The Risk Practice Ltd

ShowMed

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 well-led?	Inspected but not rated

Summary of findings

Overall summary

We carried out a focussed responsive inspection at ShowMed on 31 August 2021 as a follow up to the issue of a warning notice for breaches in Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance) which was issued on 26 November 2019 following our previous inspection of this service on 11 November 2019.

We also followed up on actions taken following the issue of requirement notices for breaches in Regulations 13, 15 and 19 from the previous inspection of this service on 11 November 2019.

During this inspection we found there had been improvements since the last inspection and the provider had addressed the concerns raised in the warning notice and requirement actions from the previous inspection.

We did not rate the service as part of this inspection because the service had not carried out any regulated activities.

We found the following areas of good practice:

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. staff carried out clinical observations and repeated these at regular intervals.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

However:

- The frequency of clinical observations was not formally specified in the provider's policies for managing deteriorating patients.
- The provider did not have a standardised process for documenting capacity assessments and best interest decision-making discussions.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Inspected but not rated	The main activity provided by ShowMed was emergency and urgent care services. We did not rate the service because this was a focussed inspection to follow up improvements made following the issue of a warning notice and requirements issued following our previous inspection in November 2019.

Summary of findings

Contents

Summary of this inspection

Background to ShowMed

ShowMed is located in Bolton, Greater Manchester and operated by the Risk Practice Ltd. The service supplies doctors, nurses, paramedics, emergency medical technicians and first aiders to sporting and public events.

CQC does not regulate activities that are undertaken on an event site. However, CQC do regulate activities involving patients being transported from an event to hospital, which was an activity that was carried out by the service.

The service has been registered since 16 September 2011 and the current registered manager has been in post since October 2019.

The service is registered to provide the following regulated activities:

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

We previously inspected the service on 11-12 November 2019 and 7 January 2020. Following the inspection in November 2019 we issued a warning notice for breaches in Regulation 12 (safe care and treatment) and Regulation 17 (good governance). We also issued requirement notices for breaches in Regulations 13 (safeguarding), 15 (premises and equipment) and 19 (fit and proper persons employed) following this inspection.

The inspection report was published in March 2020 and we rated the service as requires improvement overall, with a rating of requires improvement for safe, effective and well-led and a rating of good for responsive. We did not rate caring as part of this inspection.

How we carried out this inspection

During the inspection visit, the inspection team:

- Inspected the premises at Bolton, Lancashire and one ambulance vehicle.
- spoke with the registered manager and the nominated individual.
- looked at the training and recruitment files for six staff.
- looked at six patient report forms.
- looked at a range of policies, procedures and other documents relating to the running of the service.

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 highlight any areas of outstanding practice as part of this inspection.

Areas for improvement

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

Summary of this inspection

- There were no specific actions identified that the service must take.

Action the service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should take actions to include the frequency of clinical observations in the policies and procedures for managing deteriorating patients.
- The service should develop a standardised process for documenting capacity assessments and best interest decision-making discussions.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	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	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Emergency and urgent care

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

Are Emergency and urgent care safe?

Inspected but not rated

We inspected but did not rate safe as part of this inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

We issued a requirement notice for Regulation 13 (safeguarding) following our previous inspection in November 2019 because we found the service did not operate a system that protected people from abuse.

During the previous inspection, we found that the service had a referral system which stated that some safeguarding referrals needed to be made immediately, some within 24 hours and others had no time limit. This was not in line with national guidance, which stated that all safeguarding referrals, no matter what the concerns involve, should be made to a local authority immediately. In addition, the safeguarding policy stated that all safeguarding concerns should be reported to the registered manager who would then be responsible for making a referral to a local authority. We had concerns that on occasions when the registered manager was not available, that a safeguarding referral would not always be made in a timely manner.

We found that improvements had been made during this inspection. The safeguarding policy had been updated to state that all safeguarding concerns would be raised immediately by staff. The service had developed a safeguarding referral flow chart which provided staff with clear instructions on how to identify and escalate safeguarding concerns. This was available in the ambulance vehicles and through the provider's electronic platform so staff could access this when needed.

The safeguarding policy had been updated to state that ambulance staff were required to notify the designated safeguarding lead (the registered manager) or the designated deputy of any safeguarding concerns. The registered manager told us a team leader was allocated as a deputy, which meant that a designated person was always available to make local authority safeguarding referrals in a timely manner, even if the registered manager was not available.

During our previous inspection in November 2019, we found that that staff did not always complete the safeguarding section in the patient report forms, which staff were required to complete for every patient. During this inspection we looked at six patient report forms and found the safeguarding section had been completed correctly in each of these.

The registered manager was the designated safeguarding lead for the service and we saw evidence they had completed level four training in children and adults safeguarding within the last three years.

All staff received mandatory training in the safeguarding of vulnerable adults and children. The level of training was dependant on their role. For example, non-clinical staff (such as clerical staff) completed level 1 safeguarding training, emergency care assistants and technicians completed level two training and paramedics completed level 3 training. The provider's training compliance target was 90%. Records showed training compliance of 100% for safeguarding level one training, 85% for level 2 safeguarding training and 90% for level three training.

This showed the majority of staff had completed safeguarding training and the safeguarding training was in line with Intercollegiate Document 'Adult Safeguarding: Roles and Competencies for Health Care Staff': August 2018 and Intercollegiate Document 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019'.

The registered manager told us mental capacity awareness, female genital mutilation (FGM) training and 'prevent' (anti-radicalisation) training was included as part of the safeguarding training completed by staff.

The registered manager told us there had been two safeguarding incidents reported by the service since the previous inspection in November 2019. We looked at the records for these and both incidents were raised during July 2021 and had been referred to the relevant local authority within 24 hours. Both incidents related to staff reporting concerns about the social welfare of a vulnerable individual and the concerns raised were not directly attributable to the service.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

We issued a requirement notice for Regulation 15 (Premises and equipment) following our previous inspection in November 2019 because we found the service did not operate an effective system to maintain oversight of all equipment. The service had reported a high number of incidents when equipment had not been available for staff to use. Equipment was not always safely stored on vehicles in a way that reduces the risk to staff and patients.

We found that improvements had been made during this inspection and the service had introduced a number of new systems and processes for managing equipment. An equipment checklist had been developed since the last inspection and this listed all equipment that was required on the ambulance vehicles. Staff used a log sheet to document and check that all listed equipment was available at the start of each ambulance journey. This included calibration checks for defibrillators and battery checks for electronic equipment (such as pulse oximeters). The log sheets we looked at were complete and up to date.

The service had developed a colour-coded system for segregating and storing equipment and medicine grab bags in the ambulance station. Any equipment and grab bag that had previously been on an ambulance vehicle was placed in the 'red' and 'amber' areas, pending checks and replenishment by staff. Equipment and response bags that had been prepared and checked by staff were tagged and placed in the 'green' area and marked as ready for use. Staff responsible for checking the equipment had checklists in place to confirm what equipment was required within the grab bags and to record who had prepared the grab bags.

Inspected but not rated

Emergency and urgent care

During the previous inspection in November 2019, we found that equipment such as defibrillators and suction equipment were not secured on ambulances safely. We inspected one ambulance vehicle during this inspection and found that all equipment was stored safely with dedicated storage compartments for grab bags and medicines and secured fixings for items such as suction equipment, defibrillators and medical gasses.

The ambulance vehicle was clean, tidy and well maintained. Equipment and single use items were available for both adults and children. The registered manager told us they carried out monthly stock and expiry date checks for consumable items. All the single use items (such as syringes and tubes) we looked at were kept within their sterile packaging and were within expiry dates.

We saw that equipment such as chairs, stretchers; wheelchairs and slide sheets were well maintained. There was an arrangement with an external contractor to service all equipment on an annual basis. Maintenance records showed all equipment in use had been serviced. We saw there was sufficient stock to replace any faulty equipment.

There were suitable arrangements in place for the handling, storage and disposal of clinical waste in the vehicles and the station. This included the use of colour coded waste bags and the clinical waste bins were kept in a locked room. There was an arrangement with an external contractor for the removal of clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. staff carried out clinical observations and repeated these at regular intervals. However, the frequency of clinical observations was not formally specified in the provider's policies for managing deteriorating patients.

We issued a warning notice for breach of Regulation 17 (Good governance) following our previous inspection in November 2019 because we found the process for managing deteriorating patients was unclear. This was because although there was a clinical indications standard operating procedure, there was no information about how the deteriorating patient system should be used, including but not limited to the frequency that clinical observations should be undertaken. we found that the national early warning score (NEWS2) which was used to identify deteriorating patients had not been completed. This was not in line with the provider's policy or best practice guidance.

We found that improvements had been made during this inspection. The service had developed a number of policies and procedures for undertaking clinical observations and managing the deteriorating patient. Staff received formal training in managing the unwell patient. The service had developed a clinical decision tool to aid staff in clinical decision-making in relation to a number of medical conditions, such as stroke, asthma, abdominal pains and cardiac arrest.

Staff used the national early warning scoring system (NEWS2) and the paediatric observation priority score (*POPS*) to determine if escalation and transfer to hospital was required.

The registered manager told us they expected staff to repeat clinical observations approximately every 20 minutes, but the frequency for repeat observations had not been formally specified in the provider's deteriorating patient policies and procedures.

Inspected but not rated

Emergency and urgent care

We were not able to verify whether the service had an effective process for managing deteriorating patients because there had been no instances since the previous inspection in 2019 where a patient required emergency ambulance transfer from an event to hospital. However, we looked at the patient report forms for six patients that received first aid treatment at an event site, even though they did not require transfer to hospital.

The six patient records we looked were complete and up to date and showed staff had recorded early warning scores, pain scores and clinical observations and these had been repeated between every 15 to 30 minutes. This showed that demonstrated a good understanding and staff carried out routine clinical observations in practice and repeated these at regular intervals.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

We issued a warning notice for breach of Regulation 12 (safe care and treatment) following our previous inspection in November 2019 because we found the service did not use safe systems to safely store, record and prescribe medicines. The provider required but did not have any patient group directions (PGD's), despite storing and using medicines that were exempt from the Human Medicines Regulations 2012. We found medicines bags that contained medicines that were out of date. Medicines were not stored in their original packaging along with leaflets, meaning that there was an increased risk that medicines would be administered in error as it was difficult to differentiate between them.

We found that improvements had been made during this inspection. The service had developed medicine administration protocols (MAPs) which were the same as patient group directions (PGD's) for a range of medicines held by the service. Patient group directions provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

We looked at the medicine administration protocols for 10 medicines (including salbutamol, glyceryl trinitrate (GTN), rectal diazepam, hydrocortisone, penthrox and tranexamic acid). We saw these included key information such as instructions on administering, including dose and frequency as well as indications and other relevant information relating to each medicine. The protocols had been approved for use in February 2020 and were due for review in February 2023. Each protocol had been reviewed and approved by the registered manager, a medical consultant and a pharmacist.

Staff authorised to administer medicines required authorisation and sign off prior to use of the medicine administration protocols. The authorisation record was kept in individual staff files and we saw evidence of this in the six staff files we looked at during the inspection.

We saw that medicines were kept securely in a dedicated medicines cabinet and these were stored in their original packaging, including information leaflets. The service had implemented a monthly medicines audit after the previous inspection and this included stock reconciliation and medicine expiry date checks. We looked at a sample of medicines and found these reconciled correctly and were with their expiry dates.

Medicines were stored in pouches in the ambulance vehicles. We saw that each pouch included a record of the contents of the pouch, including expiry dates and a log for recording if any medicines had been used / removed from the pouch (for stock reconciliation.

Staff recorded details of any medicines administered to patients on the patient report forms and we saw evidence of this in the six patient report forms we looked.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

We issued a requirement notice for Regulation 17 (Good governance) following our previous inspection in November 2019 because we found the service had not always investigated reported incidents and acted to reduce the risk of similar incidents happening again.

We found that improvements had been made during this inspection. The service had an incident reporting policy and standard operating procedure that provided instructions for staff on how to identify and report incidents. Incident types reported by staff included clinical / patient safety incidents as well as incidents related to ambulance vehicle or equipment issues.

Staff used an electronic incident form to record details of any incidents. The registered manager told us there had not been any patient safety incidents reported in the past 12 months. The most recent incident was reported in June 2020, in relation to a non-ambulance vehicle accident and this had been reported and investigated to aid learning and improvement.

The registered manager had also developed a new incident investigation form since our previous inspection. This included information such as details of the incident, harm / risk grading for the incident, details of the investigation and remedial actions or lessons learned following the incident.

The registered manager and the nominated individual had a good understanding of duty of candour principles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

The duty of candour principles are only applicable if care and treatment has led to moderate or severe patient harm. There had been no incidents reported by the service during the past 12 months that had resulted in moderate or above patient harm that would trigger the duty of candour process.

The review of reported incidents was a standing agenda item on the clinical governance committee meetings, which took place every three months. The registered manager told us learning from incidents were shared through routine meetings, bulletins and other correspondence with staff.

There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner.

Inspected but not rated

Emergency and urgent care

Are Emergency and urgent care effective?

Inspected but not rated

We inspected but did not rate effective as part of this inspection.

Competent Staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

We issued a warning notice for breach of Regulation 17 (Good governance) following our previous inspection in November 2019 because the provider did not have a system in place to make sure that only competent staff were allocated to transport patients from an events site to hospital. This meant that there was an increased risk that patients would be cared for by staff who had not received the right level of training to meet their needs. In addition, there were no policies or processes which outlined the need for records to be kept in such a way that reflected all members of staff who had been involved in a patient's care and treatment. it was unclear who had been responsible for treating patients along with who had been responsible for conveying patients to hospital. This meant that it was unclear if only appropriately trained members of staff had cared for

patients on each occasion.

We also issued a requirement notice for Regulation 19 (Fit and proper persons employed) following our previous inspection because we found the service had not always checked staff competencies as well as seeking an up to date disclosure and barring service check for staff prior to the start of their employment.

We found that improvements had been made during this inspection. The registered manager told us all staff underwent recruitment checks, including employment history, identification, qualifications, driver checks, at least two references and disclosure and barring service (DBS) checks prior to commencing employment with the service.

The service had appointed a human resources (HR) lead who was responsible for carrying out routine checks and maintaining an electronic system, which included information such as DBS checks, driver checks and Health and Care Professions Council (HCPC) registration checks for paramedics.

The registered manager told us DBS checks were updated every two years. The service carried out ambulance vehicle driver checks every six months, which included a review of DVLA information detailing any convictions or penalties. The service also carried out annual HCPC registration checks for paramedics.

The electronic system flagged when staff checks were due and the registered manager told us staff were not eligible to work until all relevant checks were up to date.

The registered manager told us they maintained a list of staff that were eligible to drive ambulance vehicles. This consisted of individuals who had completed formal emergency ambulance blue light training and had up to date DVLA

driver checks. The registered manager told us individuals would not be able to drive ambulance vehicles if any concerns were identified during these checks. The service used an electronic system to allocate staff to ambulance vehicles. the registered manager confirmed they only allocated ambulance drivers that were eligible and qualified to drive ambulance vehicles.

We also saw the patient report form had been updated with an additional section to record the details all staff involved the patient's care (including first aider on site and ambulance staff if conveyed to hospital) to maintain an accurate record for continuity of care.

We looked at the electronic logs for staff DBS checks, driver checks and HCPC checks and these showed most staff were up to date. We also looked six individual staff files during the inspection and found these were complete and up to date and included up to date DBS checks, recruitment checks and training and qualification certificates.

The registered manager told us all staff underwent annual appraisal. Records showed 100% of staff that had worked for the service during 2020 (54 individuals) had completed their appraisal during January and February 2021.

Consent

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, the provider did not have a standardised process for documenting capacity assessments and best interest decision-making discussions.

We issued a warning notice for breach of Regulation 17 (Good governance) following our previous inspection in November 2019 because we found that there had been two occasions when patient record forms indicated that patients did not have Mental Capacity. Although appropriate checkboxes had been completed, there was no further documentation of what information had been relied upon to assess each patient's Mental Capacity. This was not in line with the provider's policy or best practice.

We found that improvements had been made during this inspection. The service had developed a new standard operating procedure for seeking patient consent in November 2020 and this included specific instructions for staff on how to conduct mental capacity assessments. The registered manager told us staff had received training in consent, mental capacity act and best-interest decision-making.

The registered manager told us that if they suspected a patient lacked the capacity to make their own decisions, staff would follow the capacity assessment pathway and record the capacity assessment in the patient record notes, along with any discussions or decisions made in relation to the patients best interest.

We found there were clear instructions for staff on how to conduct mental capacity assessments, however, staff were expected to record this information in the patient notes. The lack of a formal standardised record or form for recording capacity assessments and best interest decision-making discussions could lead to inconsistencies in the way staff record this information.

The registered manager told us that since the previous inspection, there had been not been any instances where a patient that lacked capacity to make their own decisions had required treatment by the service. However, we looked at six patient report forms and staff had completed the section around whether informed verbal consent was given and the section around whether patients lacked capacity in these records.

Inspected but not rated

Emergency and urgent care

Are Emergency and urgent care well-led?

Inspected but not rated

We inspected but did not rate well-led as part of this inspection.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The registered manager and the nominated individual were the main company directors and oversaw governance arrangements across the service.

Governance information was discussed during management board meetings, held every six months and clinical governance meetings that were held at least every three months and attended by the senior management team. We looked at recent meeting minutes and these included standard agenda items and action logs that were followed up at subsequent meetings.

Governance information was cascaded to staff through routine discussions, email notifications, staff meetings and staff bulletins. Staff received key information, such as policies, procedures and records through the provider's electronic platform and through paper record files kept in each ambulance vehicle.

There were a range of policies and procedures in place that provided guidance for staff in their day to day role. These were based on national guidelines and included revision histories and review dates up to every three years. The policies and procedures we saw were all up to date and within their specified review dates.

The service had a range of service level agreements with a number of external organisations, including with an NHS trust for pharmacy supplies and an external contractor for the supply of medical gasses. We saw evidence to show the registered manager carried out an annual review of all service level agreements held by the service to identify any issues or areas for improvement.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

We issued a requirement notice for Regulation 17 (Good Governance) following our previous inspection in November 2019 because we found the service had not always monitored the services that were provided.

Inspected but not rated

Emergency and urgent care

We found that improvements had been made during this inspection. The registered manager had developed and maintained a performance dashboard which included key performance indicators such as patient incidents, staff incidents staff performance and appraisal, ambulance vehicle performance and response times, complaints and patient feedback.

Information around performance, risk and quality monitoring was discussed as part of clinical governance meetings, held every three months. We looked at recent meeting minutes for the clinical governance meetings held in February 2021 and April 2021 and these showed key discussions around governance, risks and performance took place.

The service had a risk register that included key risks to the service and this was reviewed and updated at routine clinical governance meetings, held every three months. There were also a number of risk assessments in place, such as for health and safety risks, ambulance vehicle transportation risks and Covid-19 (infection control) risks, and these had been cascaded to staff across the service.

We saw that routine audit and quality monitoring of key processes took place to monitor staff performance and identify areas for improvement. The service had implemented a number of quality monitoring audits since the previous inspection in November 2019, including vehicle equipment and cleaning checklist audits, routine staff recruitment checks, monthly medicines stock and expiry date audits and infection control audits.

The registered manager told us patient report forms were reviewed when they were returned to the office to check for accuracy and completeness. The service had recently developed a formal patient report form audit and planned to launch this in the next few weeks. The audit consisted of a review of 25 randomly selected patient report forms each month by a paramedic.