Docklands Medical Services (London) Ltd

Docklands Medical Services

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Docklands Medical Services are registered to provide the regulated activity of 'transport services, triage and medical advice provided remotely'. They are sub contracted to provide a patient transport service to Basingstoke and North Hampshire Hospital by a private ambulance service that has the patient transport contract for Hampshire Hospitals NHS Foundation Trust.

The service is registered to a business address in East London. The ambulance crews are based at a residential address in Basingstoke which is close to the Basingstoke and North Hampshire Hospital where they handed over the ambulance vehicles between shifts.

The service operates seven days a week and is always crewed by two members of staff. There are two shifts. One shift is 10.30am to 7pm and the other is 7pm to 7am. The service transfers patients between hospitals and takes patients' home. The crews covered the whole of Hampshire.

We carried out a focussed, unannounced inspection at the Basingstoke residential address and at the Basingstoke and North Hampshire Hospital on 8 July 2015. This was in response to reports from members of the public regarding poorly maintained ambulances, inappropriately parked in a residential street.

We also carried out an arranged visit to the provider's registered address on 16 July 2015 to gather further information.

As a focussed inspection we looked at specific parts of the service only. This inspection was primarily focussed on the area of safety and on the suitability of the ambulances used for the patient transport service. We did not inspect the caring domain.

Our main findings were as follows:

There was no evidence that the ambulance in use had been deep cleaned, cleaned or repaired, to an appropriate standard. There were no facilities available to internally clean the ambulance on a daily basis. The vehicle contained a range of equipment which was proportionate for a patient transport service (PTS) vehicle. A contract was in place to test all medical equipment however, not all equipment had been tested. The crews responded appropriately to patient risk and were aware of the levels of complexity they could and could not manage. Incidents were appropriately reported and learnt from in quarterly reviews.

Crews' experience, competencies and training was demonstrated. They were supervised and their competencies monitored.

Complaints were appropriately reported and learnt from in quarterly reviews.

Performance meetings took place on a quarterly basis where key performance indicators and all other quality issues were reviewed.

We have made requirement notices as a result of this inspection which can be found at the end of this report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		This was a focussed rather than a comprehensive inspection. We therefore have not rated the service on this occasion.

Patient transport services (PTS)

Safe	
Effective	
Responsive	
Well-led	
Overall	

Information about the service

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Patient transport services (PTS)

Are patient transport services safe?

Summary

The ambulance in use was an old ambulance which was a replacement for a newer vehicle that had recurring mechanical and technical problems. It was not clean or hygienic. A contract was in place to deep clean ambulances but there was no evidence that it had been deep cleaned, cleaned or repaired, to an appropriate standard. There were no facilities available to clean the inside of the ambulance on a daily basis.

The vehicle contained a range of equipment which was proportionate for a patient transport service (PTS) vehicle. A contract was in place to test all medical equipment however, not all equipment had been tested. There was no evidence that the trolley bed, orthopaedic stretcher and carry chair had been routinely checked for safety. There was no razor available with the defibrillator to remove chest hair to ensure a good electrical contact and prevent the chest hair from igniting when the defibrillator is discharged.

There were no oxygen masks or nasal cannula for oxygen administration. We were told that since ambulance care assistants cannot prescribe oxygen they would continue care using the hospitals equipment. If a patient vomited and soiled their oxygen administration equipment they would be deprived of a necessary drug.

Incident reporting, learning and improvement

· Incidents were reported on the back of the log sheets which contained basic patient information. There was a space on the back for 'issues' to be recorded. These encompassed any exceptions that had occurred on patient journeys including incidents. All log sheets were scanned to the registered manager (RM) and to the private ambulance contract holder who sub contracted Docklands Medical Services (DMS) to provide the patient transport service (PTS).

· If an incident had occurred, an electronic incident reporting form was completed after the shift. All incidents were reviewed in quarterly performance meetings with the private ambulance contract holder. Any actions and learning arising from incidents were identified and fed back at this meeting. Minutes showed 'exceptions' being logged and risk rated high/medium/low. They also showed that exceptions to normal service discussed and actions taken recorded.

· There had been seven incidents reported in the last year. All seven were due to issues beyond Docklands Medical Services' (DMS) control, such as issues within the A&E department and wards not moving a patient appropriately. This meant there had been no specific learning points for DMS from incidents.

Mandatory Training

· The private ambulance contractors provided a list of what they wanted DMS staff to be trained in. This was itemised in the contract. The private ambulance contract holder had a separate team whose responsibility was to ensure quality checking took place with all of its sub-contractors. Staff training had been audited to assure them that this was taking place. This included first aid at work, manual handling for ambulances and fire safety.

Infection Control

· When not in operation, ambulance vehicles were parked at either a bay at the hospital or outside the DMS base at a residential address in Basingstoke. The RM told us that at the end of each shift all clinical waste was disposed of in to the clinical waste stream at the hospital. DMS did not have a clinical waste contract but an informal arrangement with the hospital to dispose of their daily waste.

· The RM explained that after each patient use, the chair and immediate areas such as rails were wiped down. Linen was single use which was exchanged at the hospital.

· The RM said that private ambulance contract holder's audit team carried out spot checks/audits on the cleanliness of the vehicles approximately every three months. There were audits for two vehicles, neither of which were currently used for the PTS work. There was no evidence that the vehicle currently being used had been checked for cleanliness or hygiene, either by DMS or by the audit team. We were subsequently sent an audit of this vehicle which had been conducted a week after our visit. This showed it had passed all areas that had been checked. It included checks on cracks, splits and cleanliness of

interior surfaces, consumables to comply with hygienic requirements, any sharps to be disposed of in labelled containers and medical gas equipment to comply with hygienic standards.

· At the time of our inspection, the vehicle known as Doc 5, was being used for all patient transport work. It was an old ambulance. Inside there was a strong smell of diesel. The inside of the vehicle was not clean and not hygienic. The walls and floor were visibly dirty with grime that readily lifted off. Hard surfaces which are not cleaned regularly can result in patient infection particularly when there are open wounds. It is highly likely that the patients conveyed by Docklands Medical Services would have catheters fitted and might have pressure ulcers both of which increase the risk of a hospital acquired infection. There was a high compartment that had a glass effect plastic door. This had been broken and repaired with gaffer tape which had begun to peel off, thus exposing the sticky side of the tape. There was a single foam chair that had a small rip to the vinyl, exposing the foam inside. This results in an increased risk of cross infection.

· On the ambulance we found a sharps box. This was a quarter full and was undated for both the opening date and for informing when the box must be disposed of. It was located in a compartment behind the cab seats and was laid flat, thus presenting a leak hazard. It was located next to bottles of water for patient use. The crew told us they were not aware of why it was stored on the vehicle or how long it had been there. Neither crew member told us they used.

· A specialist external company were contracted by DMS to carry out deep cleans of ambulances every six to eight weeks. Records of deep cleans were sent to the RM who told us that the vehicle we viewed on the day of inspection was last cleaned around the beginning of June. A record of this deep clean was asked for but could not be provided. We were also told that the contract wasn't responsive enough for their needs and had recently been late for a number of scheduled cleans.

· When asked about cleaning facilities, ambulance crews told us they used the power wash at the local petrol station for external cleans and carried out internal cleaning at the hospital as they went through the shift. The cleaning facilities were inadequate as there were no facilities for cleaning at the hospital. There was no sluice, mops, cleaning cloths or associated cleaning liquids.

· We spoke with a manager from the private ambulance contractor who had sub-contracted DMS to provide the PTS service. They were clear that no equipment was provided by the trust and that DMS were responsible for the provision of all equipment used, and for the provision of appropriate facilities to support a decontamination clean if required.

· At the residential address in Basingstoke, there were no facilities for cleaning. There was no sluice, mops, cleaning cloths or associated cleaning liquids.

Environment and Equipment

· When not in operation, ambulance vehicles were parked at either a bay at the hospital or outside the DMS base at a residential address in Basingstoke. We spoke to the RM by phone on our arrival at the residential address who told us the vehicles were maintained and restocked from the residential address.

· At the residential address we were shown a store room at the back of the house on the ground floor. Staff told us that this room was not used by them but did contain a number of items that we were told was used in connection with event cover. This included radios, a bag containing a CD Entonox cylinder and associated administration equipment. The CD cylinder was a BOC product containing 440 Litres of Entonox in a cylinder with integral valve. The component parts for a child's bed and the Entonox set were both strewn across the floor. The Entonox set was attached to an inline filter and mouthpiece. It was not possible to establish if the mouthpiece had been used, however leaving items such as this connected does not reflect best practice and could present infection control hazards. Overall the equipment was not well organised and structured in the environment and significant trip hazards were presented.

· In the cupboard under the stairs was a box of assorted equipment, this included a super glottic airway (I-jell) which was open, bag- valve masks which were incomplete and lacking masks, together with dressings, the I- jell was out of date. Staff present told us they did not use any of this equipment.

· We were shown a store shelf under the stairs which contained vomit bowls and bottled water only. The water bottles were stored in their original packaging. Best practice is that items which may come into contact with patients are stored in a covered area, utilising the original

packaging is reflective of this approach. Both staff told us the vomit bowls and water were the only consumable stores available to them at the residential address and that any other equipment required was collected at the hospital along with the patient.

· There was a single large HX oxygen bottle lying in the hallway of the ground floor. It contained 2300 litres of oxygen and had a nominal weight of 19kg. There was a single oxygen cylinder immediately behind the entrance door to the property. This was a smaller CD cylinder containing 460 litres of oxygen with integral valve. Both the HX and CD products were supplied by BOC and have a three year shelf life, each of these products were within their shelf life.

· The house's garage contained screen wash, brake fluid, radiator fluid and oil, which were, in the main stored on a shelving unit. The garage was a significant health and safety hazard. These hazards were created by a significant range of products chaotically arranged on the floor, this included items such as a 110 volt transformer and cable, a battery jump start kit, three ambulance seats (Jany seats or similar, these are removable seats for patient use), a tracked carry chair, a trolley cot mattress, lifting equipment such as lifting belts, a number of ambulance ramps and in excess of 30 fire extinguishers that were tagged, but undated. In overall terms items were not maintained or logged and the presentation of the garage presented health and safety risks including trip hazards.

· The RM told us that the crew let him know when items relating to the vehicle was broken or in need of repair via the 'issues' section on the back of the log sheet. The vehicles were mechanically maintained by a local mechanics for any mechanical faults that may arise.

· The 'drivers daily defect sheets', which checked any vehicle defects, were stored on the shelves of the lounge area in the residential address in Basingstoke. June 2015's sheets showed that 14 days in June were unaccounted for. At Basingstoke Hospital, vehicle known as Doc 5, was currently being used for all patient transport jobs. The 'drivers daily defect sheets' for June 2015 we had checked back at the house had identified a defective front left side light and a faulty bumper that had become detached from the rear step.

· At Basingstoke Hospital we met the crew who had covered the day shift and looked at the vehicle known as Doc5. This was the vehicle which had been found to be defective in mid-June. Neither defect had been fixed.

· The RM showed us a contract with a company approved by the British Ambulance Association to test all medical equipment. Records of equipment testing showed that the vehicle currently being used of patient transport journeys was last tested on 24 May 2015. However, on the ambulance the trolley bed, orthopaedic stretcher and carry chair did not have stickers of when they had last been serviced and were not itemised as having been serviced. LOLAR regulations (The Lifting Operations and Lifting Equipment Regulations 1998) require that lifting equipment is serviced on a regular basis, a failure to display the next service date does not reflect best practice and could lead to patient harm if the device fails due to lack of routine servicing and checks.

· There were three cylinders of oxygen present in the vehicle, one HX and two CD cylinders, all were in date.

· The vehicle was equipped with an Agilent advisory defibrillator, which was not itemised on the equipment check that took place in May 2015. The RM told us that this was a recent replacement for a faulty defibrillator. Both sets of pads associated with the defibrillator were in date and the self-test was passed. It is potentially unsafe to both the patient and the operator to use equipment which is outside it service date. The service includes basic safety checks which will ensure that the shock delivered can support the recovery of a patient and not cause harm to the operator.

· The vehicle was fitted with a 12 lead defibrillator / monitor. There was no razor available. A razor is a basic adjunct when using a defibrillator as it is necessary to remove chest hair to ensure a good electrical contact and to prevent the chest hair from igniting when the defibrillator is discharged.

· The vehicle contained a range of other equipment which was proportionate for a PTS vehicle, this included a small first aid kit, incontinence pads, vomit bowls, hand wipes.

Patient transport services (PTS)

· The provision of other equipment such as a 12 lead defibrillator and suction unit suggest that the vehicle was also used for event cover or higher acuity work, if this vehicle were deployed to this type of work then its equipment levels would be inadequate.

· The vehicle being used was a spare vehicle as the main vehicle that was used was being repaired. Staff feedback suggested that the core vehicle had recently spent significant time in the garage for repair which would suggest that this vehicle had been in regular use.

Medicines

· No medications were carried on vehicles apart from patients' own medicines that were being transported with the patient. The RM told us that oxygen might be used but on a pre-set level prescribed by the hospital.

· There were no oxygen masks or nasal cannula for oxygen administration, we were told that since ambulance care assistants (ACAs) cannot prescribe oxygen they would also continue care using the hospitals equipment.. If a patient vomited and soiled their oxygen administration equipment they would be deprived of a necessary drug.

Records

· The ambulance base at a residential street in Basingstoke, was specifically rented for this purpose by the provider. It also provided overnight accommodation for a crew member. The house was thus a mix of residential and business functions.

· The basic patient information was recorded on journey log sheets which were the only paper records held by the crew. Log sheets were scanned and sent to the provider electronically if there was an issue to report and there was space for issues to be reported on the reverse of the log sheet. After this, they were shredded, although there were a pile resting on the shelving unit yet to be shredded. Vehicle check sheets were scanned and sent to the RM if there was an issue.

· Electronic devices, personal digital assistants (PDAs) were owned by the private ambulance contractor who had sub-contracted DMS to provide the PTS services and all of the information was kept by them.

· All personnel information and business records were stored at also the registered address of the service.

Assessing and responding to risk

· Calls were received in a control centre by the private ambulance contractor who assessed mobility and eligibility and passed this on to the sub contracted crew either by mobile data to the PDA or by phone when out of hours. The service criteria were known by all crews and the hospital and did not include any mental health work. Hospital staff assessed the mobility of complexity of each patient and coded this appropriately prior to patient pick up. The DMS crew also assessed this when they initially met the patient.

· If a crew refused to transport a patient on account of its complexity or being beyond the contractual remit, the control centre of the private ambulance contractor was called. This was available daytimes and evenings with an on call at night. The RM was also available on call at all times.

· We were given examples where DMS had worked with assessing and responding to risk. This included refusing to transport a patient due to their complex health needs and taking patients back to hospital when access could not be gained to their home or care home.

Staffing

· A crew of two was provided during the day and at night.

Are patient transport services effective?

Summary

Experience, competency and training was demonstrated to the service who had subcontracted them. Staff were supervised and competencies monitored by the registered manager (RM), who regularly did shifts on the patient transport vehicle.

Competent Staff

· A record listing ambulance staff competencies and experience was provided to the private ambulance contractor's audit department by DMS. This was also demonstrated by providing certificates of training. Where there were gaps in staff competencies the private contractor had provided training. For example, training in handling paediatric patients and in use of the personal digital assistant.

· All staff were appraised by the private contractor before commenced work. Checks showed 22 items under the heading of 'knowledge' that included health and safety,

infection control, disability awareness and respiratory conditions. There were 38 items under the heading of 'skills and equipment' that included adult and paediatric basic life support, administration of oxygen and patient positioning.

· The RM told us they did a couple of shifts a week including weekends and nights which enabled them to monitor the competency of the overall competency of crew members.

· For driver training and competence the RM told us they regularly went out with crews and got feedback from other drivers. As part of induction the RM went out with drivers, who would also spend a period of time driving the vehicle when patients weren't on board such as on the journey to the patient or away from drop off.

· The private contractor audited driving licenses every three months. Drivers were allowed a maximum of 3 points. In terms of other induction, we were told new crew shadowed a couple of shifts and received instruction on use of pat slides, moving and handling and understanding processes and procedures of DMS.

· We spoke to crew members who told us they had received some induction training, and that licences had been checked on employment but not subsequently. Both staff were clear that they were not authorised to use blue lights and so had not received blue light training or associated assessments.

Are patient transport services responsive?

Summary

Complaints were being appropriately reported and learnt from in quarterly reviews.

Complaints

· Complaints were reported to the private ambulance contractor. All complaints were reviewed in quarterly performance meetings with the private ambulance contract holder. Any actions and learning arising from these would be identified and fed back at this meeting.

· There had been one complaint in the last year. Complaints went to the private ambulance contractor and were reported back to DMS who investigated and reported on this at the quarterly performance review meetings.

Are patient transport services well-led?

Summary

Performance meetings took place on a quarterly basis between Docklands Medical Services (DMS) and the contract holder to whom DMS were sub contracted, where key performance indicators and all other quality issues were reviewed.

Governance & Quality measurement

· We spoke with the representative of the private ambulance contractor, to who DMS were sub contracted. They were assured with the quality of the service received through focussed questions and audit. Quarterly meetings with the private ambulance contractor monitored incidents, complaints, comments and overall performance.

· Quarterly reports also broke down the number of patient journeys completed, the amount of mileage covered and the level of complexity of the jobs undertaken. However, performance data in the quarterly reports did not show specific key performance indicator (KPI) data. KPI data was shown to the RM on a laptop at the quarterly meetings by the contractor. Shared data was a much shortened version of this.

· If a crew fell below the KPI performance level, review meetings discussed the reasons why this may have happened on a case by case basis. For instance, finding the location the patient was being returned to empty, travelling a long distance thus not achieving pick up/ drop off time, or the job was more complex for any reason.

This section is primarily information for the provider

Requirement notices

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 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises and equipment because the ambulance in use was not adequately clean or hygienic. Regulation 15 (1) (a) (2)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises and equipment because equipment on the ambulance in use had not been properly maintained. Regulation 15 (1) (e)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises and equipment because equipment at the Basingstoke premises was not stored securely and was not properly maintained.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not properly established or operated effectively. Checks on the ambulance in use had not been carried out effectively. Regulation 17 (1) (2) (a) (b)
	Regulation 15 (1) (b) (e)