E-Zec Medical Transport Services Ltd

E-Zec Medical - Dorset

Quality Report

Unit 1, The Dominium Centre, Elliot Road, West Howe Industrial Estate, Bournemouth, BH11 8JR
Tel: 01737 822782
Website: www.e-zec.co.uk

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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

This inspection was a focused inspection, to check the service had achieved compliance with medicines management and to follow up on other concerns we had received relating to patient safety.

The inspection focused on safety and we found some areas of concern.

Systems for assuring that vehicles and equipment to a safe standard were not robust which meant there was a risk these items could be used when it was not safe to do so. Records were not consistently accurate.

The service had an incident reporting procedure and there was some evidence of learning from incidents resulting in changes in practices. Incidents were not consistently reviewed however, and systems for sharing learning were not robust. The detail of the Duty of Candour legislation was not well understood by staff, but staff recognised the need to be honest and open about incidents.

Although the vehicles were visibly clean and there were cleaning rotas in place, the mop heads were not clean and some items of patient equipment were not stored correctly to keep them clean. Staff recognised the importance of maintaining a clean environment.

Staff training was monitored and staff were up to date with essential safety training. They understood their role in reporting situations of suspected or actual abuse and the service had built links with local safeguarding teams. There were safe systems for medicines management and for assessing patients for transport. Staffing levels met the needs of the service and were flexed to support times of high demand.

Action the ambulance service MUST take to improve

The provider must ensure:

- Equipment used by the service is safe for use and maintain records locally to demonstrate this.
- Staff must receive regular supervision and appraisal to support the delivery of a safe service.

Action the ambulance service SHOULD take to improve

The provider should ensure:

- Cleaning equipment, such as mops and buckets, is available and stored in a clean condition.
- Equipment is always stored safely.
- Incidents are reviewed consistently, staff receive feedback and learning is shared effectively and the Duty of Candour is applied and monitored safely.
- Accurate records are maintained to demonstrate the safe management of the service.
- Medicines for disposal are removed from site

Professor Sir Mike Richards
Chief Inspector of Hospitals

E-Zec Medical - Dorset

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Background to E-Zec Medical - Dorset

E-zec Medical–Dorset is contracted to provide transport services for NHS patients in Dorset. E-zec provides non-urgent, planned transport for patients with a medical need who need to be transported to and from NHS services. The service is primarily for patients registered with a GP in Dorset, Bournemouth and Poole who meet eligibility criteria agreed with the commissioners. The E-zec fleet consists of 74 vehicles, including cars, vehicles for transporting people in stretchers, vehicles with wheelchair access and five high-dependency vehicles. The latter are staffed by a crew including at least one paramedic and they transport patients with more complex needs, who may require support from trained staff during their journey.

The service was last inspected by the Care Quality Commission (CQC) in June 2014. We judged the service was compliant in areas relating to care and welfare of patients, staffing levels, staff training, staff recruitment, complaints and infection prevention and control.

However we identified non-compliance with medicines management. The provider sent us an action plan and submitted evidence of changes made to improve the safe handling and storing of medicines.

This inspection, August 2015, was a focused inspection, to check the service had achieved compliance with medicines management and to follow up on other concerns we had received relating to patient safety. We found the service had achieved compliance with the medicines regulation.

The location did not have a registered manager, but was seeking to make this appointment. Registered managers have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run. The previous registered manager had left in November 2014. A registered manager from another location was providing management cover.

Our inspection team

Our inspection team was led a CQC inspector and included a further CQC inspector and a specialist advisor. The specialist advisor was a professional paramedic who had held management roles in ambulance services, including patient transport services.

Detailed findings

How we carried out this inspection

For this inspection we reviewed information we held about the service prior to the visit. We announced the visit the day before, to ensure we would be able to speak with managers during the inspection.

When planning the inspection, we referred to information we held about the service, for example any events the provider had notified us of or any concerns raised about the service. We also spoke with a representative from the commissioning organisation.

During the inspection we spoke with two senior managers; the head of governance, compliance and health and safety and the national operations manager.

We also spoke with two managers based at the Bournemouth location, three paramedics including the paramedic trainer, six ambulance care assistants and five staff with responsibilities in operations and complaints. We also observed the premises and environment, three vehicles, reviewed three patient care records, and records relating to the management of the service. These records included performance reports, service and maintenance records, complaints, incident forms, medicine records and reports on staff training. We also reviewed a selection of policies and procedures, training documents and safeguarding records.

Patient transport services (PTS)

Summary of findings

This inspection was a focused inspection, to check the service had achieved compliance with medicines management and to follow up on other concerns we had received relating to patient safety.

The focus of the inspection was safety and we found some areas of concern.

Systems for assuring vehicles and equipment to a safe standard were not robust which meant there was a risk these items could be used when it was not safe to do so. Records were not consistently accurate.

The service had an incident reporting procedure and there was some evidence of learning from incidents resulting in changes in practices. Incidents were not consistently reviewed however, and systems for sharing learning were not robust. The detail of the Duty of Candour legislation, which defines a duty to explain incidents to patients, was not well understood by staff, but staff recognised the need to be honest and open about incidents.

Although the vehicles were visibly clean and there were cleaning rotas in place, the mop heads were not clean and some items of patient equipment were not stored correctly to keep them clean. Staff recognised the importance of maintaining a clean environment.

Staff training was monitored and staff were up to date with essential safety training. They understood their role in reporting situations of suspected or actual abuse and the service had built links with local safeguarding teams. There were safe systems for medicines management and for assessing patients for transport. Staffing levels met the needs of the service and were flexed to support times of high demand.

Are patient transport services safe?

Incidents

- The service's quality scorecard showed there had been 70 incidents in the 12 months July 2014 to June 2015. Of these, three were recorded as serious incidents requiring investigation. The quality scorecard showed these occurred in September, November and December 2014.
- The service had reported two statutory notifications to the CQC in the same 12 months. One related to an incident in February 2015 where a patient was harmed when their stretcher was not safely secured in the ambulance. This was not notified to the CQC until April 2015. The other, notified in August 2014, concerned a patient at end of life, who died during transit. The head of governance had recognised that historically, CQC had not been informed of incidents consistently and in line with legislation. They fully understood their responsibility to submit notifications promptly to CQC
- Staff said they were encouraged to report incidents and could explain the process. However, they commented they did not often receive feedback on the incidents they had reported.
- Each incident report summarised the event, when it happened and the outcome. The section for managers to complete, to show that the incident had been reflected upon and any changes implemented as a result, was not always completed. The head of governance gave examples of how they had investigated and followed up specific incidents, but agreed this was not always included in the incident forms.
- Learning from incidents was shared with staff via email. However, when interviewed, some staff could not recall a specific incident that had occurred within the past six months.
- The head of governance outlined an example of an improved procedure implemented as a result of learning from incidents. There had been an incident where the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form had not been handed to the patient transport crew. As a result, training and documentation relating to DNACPR had been reviewed,

standardised and updated, with advice from the commissioners. A memo had been circulated to staff, with a 'myth buster' information sheet, to help clarify the form and guide staff in how to use it.

- The induction training course included how to report an incident. The head of governance said scenarios were discussed during the induction training, to reinforce understanding of when to report incidents and accidents.
- The service had a system for managing safety alerts and these were reviewed, acted upon and closed appropriately.
- Patient Transport Liaison Officers, based in hospitals, also had a role investigating incidents locally. We were not able to visit these sites to review this approach in detail.
- The principles of Duty of Candour, whereby staff must be open and transparent with people when things go wrong with their care or treatment, were understood by staff. However, there was a lack of understanding of the legal requirement and procedures underpinning these principles.

Mandatory training

- Staff were required to complete statutory and mandatory safety training, in topics such as health and safety, safe moving and handling, safeguarding adults and children, fire safety, infection, prevention and control and safe driving. Compliance with staff training in safeguarding was reported to the commissioners each month, and all staff were up to date with this course. Completion of training was monitored; however this was reported by individual staff member or by course type, so it was hard to gain assurance that all staff were up to date with the full range of topics. From reviewing a selection of staff reports, we identified that staff were receiving the appropriate level of staff training. Staff also told us they were prompted to complete training on a regular basis, and they said the training provided was effective and useful.
- A new course had been introduced on safe driving and all ambulance care assistants had completed their annual skill development course.
- Some staff were trained to manage a medical emergency until the arrival of paramedic support. About 10% of staff had been trained for First Person on Scene (FPOS) duties. The five-day training covered, for example, advanced airway management, suction and cardiac monitoring.
- Paramedics complied with the professional training guidance's and staff driving 'blue light' vehicles completed a four-day specialist driving course to promote safe driving skills.
- The lead trainer at the service was also a practicing paramedic and related the training to relevant scenarios and topics.
- The service also used volunteer drivers, who completed induction training and were assessed for their driving skills.

Safeguarding

- Staff were knowledgeable about what constituted adult or child abuse and knew how to report any concerns. Records showed staff reported incidents of suspected abuse and their concerns were recorded clearly and factually.
- Concerns were referred promptly to the relevant local authority safeguarding teams, and the records showed what further action was taken, or if the safeguarding team were already aware of the situation. These concerns included when staff were concerned about vulnerable patients living in their own homes, or when they witnessed poor practice in care homes.

Cleanliness, infection control and hygiene

- The vehicles appeared visibly clean and there were cleaning procedures for vehicles, including monthly deep cleans. Staff outlined their procedures for maintaining clean vehicles during a shift, including how to clean a vehicle contaminated with vomit. They said the training on infection prevention and control was good and they were given training packs to refer to if necessary.
- Staff reported that if vehicles needed to be deep cleaned ahead of schedule this would be facilitated.
- There was evidence of guidance issued to staff on how to minimise risks of infection for people whose condition places them at an unusually high risk. For example, when transporting renal patients.
- Some items of equipment were on the floor of the storage cupboard and this was acknowledged as poor practice by the infection control lead. The equipment included straps and head blocks that could come into

direct contact with patients and present an infection risk. This was not a safe storage arrangement for this type of equipment, and the lead for infection, prevention and control confirmed that this was not normal practice, and would be rectified.
- The storage cupboards were built with plastic sheeting for roofing. These were not clean, and the design made them difficult to keep clean.
- The mops for cleaning vehicles were appropriately colour coded, but the mop heads were dirty and needed replacing to promote effective cleaning. There was a blue bucket (for use in general areas) but no corresponding blue mop, which meant there was a risk of cross contamination if the wrong mops were used in different areas. The colour coding schedule, stating which colour mop and bucket to use in different situations, was not positioned near the mops and buckets for easy reference.
- The service had received advice on infection control and there was a comprehensive policy in place for reference.

Environment and equipment

- Following the reported incidents relating to unsecured equipment, we reviewed how wheelchairs and stretchers were fixed safely into vehicles. Staff understood how to check equipment was secured safely. This was also part of a safety check they were required to complete.
- The service maintained a fleet of over 70 vehicles, including high dependency vehicles, cars and a range of vehicles specific for carrying people in wheelchairs or stretchers.
- The fleet summary workbook was not accurate or up to date. The workbook was used to inform the frequency of servicing of vehicles, but there was a 7,000 mileage discrepancy for one vehicle, between the mileage recorded in the workbook and that shown on the MOT report. After the inspection, the provider advised that maintenance records were held in head office, which was why they were not available to view at the service during the inspection. We saw forwarded copies of the maintenance records and these were up to date. The provider has since set up systems to allow the manager at the service to review the most up to date information, held at head office.
- The system for recording and managing defects was not used consistently. The last defect recorded was in June 2015, and there was no evidence noted it had been resolved. A vehicle check showed a tear in one of the seats, and although we were told it had been reported, this was not observed in the register.
- Equipment storage cupboards had been built within the garage. These were kept locked. However there was a lack of organisation in the way equipment was arranged within the cupboards. This meant there was a risk that staff would not find equipment easily.
- The service held an asset register for all clinical equipment. The clinical equipment on the High Dependency vehicle was not listed on the current asset register however and staff could not explain this discrepancy. The equipment was marked with service stickers which indicated it had been checked and was safe to use.
- Two clinical devices were not recorded on the asset register and we were told they were no longer in use and were to be disposed of. They had not been marked as such, to warn staff not to use the equipment in error, and had not been removed from the storeroom. This meant there was risk this equipment could have been used for patient care after having been identified removed from the asset register.
- Resuscitation equipment was checked and systems were in place for monitoring that the right equipment was in use.
- Equipment was standardised across the service, to minimise the risk of staff not being trained in its safe usage. Staff reported that access to equipment was good.
- A range of child car seats and booster seats were kept in store. These clearly stated the suitable weight range of the child and staff reported that risk assessments alerted them to use the correctly sized seats when transporting children.
- Staff were responsible for checking safety equipment on vehicles before going out. This included equipment such as defibrillators, first aid boxes and oxygen cylinders. Vehicle checklists were being used to record these checks.

Medicines

- There was safe storage of in-date medicines; however medicines identified for disposal were not isolated from use. The medicine disposal-container was full and action had not been taken to arrange for it to be

removed. Out-of-date fluid bags were stored next to this container, locked within the medicines cabinet. The manager and lead paramedic were aware of the need to arrange for medicine disposal.

- The medicines storage room was constructed in the ambulance garage, with locked metal drugs cabinets used for storing medicines including controlled drugs (CDs). The key to the medicines room was kept on a chain within a coded key safe adjacent to the door. Inside the room, a different coded key safe held the key to the metal drugs cabinet. The key to the CD cupboard was kept in a third coded key safe within the locked medicines cabinet. The metal cabinets were secured to a solid, interior wall and the interior of the medicine room was monitored by CCTV.
- There was a safe system for controlling access to medicines. Registered paramedics, trained to manage medicines safely, were authorised to access the medicines room and to sign medicines in and out of storage. The service maintained two drugs bags containing emergency drugs, one for each paramedic crew. When taken out from the medicine storage room, these drugs bags were stored within locked, purpose built storage cabinets secured within the vehicles. The key for each cabinet was held by the paramedic using the vehicle.
- Ampoules of CDs were kept in specially designed pouches attached to the paramedic's belt.
- Oxygen stored on the vehicles was secured safely and checked regularly.
- There were accurate records of medicines. Paramedics signed to withdraw and return medicines in medicine record books, and wrote the date and time, their professional PIN numbers and stock balances. There were separate books for the two CDs kept on site and the signing in or out of these drugs was witnessed. A running total of stock provided a daily reconciliation of medicines, and the record books showed monthly stock checks were carried out.
- The medicines were all in date, and there was a record of expiry dates to help the lead paramedic manage medicine orders and disposals.
- We were shown the patient report forms that would be completed when paramedics administered medicines. These were designed to detail the dosage given, the professional administering the medicine and the amount disposed of.
- Staff confirmed that they did not carry, or take responsibility for, patients' own drugs.
- An independent review of the secure management of controlled drugs had carried out in July 2015, and systems had been approved.

Records

- The records relating to the operation of the service were available on site for review. These included complaints, safeguarding reports and incident reports, as well as records relating to the management of staff, the vehicle fleet and equipment.
- The records relating to the fleet and equipment held at the service were not accurate or up to date. This meant there was a risk that vehicles and items of equipment might be used without assurance they had been safety checked. Some of the daily vehicle checklists were not filed safely for easy reference.
- Although background safety checks were carried on new recruits, this was managed by the HR department, based in Redhill. The management in Bournemouth could not access the recorded assurance that all the necessary checks had been completed on their staff, at the time of the inspection. However, after the inspection, the provider confirmed evidence of these completed checks had been forwarded to the service for reference, and provided evidence of this.
- The monthly scorecard to commissioners, reporting on a range of indicators including those relating to incidents, complaints and workforce matters, was not an accurately compiled record. The scorecard stated that all staff had participated in an appraisal and were compliant with supervisions. However, all the staff we spoke with said they could not recall having had an appraisal or supervision. The service did not operate a formal staff appraisal system.
- Care records were created with relevant patient information. Key information about patients' needs was collated and recorded and shared with staff on their handheld electronic devices ('personal digital assistants' or PDAs). Staff were alerted to any special requirements and were able to contribute to any updates in patient records.
- Systems were in place to promote confidential handling of patient information. Staff PDAs were controlled by secure PIN numbers, and access to information was limited to specific staff.

Patient transport services (PTS)

Assessing and responding to patient risk

- Call handlers identified patients' particular health conditions, access requirements or mobility issues that needed risk assessment before transport could be confirmed. Staff said they received information detailing specific risks about patients, which meant that transport was planned safely, with the right equipment or crew.
- Any changes to patients' transport requirements were communicated promptly by the call handling team. Ambulance care assistants said they also provided feedback if they found risk assessments were incorrect or needed updating, for example if a patient's mobility had improved since their last risk assessment had been completed.

Staffing

- The service operated with office staff and 65 ambulance care assistants, with 10 trained to provide 'first person on scene' (FPOS) care. E-Zec also employed three paramedics with a further two paramedics on their bank. On the day of our inspection, three staff were completing their induction training to join the bank team of ambulance care assistants.
- Shifts were arranged with one night shift crew and two shifts operating until 2am. The shifts had recently been reorganised to fit in with clinic times at Poole Hospital, and to support patients attending dialysis appointments. Staff reported that there were sufficient staff to meet people's needs.
- The service's staffing model was agreed with commissioners and reflected the projected, planned patient transport journeys with a built in contingency level. The contingency level was also based on seasonal fluctuations. Staffing levels were also linked to the size of the vehicle fleet.

Anticipates resource and capacity risks

- Prior to our inspection, the service had experienced a roof leakage in the offices in Bournemouth. They were able to maintain services without disruption, by moving affected staff to alternative offices downstairs. The service had a business continuity policy and procedures, reviewed in May 2015, which included incidents of this type as well as those relating to civil emergencies, severe weather and IT failures.
- The service monitored transport journey time and staffing and used trend analysis to plan for staffing levels. For example, the staffing level could be flexed to respond to local events and seasonal fluctuations.
- To support this approach, the service reported operating a flexible rota and employing trained bank staff. In addition, some staff were dual trained for extra flexibility, with office staff trained to drive patient transport vehicles if necessary.

The service used two external contractors, primarily for the weekly routine journeys, for example for long out-of area transfers which enabled their own staff to focus on local journeys and respond to on-the-day changes to schedules.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment must be provided in a safe way for service users. To comply, the registered provider must ensure the equipment used by the service provider is safe. Regulation 12 (1)(2)(e) HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff were not receiving regular supervisions and appraisals to support them in delivering a safe service. Regulation 18 (2)(a) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing