Event City

Quality Report

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

Overall summary

A&E Life Support Ltd is an independent ambulance service that mainly provides patient transport services across the North West region. This includes transport of patients detained under the Mental Health Act (1983).

The service also provides emergency services for patients that may require transport from events to a hospital. This is only a small part of overall activities.

We carried out a focussed responsive inspection at the provider's premises in Blackburn, Lancashire on 17 January 2020.

We carried out a focussed responsive inspection because of concerns that we identified during our previous inspections of the service on 04 and 05 November 2019 as well as on 25 November 2019.

We inspected specific key lines of enquiry for safe, effective and well-led. We did not inspect caring and responsive as part of this inspection.

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

Services we rate

We did not rate the service because this was a focussed responsive inspection. We found the following issues that the service provider needs to improve:

- The service did not provide mandatory training in key skills to all staff and did not make sure everyone completed it. Although the service had listed mandatory training modules that staff were required to complete, it was unclear how these would be delivered.
- Patients were not always protected from potential abuse because not all staff had been trained on how to recognise and report abuse. This was because the service had not completed appropriate Disclosure and Barring service checks for all staff.
- The service controlled some infection risks. The policies and procedures for infection control did not always reflect the service that was provided. We found that the infection and prevention control policy contained several inappropriate references, meaning that staff would not always have the correct information to support them to reduce the risk of infection being spread.
- We were not assured that all equipment used by the service for providing care or treatment was safe for

Summary of findings

such use. We had concerns that not all equipment was immediately available. We did not see evidence that all equipment had been serviced in line with manufacturers guidance.

- The service did not have clear processes in place to remove or minimise risks to patients. Although the service implemented guidance for staff to follow when managing the deteriorating patient following the inspection, it was still unclear how patients would be assessed to make sure that they received the most appropriate care. Additionally, policies and processes were not always in place to support staff in the use of mechanical restraint.
- We were not assured that improvements that had been made to patient records would be effective, sustained or monitored. Although the service had made improvements to patient records, we found that the service had not updated their policies and procedures regarding this or had planned to monitor compliance against the changes that had been made.
- The service did not have systems in place to make sure all staff were competent for their roles. We were informed that staff had received mental health training. However, we did not see evidence of what this training had included.
- The service had not planned to seek the consent of patients before providing care and treatment, in line with national guidance. Although the service had made amendments to patient documentation, it was unclear how staff were supported to seek and document consent before providing care and treatment.
- The service did not have a formal strategy to turn what they wanted to achieve into action. We found that the service had a vision of what they wanted to achieve but it was unclear how this would be achieved in a timely manner.
- The service did not operate effective governance processes. The service did not have processes outlining how policies and procedures would be reviewed to make sure that they were reflective of up to date best practice guidance and legislation.
- The service did not have systems to manage performance effectively. We had concerns that the process in place to manage risk would not be effective. The service had not planned to monitor the services provided so that improvements could be made when needed.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also took urgent enforcement action against the provider and issued an urgent suspension notice because we identified significant concerns that posed a potential risk of harm to patients. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North Region), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services		The main activity provided by the service was patient transport services. The service also provided emergency services for patients that required transport from events to a hospital. As this was only a small part of overall activities, this has been reported under patient transport services. We did not rate the service because this was a focussed responsive inspection.

Summary of findings

Contents

Summary of this inspection

Background to Event City

A&E Life Support Ltd has been registered with the Care Quality Commission (CQC) since June 2016. The provider's registered address is 15 Forsythia Drive, Clayton-le-Woods, Chorley, Lancashire, PR6 7DF.

As part of its registration, A&E Life Support Ltd has one registered location; Event City, Barton Dock Road, Urmston, Manchester, Lancashire, M41 7TB.

Since February 2019, the service has been operating from another location; Units 5/6, Point 65 Business Centre, Greenbank Way, Blackburn, Lancashire, BB1 3EA. This location has not yet been registered by the Care Quality Commission (CQC).

The service has not had a registered manager in place since 16 February 2018 when the previous registered manager cancelled their registration. An application for a new registered manager has been submitted to the Care Quality Commission (CQC) in May 2019 but this was refused in October 2019. The service is in the process of submitting a new registered manager application with the CQC.

Our inspection team

The team that inspected the service on 17 January 2020 comprised of a CQC lead inspector and a CQC inspection manager.

The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Event City

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

During the inspection on 17 January 2020, we visited the premises at Blackburn, Lancashire. We spoke with the nominated individual and looked at five ambulance vehicles. During our inspection, we looked at policies and other records held by the service.

- The service had not undertaken any Regulated activity since our last inspection of the 25 November 2019.

The service was managed by the nominated individual (also the operations director). The service had appointed a finance director and a business director in October 2019. The nominated individual and one other staff member were involved in the non-emergency transport of patients with mental health conditions. The service also had five additional staff that were involved in events cover. The nominated individual was directly employed by the service. All other staff had other substantive employment and mainly worked for the service on a contractual basis.

Patient transport services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

A&E Life Support Ltd is an independent ambulance service that mainly provides patient transport services across the North West region. This includes transport of patients detained under the Mental Health Act (1983).

The service also provides emergency services for patients that may require transport from events to a hospital. As this is only a small part of overall activities, this has been reported under patient transport services.

Summary of findings

The main activity provided by the service was patient transport services.

We did not rate the service because this was a focussed responsive inspection.

We inspected specific key lines of enquiry for safe, effective and well-led. We did not inspect caring and responsive as part of this inspection.

Patient transport services

Are patient transport services safe?

We did not rate safe for the service as this was a focussed responsive inspection.

Mandatory training

The service did not provide mandatory training in key skills to all staff and did not make sure everyone completed it.

During our last inspections of November 2019, we found that the staff training and development policy did not clearly outline the mandatory training requirements for staff working within the service. At the time of this inspection, the service had not amended this.

Following the inspection, the service provided evidence that the policy had been updated with a list of training that staff were required to complete. However, the service had not indicated how often this was to be completed as well as how training compliance was to be monitored. The policy also indicated that only permanent staff were required to complete mandatory training. This meant that there was an increased risk that staff would not always complete training that was needed to undertake their roles if they were employed on a temporary basis.

Since our last inspection, the service had gained access to an e-learning portal which provided access to a large number of health-related courses. During the inspection, we found that although one member of staff had completed several modules including health and safety as well as moving and handling, others had not.

Since our last inspection, the nominated individual had undertaken a driving assessment to evidence their own up to date driving skills and competencies. Although the nominated individual informed us that this assessment had been completed under emergency conditions, there was no evidence of this. This was important as we were informed that patients had been transported to hospital using blue lights on occasions when their condition had deteriorated.

In addition, we found that two other members of staff were potentially able to drive under blue light conditions. On reviewing their personnel files, we found no evidence that the service had planned to make sure that they had completed relevant driving assessments.

Safeguarding

Patients were not always protected from potential abuse because not all staff had been trained on how to recognise and report abuse. The service had not completed appropriate Disclosure and Barring service checks for all staff.

The service had a safeguarding policy that provided guidance for staff on how to identify and report safeguarding concerns for vulnerable adults and children. The nominated individual told us there had been no safeguarding incidents reported by the service in the past 12 months.

On reviewing the safeguarding policy, we noted that there was reference to staff working in another organisation and that the policy did not contain key contact details for staff. This meant that there was an increased risk that staff would not have access to up to date information when needed. The service updated the safeguarding policy to reflect this following the inspection.

The nominated individual was the safeguarding lead for the service and had completed children's safeguarding (level three) training in November 2016. During the inspection we were informed that their update training for this was overdue and that they had started this via e-learning. However, we had concerns that this was not in line with the Intercollegiate Document; Safeguarding Children and Young People; Roles and Competencies for Healthcare Staff 2019, which states that the training should include face to face training.

During our last inspection of November 2019, we found that one member of staff who was providing Regulated Activity had not completed any safeguarding training. During this inspection, we found that they had completed appropriate safeguarding training for adults and children.

We found that the service had developed access to e-learning training for female genital mutilation. This was important as reporting any incidents of female genital mutilation is a legal requirement for all healthcare staff. The service had also introduced access to 'prevent' training since our last inspection.

We had continued concerns that the service had not operated an effective system to make sure that role specific Disclosure and Barring service checks had been competed

for all staff. We found that one member of staff had only applied for a standard Disclosure and Barring service certificate, despite providing care and treatment to vulnerable patients.

In addition, we found that a Disclosure and Barring service certificate had been transferred from a previous employer on one occasion. The service did not have evidence that a Disclosure and Barring check had been completed at all for two members of staff. However, on one of these occasions, we found evidence of a letter that had been received from an NHS Trust stating that a Disclosure and Barring Service check had been completed. This was important as they could potentially be responsible for transporting patients from an event to hospital.

Cleanliness, infection control and hygiene

The service controlled some infection risks. The policies and procedures for infection control did not always reflect the service that was provided.

The service had an infection prevention and control policy which provided guidance for staff on hand hygiene, personal protective equipment, aseptic non-touch technique and management of sharps. However, we found that this contained references to an NHS organisation and made references that were not applicable to the services provided. For example, there was a reference to aircraft cleaning. This meant that there was an increased risk that staff would not have correct policies and procedures to follow and that infection would be spread.

We were informed that the service had been working alongside an external governance advisor and that they had planned to look at completing infection control audits. However, it was unclear how often this would be undertaken and how it would be completed and monitored.

The service had a deep clean programme for all vehicles. However, the service that was used to transport patients with mental health needs was overdue a deep clean. We were informed that this was because the service was not currently undertaking Regulated Activity. Although we were informed that this would be undertaken in the future, there was no indication of when this would be completed.

Since our last inspection of November 2019, the service had provided access to infection control training via e-learning for staff to complete. We found that only the Nominated Individual had completed this at the time of the inspection.

Environment and equipment

We were not assured that all equipment used by the service for providing care or treatment was safe for such use. We had concerns that not all equipment was immediately available.

The service operated from a location based at Blackburn, Lancashire. The premises consisted of an office area with an adjacent room used for equipment storage. The nominated individual told us they had access to a training room and toilet facilities located at the rear of the premises. We found the premises were clean and well maintained.

We were not assured that the service had maintained oversight of all equipment that was used to deliver care and treatment to patients. This was because we were shown two different logs of what equipment was overdue a service. In addition, we were informed that the service had access to wheelchairs and a carry chair. These were off site at the time of the inspection and there was no documented evidence that these had been serviced. However, we found that the stretcher in one ambulance had been serviced in the last 12 months. Since the inspection the provider has put in place a service log, but we were not able to review this to see if this covered all equipment available.

During our last inspection of November 2019, we found that the service had not completed a fire risk assessment for the premises. This was important as all employers must have adequate and appropriate fire safety measures in place to minimise the risk of injury or loss of life in the event of a fire. During this inspection, we found that a fire risk assessment had been completed.

We also reviewed the health and safety assessment as during our last inspection of November 2019, this did not include specific details on how health and safety risks were managed. During this inspection, we found that this had been updated and included controls so that the risk to staff and patients was reduced as much as possible.

Since our last inspection, the service had implemented a vehicle checklist that was to be completed at the start of

every shift. The vehicle checklist included important equipment such as a defibrillator, medical gases and a response bag. However, it was unclear what should be included in the response bag. This meant that there was an increased risk that equipment would not always be available when needed. Following the inspection, the nominated individual provided evidence that this had been implemented but we were unable to check if this had been used.

We were informed that the automatic external defibrillator that was used most often had been loaned to a different organisation and was not available on the day of inspection. In addition, on checking the other automatic external defibrillators that were available, we found that there were no defibrillator pads for adults or children available. This was important as it meant that there was an increased risk that emergency equipment would not always be immediately available when needed. Automatic external defibrillators are portable electronic devices with simple audio and visual commands, which through electrical therapy allows the heart to re-establish an organised rhythm so that it can function properly.

We found that the service had made improvements to the way in which medical gases were stored. We found that all medical gases were stored in line with the British Compressed Gases Association guidelines. The service had also undertaken a risk assessment for the transport of medical gases since our last inspection of November 2019.

We sampled a range of consumable items including oxygen masks and dressings, finding that they were in date and packaged appropriately. Any equipment for which the use by date had expired had been marked for training use only.

Assessing and responding to patient risk

The service did not have clear processes in place to remove or minimise risks to patients.

The main activity carried out by the service was the non-emergency transport of patients with mental health conditions. This included patients detained under the Mental Health Act 1983. The nominated individual told us all patients requiring transport were allocated using a third-party procurement platform who acted on behalf of other providers, including NHS Trusts.

In our last inspection of November 2019, we identified concerns that the service had not planned to undertake risk assessments for all patients who had been transported. This meant that it was unclear what actions the service had taken to make sure that patients were suitable for transport and to make sure that the patients' needs had been met.

During this inspection we found that the service had implemented a risk assessment form which had been designed to support staff in documenting how patients had been assessed.

However, we had continued concerns that the service had not implemented a clear process which outlined how and when risk assessments should be undertaken, and more importantly what actions staff should take in line with the level of risk that had been documented. This meant that we were not assured that the service had implemented an effective process to keep patients safe.

In addition, the service had access to mechanical restraint equipment, such as handcuffs, leg restraints and spit hoods. However, we found that the service did not have clear processes in place to support staff to apply these safely or to make sure that any incidents of the use of restraint had been documented fully. It was also unclear about who was responsible for authorising the use of mechanical restraint if this was needed.

We were informed that this had been covered in mental health training that had been delivered to staff. However, the service did not provide any information regarding the content of this training to evidence what had been delivered as part of it. This meant that it was unclear what training staff had received regarding the transport of patients with mental health illnesses.

We reviewed the Mental Health policy, finding that it did not reflect up to date best practice guidance. For example, although there was a section about control and restraint, there was no reference to guidance from the National Institute for Health and Social Care Excellence; NG10. This was important as the service had not planned to investigate incidents of restraint to make sure that the least restrictive option had been used or to undertake physical patient observations to make sure that patients were safe on occasions when mechanical restraint had been used.

We found that the service did not have a clear process to support staff in managing the deteriorating patient. This was important as it was unclear what actions staff would take if a patient became unwell during a journey. The

nominated individual informed us that patients would be taken to hospital immediately, but it was unclear how patients would be assessed to make sure that they could be cared for safely.

Following the inspection, the service provided evidence that this had been added to the duty of care policy. However, it was still unclear how patients would be assessed to make sure that they received the most appropriate care and treatment. This meant that it was still unclear whether patients would be treated in a way that kept them safe.

We were informed during the inspection that managing the deteriorating patient would be added to induction training for all staff. However, at the time of the inspection this had not been completed.

The service had access to a range of monitoring equipment to assess patient's blood pressure, temperature and pulse rate. The service had implemented a patient record form for use on occasions when patients had been transported from an events site to a hospital.

We had previously identified concerns that a comprehensive ligature risk assessment had not been carried out for the vehicle that was used to transport patients with mental health illnesses. During this inspection, we were not provided any additional evidence that indicated that the risk assessment had been reviewed. This meant that it was unclear what actions the service had taken to reduce the risk to patients as much as practicably possible.

We were informed that the service could potentially use three further vehicles to transport patients who had not been sectioned under the Mental Health Act 1983. However, we were not provided with any evidence that these vehicles had been assessed for ligature points.

Records

We were not assured that improvements that had been made to patient records would be effective, sustained or monitored.

During our last inspections of November 2019, we found that a contemporaneous record of each patient journey had not been kept. This was important as it meant that it was unclear if patient's needs had been met during journeys.

On this inspection the nominated individual informed us that several improvements had been made to the way in which patient journeys would be recorded. For example, patient risk assessment forms, personalised care plans and consent forms had been implemented. In addition, we were informed that any other parts of patient journeys would be documented on the patient transport log.

However, we had continued concerns that the service had not updated their policies and procedures to outline these amendments or planned to monitor compliance. The nominated individual informed us that this would be covered as part of the induction training delivered to all staff but was unable to produce any evidence of this. This meant that it was unclear how staff would be supported to fill in all relevant documentation correctly.

Are patient transport services effective?
(for example, treatment is effective)

We did not rate effective for the service as this was a focussed responsive inspection.

Competent staff

The service did not have systems in place to make sure all staff were competent for their roles.

In our previous inspections of November 2019, recruitment and training records that we looked at did not show evidence that any staff had undergone induction training.

We were informed by the nominated individual during this inspection that induction training would be delivered to staff at the start of their employment. However, it was unclear how this would be delivered. This was because the service did not have an up to date accreditation to deliver training and the service did not have plans in place to make sure that accredited trainers could be accessed to deliver this.

During our last inspections of November 2019, we were informed that staff had received mental health training and we saw evidence of certification for this. However, we had concerns that this had not been delivered by an accredited trainer and we did not see evidence of what the training had included.

We were shown evidence during this inspection that the person who had delivered the mental health training was

accredited. However, it was unclear if the accreditation was to deliver mental health training specifically. In addition, the nominated individual informed us that topics such as control and restraint had been covered but was unable to provide evidence of this.

The service had not planned to check the professional registration of members of staff when needed. This was important as it meant that the service did not operate a system to make sure that individual members of staff professional registration was up to date.

Since our last inspection, the nominated individual informed us that the service had planned to undertake staff supervision and appraisals in the future. This was important as it meant that staff had the opportunity to review their performance and provided an opportunity for staff discuss any development needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service had not planned to seek the consent of patients before providing care and treatment, in line with national guidance.

During our last inspections of November 2019, we found that the service had not planned to seek consent before providing care and treatment to patients. During this inspection we were informed by the nominated individual that improvements had been made and that personalised patient care plans had been implemented.

However, we had continued concerns that the consent section was about sharing patient information, rather than seeking consent from patients when providing care and treatment. This meant that we were not assured that the service had an effective system in place to seek and document consent when needed.

Additionally, we had concerns during our last inspections of November 2019 that the service did not have a process to document the process followed when undertaking Mental Capacity assessments or making best interest decisions.

During this inspection we saw evidence that patient records had been amended so that this could be documented. The amended document covered important questions such as 'what actions have staff taken to support a patient in making a decision about their care and treatment'.

Are patient transport services caring?

We did not inspect caring as part of this inspection.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

We did not inspect responsive as part of this inspection.

Are patient transport services well-led?

We did not rate well-led for the service as this was a focussed responsive inspection.

Leadership

We were not assured that leaders had effectively planned to fully manage priorities and issues that the service faced.

The nominated individual had overall responsibility for managing the service and was also the operations director. The service had appointed a finance director and a business director in October 2019. These two directors were not involved in the day to day management of the service.

The nominated individual and one other staff member were involved in the non-emergency transport of patients with mental health conditions. The service also had five additional staff that were involved in events cover. The nominated individual was directly employed by the service. All other staff had other substantive employment and mainly worked for the service when required.

The service had not had a registered manager in place since 16 February 2018 when the previous registered manager cancelled their registration. An application for a new registered manager had been submitted to the Care Quality Commission in January 2019. This was rejected because the application had not been completed in line with CQC guidance. A further application was made in May 2019. This was reviewed by the CQC registration team and the application was refused in October 2019. The nominated individual told us they had identified an individual to take on the role of the registered manager and planned to submit a new application with the CQC.

Patient transport services

The nominated individual had overall responsibility for the service in the absence of a registered manager. We found during the inspection that the nominated individual had continued to have a large area of responsibility including developing policies and procedures, managing patient bookings and the management of vehicles and equipment.

Since our last inspection of 4 and 5 November 2019, the service had recruited an external consultant to help with health and safety. We were also informed that the services of a further consultant had been recruited to help develop governance within the organisation. However, at the time of the inspection, the service had not yet committed to using this service fully.

Vision and strategy

The service did not have a formal strategy to turn what they wanted to achieve into action.

During the inspection we found that the vision for the service had been discussed as part of recent management meetings. For example, the service had a vision of expanding the service and recruiting additional staff as well as improving the system regarding policy updates.

However, we had continued concerns that the service did not have workable plans to turn this into action. On reviewing minutes of these meetings, we did not find any documented evidence of how these would be achieved or when they would be achieved by. This meant that there was an increased risk that improvements would not be implemented in a timely manner.

Governance

The service did not operate effective governance processes.

During our last inspections of November 2019, we found that the service did not have effective governance processes in place. During this inspection we found that the service had made some improvements. For example, we saw minutes of management meetings that had been held.

We reviewed minutes of meetings that had been held, finding that although there was no set agenda a variety of topics had been discussed. However, we had concerns that any improvements that were needed would not be made in a timely manner as there was no evidence of how such improvements would be made or when they were to be completed by.

The nominated individual informed us that they had been responsible for developing and reviewing policies and procedures. However, we found that four out of nine policies which were held in the office did not have review dates. This meant that these would not always be reviewed to make sure that they reflected up to date best practice guidance and legislation. In addition, the service did not have any policies or procedures which outlined the process for policy review.

Additionally, we found that policies and procedures did not always reflect the service that was being provided. For example, the infection control policy contained several inappropriate references, including a reference to cleaning aircraft and providing key contact details for staff who worked at another organisation. This meant that there was an increased risk that staff would not have the correct information available to support them in reducing the risk of infection being spread. Since the inspection this policy had been amended but were not given any evidence of how other policies would be reviewed to ensure they contained the correct information and were up to date in line with national guidance.

Although the service had made some improvements, we continued to have concerns that not all policies and procedures reflected these. For example, the service had introduced new patient documentation. However, it was unclear how these should be completed and how compliance was to be monitored. This meant that we were not assured that improvements that had been made by the service would be sustained.

We were informed that an external consultant had been employed to help make sure that policies and procedures were up to date. However, at the time of the inspection it was unclear whether these services were to be continued. This meant that we were not assured that the service had made any improvements to the management of policies and procedures.

The service had a recruitment and selection policy in place. Since our last inspection, we found that the service had

implemented a recruitment checklist which indicated if all parts of the recruitment process had been completed. For example, if references had been received. On reviewing personnel files, we found that this was in place for all staff.

During our last inspections of November 2019, we had concerns that the service did not have a Fit and Proper Persons policy for employing directors and that appropriate checks had not always been completed. This was important as there is a regulatory duty for all providers to check whether directors who they employ are fit and proper to undertake their roles.

On reviewing the files of all directors, we found that some improvements had been made. For example, references had been sought for one director and insolvency checks for all directors had been completed. However, we found that an appropriate Disclosure and Barring service check had not been completed for the nominated individual. This was because they had only applied for a standard Disclosure and Barring certificate despite providing care and treatment to vulnerable adults and children.

We raised this with the nominated individual at the time of the inspection who informed us that they had applied for a standard Disclosure and Barring service check under their role as an operations director at the service. At the time of our inspection, the nominated individual had not planned to apply for an enhanced Disclosure and Barring service check to be completed. This meant that there was an increased risk that they would not be suitable to undertake their role.

Management of risks, issues and performance

The service did not have systems to manage performance effectively. We had concerns that the process in place to manage risk would not be effective.

During our last inspections of November 2019, we found that the service did not have a risk management process in place. This included systems to manage health and safety risks as well as organisational risks.

During this inspection we found that the service had undertaken three health and safety risk assessments covering medical gases, general work within the public domain as well as administering first aid in both primary and secondary care. Each risk had been scored and had documented controls to reduce the identified risks as much as practicably possible.

However, at the time of the inspection the service had not undertaken other important health and safety risk assessments such Controlled Substances Hazardous to Health (COSHH). This meant that it was unclear how the service was effectively managing risks associated with this.

We noted that the risk management strategy stated that a risk register would be developed as part of the business planning process, detailing any organisational risks that the service faced, such as finance, governance, operational and reputational risks. However, during the inspection we found that this had not yet been implemented. Effective risk management processes enable organisations to ensure actions are taken to identify areas of risk and strategies to reduce or prevent this which are reviewed regularly.

During our last inspections of November 2019, we found that the service did not have effective process to check compliance with important topics areas such as the completion of patient records or infection and prevention control. We were informed by the nominated individual that an infection and prevention control audit was planned to be undertaken quarterly. However, the service had made no plans to monitor any other parts of the service. This meant that there was an increased risk that areas for improvement would not always be recognised so that improvements could be made.

Outstanding practice and areas for improvement

Outstanding practice

We did not identify any areas of outstanding practice as part of this inspection.

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that systems and process are operated in a way to make sure that patient risks are identified, assessed and managed effectively. Regulation 12(2)(a)(b).
- The service must ensure that they have clear processes in place for staff to follow when managing the deteriorating condition or behaviour of patients during a journey. Regulation 12(2)(a)(b).
- The service must ensure that there are processes in place to manage patients safely on occasions when mechanical restraint has been used and must implement clear policies and processes for staff to follow when using mechanical restraint. Regulation 12(2)(a)(b).
- The service must ensure that staff are up to date with safeguarding training for adults and children. Regulation 13(2).
- The service must ensure that safeguarding policies and procedures are reflective of the services provided. Regulation 13(2).
- The provider must take actions to ensure the equipment is fit for purpose and that there is oversight of servicing for all equipment. Regulation 15(1).
- The service must ensure that all equipment is available for use, including defibrillation pads for adults and children. Regulation 15(1).
- The service must take actions to ensure effective risk management processes are implemented; including the identification, assessment and management of risks to the services and patient safety. Regulation 17(2)(a)(b).
- The service must ensure that there is a process for reviewing all policies and procedures, making sure that they are reflective of the service provided, so that staff have access to all relevant information. 17(2)(a)(b).
- The service must ensure that clear plans are in place to make sure that all staff have access to training that is required for them to undertake their role. Regulation 18(1).
- The provider must ensure that a Disclosure and Barring check has been completed for all staff in line with the roles that they are undertaking. 19(1).

Action the provider SHOULD take to improve

- The service should ensure that systems and processes are in place to support staff in seeking consent before care and treatment is delivered to patients.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulation 18 HSCA (RA) Regulations 2014 Staffing