulting actions were made by another organisation.

Staff have a duty of care to their patients and must be aware of all their responsibilities in situations where a patient has to be restrained whilst a patient transfer is being undertaken. As the policy did not reflect best practice and guidance, there was a risk that staff may use restraint inappropriately and fail to adhere to the necessary safety precautions, thereby meaning patients may or will be exposed to the risk of harm.

We found that the transfer and booking policy outlined the vitals such as pulse rate, respiration and level of consciousness that would be required to be undertaken during restraint or if the patient deteriorated. However, we were told that this was reliant on the commissioning service stating what observations to carry out if they were not providing an escort.

Inspected but not rated

Patient transport services

At the last inspection we found that not all staff had completed additional first aid training in addition to basic life support training. Additional first aid training was important as part of staff roles and responsibilities was to monitor patients for signs of deterioration. At this inspection we found that all staff employed to transfer patients had completed first aid training which was an improvement. However, there was no guidance around the ongoing training requirement on how to support staff to undertake these observations to monitor signs of deterioration.

The exclusion criteria had been updated since the last inspection to include those who were immobile; we were told at the last inspection that these patients would not be transported but this was not included in the exclusion criteria. At this inspection, we still had concerns about the robustness of the exclusion criteria. We were told that patients who were not detained under the Mental Health Act would not be transported; this had not been included as part of the exclusion criteria. We also found that the exclusion criteria was not adequately defined to ensure the clinical safety of people being transported, for example the lack of specific physiological criteria including chronic comorbidities, lack of clarity about definition of bariatric and immobility.

The recruitment, selection and retention policy in place at the time of the inspection in October 2020 and dated October 2020 stated that driving assessments under test conditions would be required for all staff who drove vehicles; these had not been completed. In the recruitment, selection and retention policy updated in November 2020 these driving assessments, to ensure patients would be transported safety, had been omitted from the policy. Also, any reference to driving checks to be carried out had been omitted from the revised policy in November 2020. For example, driving licence checks and driving offences.

We found at the last inspection there was no clear policy or process to support staff to determine how many staff members were needed to safely care for patients during transportation. On reviewing the transfer and booking policy at this inspection it stated that a minimum of three staff would be used and we were told this could be potentially increased. However, there was still no clear process based on the outcome of the risk assessment to determine the required level. This meant that there was still an increased risk that there would not always be enough numbers of staff to meet the needs of the patient.

At the last inspection we saw that the provider had implemented a new risk assessment process so that patients were risk assessed. We found that there was no supporting policy or procedure to support staff completing these risk assessments in practice. At this inspection we found that key elements (service specific risk assessments and dynamic risk assessments) of the safe transfer pack were still not underpinned by an associated policy or procedure. This meant that there was an increased risk that the patient risk assessment process would not always be followed, completed properly or documented as required.

As at the last inspection we were told that the operations manager would be on every journey and they would be responsible for completing the risk assessments.

We reviewed the transfer and booking policy and found it had a risk assessment section. However, this section referenced risk assessments in line with the Health and Safety at Work Act, regulation 3 of management of health and safety at work regulations and regulation 12 of the Health and Social Care Act 2008. It was not clear to staff on how they should be completing patient risk assessments as the principles outlined were more in line with employee health and safety risk assessments, rather than clinical risk assessments

The transfer and booking policy stated that the service would only provide hydration during the journey based on what information was provided by the transferring site. There was no reference to nutrition being provided if on a long journey or if the individual had a medical condition which required regular food, such as patients who were diabetic.

Inspected but not rated

Patient transport services

In response to our concerns we took immediate action with the provider.

Medicines

We were not assured there were systems and process in place to safely manage the risks to patients being transported while sedated.

During previous inspections, we found there were no policies, processes or procedures to determine and manage the risk during transfer for patients who had received sedation medicine.

We were told at this inspection that the service would transport a patient who had been sedated. However, the section in the transfer and booking policy in place to support staff in managing patients who had received sedative medication was unclear. For example, the guidance and what we were told on inspection had been based on American Society of Anaesthesiologists grades which are used in the pre-operating environment for undertaking a procedure and not in the environment that would transport patients who had received rapid tranquillisation and be detained under the Mental Health Act. Also, we found the overarching medication policy had not been amended to include the use of rapid tranquillisation or a cross reference to the relevant section of the transfer and booking policy. We were concerned that policies would not fully support staff in managing a patient who had been sedated.

At our previous inspection we had continued concerns that medicines would not be managed safely and that there was a risk that staff would administer prescribed or non-prescribed medicines inappropriately. We were not assured that the provider's overarching medication policy was specific to the service and adequately supported staff around the management of medication to keep patients safe from avoidable harm.

At this inspection we found that the overarching medication policy and procedure outlined that staff were not permitted to administer medication and if support or administration of medication was required then a member of staff from the transferring hospital must accompany the patient.

We were told that arrangements had been put in place with an agency for registered mental health nurses to support transfers, if required, to administer medication and there was no one available from the transferring hospital. However, there was no evidence of this in any policies we reviewed.

At the last inspection we found that the overarching medication policy did not clearly outline and support staff in the safe storage of patients' medicines to ensure patients would not potentially be placed at a risk of avoidable harm.

On this inspection we found that the policy included where a patient's medication should be stored within the ambulance and that staff should reconcile all medicines with the transferring hospital staff prior to taking possession of the medication to ensure there were no discrepancies when checked by the receiving hospital.

In response to our concerns we took immediate action against the provider.

Are Patient transport services effective?

Inspected but not rated

Consent, mental capacity

Inspected but not rated

Patient transport services

We were not assured that restraint would only be used as the least restrictive option or that there were sufficient policies and procedures to support staff in the application of the *Mental Capacity Act*.

At the last inspection we were not assured that the provider would always recognise occasions when restraint had been used and would potentially use restraint on occasions when not needed. The provider was not aware that the use of the cell in the ambulance was a form of restraint including when the cell door was not closed nor was this recognised on the risk assessment forms.

At this inspection we reviewed the risk assessment forms, both primary and dynamic, and found that the use of the secure cell was not included for staff to assess to ensure that this form of restraint was only used when appropriate and as the least restrictive option. However, staff in the service had been informed by the managers that the use of the cell in the ambulance was a form of restraint.

There was no clear policy or procedure which supported staff in seeking consent, acting in a patients's best interests or undertaking a mental capacity assessment. Although limited aspects of mental capacity were documented in the safeguarding policy, the staff induction guide and elements of online training, there was insufficient information which detailed how this would be applied in practice on the occasions when this was needed. This was the same at the last inspection.

At the time of inspection, we were told a draft mental capacity policy and procedure was currently in draft. CQC have not been provided with evidence of this. This means that there was a continued risk that systems were not in place to support staff about when to seek consent, act in a person's best interest or how this should be documented. The provider had undertaken no additional actions since our last inspection to make sure that systems and processes were in place to support staff with this.

We were informed that the provider had commissioned training in the Mental Capacity Act. This was planned for a date after this inspection. This had been raised as a concern at the previous inspection.

The transfer and booking policy contained guidance referencing Deprivation of Liberty Safeguards (DoLS) and authorisation. DOLS authorisations contain no powers relating to conveyance of people and are location specific. DoLS is the procedure prescribed in the Mental Capacity Act when it is necessary to deprive of their liberty a patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

In response to our concerns we took immediate action with the provider.

Are Patient transport services well-led?

Inspected but not rated

Leadership of service

We were not assured the provider had robust processes to ensure that directors who had responsibility for the quality and safety of care and for meeting the fundamental standards of care were fit and proper to carry out the role.

Inspected but not rated

Patient transport services

At our previous inspection we found that a new director had been appointed and that steps had not been taken to make sure that all the relevant checks had been undertaken to ensure that they were fit and proper to undertake their role.

At this inspection we found that all the requirements as set out in Schedule 3 and Schedule 4, part 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had still not been completed such as bankruptcy and insolvency checks.

There was no policy in place for fit and proper persons: directors, nor anything outlined in any other relevant policy such as the recruitment, selection and retention policy.

We also found that there were effective processes to ensure that staff undertaking the role of the nominated individual had the necessary qualifications, competence, skills and experience in line with schedule 3 and schedule 4 of the Health and Social Care Act 2008, to properly supervise the management of the carrying on of the regulated activity. The provider had not set out what the roles and responsibilities of the nominated individual would be; we therefore could not be assured that the nominated individual would know what was expected of them.

There was no registered manager in place at the time of our inspection. Plans had been put in place to support the operations manager by means of mentorship. The provider had taken steps to advertise for a registered manager but had been unsuccessful at the time of the inspection.

The Health and Social Care Act 2008 states that registered providers must have a registered manager. This is to ensure that people who use services have their needs met because the regulated activity is managed by an appropriate person.

In response to our concerns we took immediate action with the provider.

Governance

We were not assured there were effective systems for governance and risk management to ensure patients received safe care and treatment.

Following our last inspection, the provider had put in place an action plan/tracker about how it was going to improve the services being provided.

We reviewed the action tracker; although the tracker indicated that all actions were complete, we found continued concerns during this inspection.

The policies submitted as evidence of improvement from our previous inspection did not always contain reference to appropriate best practice or national standards. This was also found on the last inspection. They also contained comments following a review of them, by a person external to the provider, but were submitted to CQC as final policies to be implemented. It was not clear what if any changes to policies had been made following these comments. It was also not clear if the documentation control and retention policy was effective as several policies did not indicate that they had been approved or had a review date.

The system for reviewing policies was not effective. There was no evidence provided of what the role and responsibilities of the external clinical person was in relation to policy review or what input they had into the service.

Inspected but not rated

Patient transport services

We found policies were not always reflective of the services being provided or of sufficient quality to support staff. For example:

- The document titled patient incident report procedure was in fact the first aid policy and procedure. The contents and the procedure was more around providing first aid at work in line with health and safety legislation. It stated it was to ensure that the provider ensures that they have staff with sufficient skills to meet any situation where first aid was needed. This policy was unclear as it talked about providing first aid to those in receipt of services in one paragraph (3.4) but the procedure was around providing first aid at work in line with health and safety legislation.
- The transfer and booking policy did not mention whether any of the content superseded or was in conjunction with any other policies already in place, such as the deteriorating patient, exclusions and restraint. Also, it was not clear who this policy was for; in places it read as though it was for the commissioning service on what would happen during the transfer
- The exclusion criteria did not seem to take into consideration the Equality Act 2010.
- The restraint section of the transfer and booking policy made reference to Deprivation of Liberty Safeguards which were not appropriate for the service; did not correctly reference **'*National institute for Health and Care Excellence NG10 and Department of Health: Positive and Proactive Care (2014)* (sections 1.423)**'; and stated that the service did not carry out any chemical restraints but may assist at the request of a healthcare profession in accordance with staff training. There was no guidance to support staff in assisting with chemical restraint and there was no evidence of what training would be required; it made reference that use of surveillance methods must be justified as necessary only to keep people safe but there was no guidance for staff. It also contained examples which were related to different services such as 'the home' undertakes to provide staff with appropriate guidance. The service was not a home but an independent ambulance provider.
- We found within the transfer and booking policy a statement relating to the Mental Health Act with the description of patients receiving medical treatment under section 1 of the Act. Section 1 of the Act outlines the provisions and terminology of the Act. There are no powers of detention relating to this part of the Act.

It is important that policies are specific to the service provided to support staff in delivering safe care and treatment.

Further the provider did not have clear policies and procedures covering important topics such as health and safety. This meant that there was a risk that staff would not have the necessary guidance to support them to undertake their roles.

There was a risk management procedure in place, but this only briefly outlined what could be a risk, how the risk management processes should be recorded and that a risk register should be produced for every risk identified. It was noted that the policy did not outline how risks should be reviewed or further actions that might be required to lower the risk. It did not outline descriptors for each level of severity to aid correct level of assessing the risk. There was an equipment risk register, but this was incomplete.

At our last inspection we found concerns regarding the lack of clear processes to determine how incidents of restraints would be reviewed. We were told that incidents of restraint would be investigated by a manager. At this inspection, there was still no clear process, policies or procedures which determined how these would be reviewed to identify potential failures in care or whether improvements were needed. We did see that on the standard agenda for the management meetings incidents was an agenda item.

Inspected but not rated

Patient transport services

At the last inspection we found there was no system or process to undertake patient quality monitoring audits in relation to key processes such as infection control processes or patient records. At this inspection we were told that going forward patient monitoring would take place. However, there were no patient monitoring audit programmes outlined in the policies we reviewed. This meant that any improvements needed in the delivery of care would not be recognised and acted upon.

At our previous inspection we found that the provider did not have a policy or process for mandatory training. At this inspection we found that there was still no policy or process which outlined mandatory training requirements and how often this training should be undertaken. This meant there was a risk that the provider would not be assured that staff would know important updates and have had the necessary mandatory training. It is important that staff are kept up to date with changes to best practice guidance and legislation for them to undertake their roles safely.

The recruitment selection and retention policy did not contain all the checks as outlined in schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It did not contain the need to have proof of identity before employment, or satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform. Also, it did not include obtaining satisfactory information about any physical or mental health conditions which were relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which were intrinsic to their employment or appointment for the purposes of the regulated activity.

We were told the service had procured the services of a registered mental health professional to review all the policies and procedures and for clinical advice. However, no evidence was available about this person to ensure that all the appropriate checks had been completed, including competencies to undertake their role as well as professional registration checks.

We were also told the service had procured the services of a registered mental health professional who was a registered manager for another provider, to provide advice and support to the service as there was no registered manager currently in place. However, no evidence was available to ensure that all the appropriate checks about this person had been completed, including competencies to undertake their role.

Although the service had implemented an incident form for all staff to complete, there was not a clear process which determined how these would be reviewed to identify potential failures in care or whether improvements were needed. The provider did not have a policy or process to support this.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 6 HSCA (RA) Regulations 2014 Requirements where the service provider is a body other than a partnership

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment