Location Medical Services Limited

Location Medical Services - Shepperton Studios Medical Centre

Quality Report

Shepperton Studios
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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

Location Medical Services - Shepperton Studios Medical Centre is operated by Location Medical Services Limited. The service provides emergency and urgent care and conveys patients from event sites to hospital emergency departments where clinically necessary.

We inspected this service using our comprehensive inspection methodology. We carried out this announced inspection on 1 November 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

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 do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following issues that the service provider needs to improve:

- We found two out-of-date oxygen cylinders on one of the ambulances we inspected, and a further expired cylinder in the medical gas store. We informed the provider, who immediately removed the expired cylinders. The provider also sent written confirmation that an external contractor had audited all oxygen cylinders and removed any others that had expired or were close to expiry. The provider also introduced a daily check of oxygen cylinder dates as part of their daily vehicle checks to prevent this from happening again.
- The provider did not have assurances all staff carrying out regulated activity had appropriate, up-to-date mandatory training in key areas. These included infection prevention and control and safeguarding children level three training for staff that treated children and young people under the age of 18.
- The provider did not have assurances all staff carrying out regulated activity had a meaningful annual appraisal to provide ongoing assurances of their performance and competencies. Following our feedback, the provider began writing to NHS ambulance trusts where staff held substantive posts to establish a pathway to share evidence of mandatory training and appraisal.
- Five out of seven patient records we reviewed showed gaps in documentation, including missing observations. This meant the provider had not maintained accurate, complete and contemporaneous records for all patients. Following our feedback on this issue, the provider updated their clinical documentation policy and circulated to all staff. The members of staff who had completed the records we raised concerns about also reflected on their performance and produced a reflective statement.
- The provider had not taken sufficient action to mitigate identified clinical risks to the service. Other than client satisfaction questionnaires, there were no systems in use to assess, monitor and improve the quality and safety of the services provided at the time of our inspection.
- We raised concerns with the provider about the cleanliness of one of the three vehicles we inspected, as well as two pieces of equipment. The provider took immediate action to remove the equipment and vehicle in question from service, as well as producing audit tools to monitor cleanliness going forwards.

However, we also found the following areas of good practice:

Summary of findings

- Staff spoke positively about the culture of the service. The leadership team told us they made themselves accessible to staff at all times and encouraged a culture of openness and transparency. Staff told us they felt they could approach the leadership team at any time if they wanted to raise a concern or needed support.
- The provider had systems to ensure they maintained vehicles to keep them roadworthy. We saw evidence all ambulances the service used to carry out regulated activity complied with MOT testing, and had valid insurance and vehicle tax.
- We saw evidence that all medical equipment underwent annual testing and servicing by an engineer. The provider's equipment servicing log provided assurances all equipment had passed the engineer's inspection and testing within the last year.
- We saw evidence of effective pre-employment checks to assess the suitability of new staff. These included Disclosure and Barring Service (DBS) and reference checks, and evidence of professional registration.

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 issued the provider with four requirement notices that affected the Emergency and urgent care service. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		The main activity provided by this service was event medical cover. However, CQC does not currently have the power to regulate event medical cover. A small proportion of the service's activity was the urgent transfer of patients from event sites to hospital. In the reporting period September 2016 to August 2017, the service undertook 108 emergency and urgent care patient journeys from event sites to hospitals. This activity is regulated by CQC. We found areas the service provider needed to improve: • The provider did not have assurances all staff carrying out regulated activity had appropriate and up-to-date mandatory training in key areas. • The provider did not have assurances all staff carrying out regulated activity had a meaningful annual appraisal to provide ongoing assurances of their performance and competencies. • The provider had not taken sufficient action to mitigate identified clinical risks to the service. Other than client satisfaction questionnaires, there were no systems in use to assess, monitor and improve the quality and safety of the services provided at the time of our inspection. • At the time of our inspection, we saw evidence the provider had not maintained accurate, complete and contemporaneous records for all patients. • We raised concerns with the provider about the cleanliness of one of the three vehicles we inspected, as well as two pieces of equipment. We also raised concerns around three out-of-date oxygen cylinders we identified. The provider took immediate action to rectify these issues, and provided written confirmation of this to CQC. However, we also identified the following areas of good practice:

Summary of findings

- Staff spoke positively about the culture of the service and could approach the leadership team at any time if they wanted to raise a concern or needed support.
- The provider had systems to ensure vehicles were maintained to keep them roadworthy. We saw evidence of up-to-date tax, MOT, insurance and servicing for all vehicles used to carry out regulated activity.
- We saw evidence of effective pre-employment checks to assess the suitability of new staff. These included Disclosure and Barring Service (DBS) and reference checks, and evidence of professional registration.

Location Medical Services - Shepperton Studios Medical Centre

Detailed findings

Services we looked at
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Detailed findings

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Background to Location Medical Services - Shepperton Studios Medical Centre

Location Medical Services - Shepperton Studios Medical Centre is operated by Location Medical Services Limited. The service opened in 1997. It is an independent ambulance service in Shepperton, Middlesex. The service primarily serves the communities of the South East region.

The service had a registered manager, who had been in post since the service registered with CQC in June 2011.

The main service provided by Location Medical Services - Shepperton Studios Medical Centre was medical cover on event sites and at film productions. The provider also had a small medical centre at the registered location to provide basic first aid treatments for contracting staff working in the adjacent film studios. In England, the law makes event organisers responsible for ensuring safety at the event is maintained, which means that event medical cover comes under the remit of the Health & Safety Executive. Therefore, the Care Quality Commission (CQC) does not regulate services providing clinical support on event sites and this is not a regulated activity.

However, any conveyance of patients from an event site does fall within the scope of CQC registration. Location Medical Services - Shepperton Studios Medical Centre carried out 108 patient journeys from event sites to hospitals during the inspection reporting period, September 2016 to August 2017. These journeys were all urgent or emergency transfers to hospital. This was the service's only regulated activity during this period. The provider did not carry out any non-urgent patient transport services or repatriations.

The provider had a fleet of four ambulances they used to carry out regulated activities. They also had additional rapid response cars that they used for unregulated activities only. Therefore, we did not inspect the rapid response cars as the activity staff carried out with these cars did not fall within CQC's regulatory remit.

The service employed over 100 staff. However, only 12 members of staff carried out regulated activity. These staff were registered paramedics, ambulance technicians and registered nurses.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,three other CQC inspectors, and a specialist advisor with expertise as a paramedic.The inspection team was overseen by Amanda Stanford, Deputy Chief Inspector of Hospitals.

Detailed findings

How we carried out this inspection

During the inspection, we visited the registered location. We spoke with five members of staff. These were, the registered manager, a registered paramedic, a technician, the fleet and equipment manager and the operations manager. We also received one "tell us about your care" comment card, which a patient had completed before our inspection. During our inspection, we reviewed seven sets of patient records.

Facts and data about Location Medical Services - Shepperton Studios Medical Centre

The service is registered to provide the following regulated activities:

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

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice before, and the most recent inspection took place in February 2014. The service was meeting all standards of quality and safety it was inspected against on the previous inspection.

Activity (September 2016 to August 2017)

- In the reporting period September 2016 to August 2017, the service undertook 108 emergency and urgent care patient journeys.

Track record on safety (September 2016 to August 2017)

- The service reported there were no never events during the reporting period.
- The service reported there were no clinical incidents during the reporting period.
- The service reported there were no serious injuries during the reporting period.
- The service reported there were no formal complaints during the reporting period.

No other providers operated within the service.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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No other providers operated within the service.

Emergency and urgent care services

Summary of findings

The main activity provided by this service was event medical cover. However, CQC does not currently have the power to regulate event medical cover. A small proportion of the service's activity was the urgent transfer of patients from event sites to hospital. In the reporting period September 2016 to August 2017, the service undertook 108 emergency and urgent care patient journeys from event sites to hospitals. This activity is regulated by CQC.

We found areas the service provider needed to improve:

- The provider did not have assurances all staff carrying out regulated activity had appropriate and up-to-date mandatory training in key areas.
- The provider did not have assurances all staff carrying out regulated activity had a meaningful annual appraisal to provide ongoing assurances of their performance and competencies.
- The provider had not taken sufficient action to mitigate identified clinical risks to the service. Other than client satisfaction questionnaires, there were no systems in use to assess, monitor and improve the quality and safety of the services provided at the time of our inspection.
- At the time of our inspection, we saw evidence the provider had not maintained accurate, complete and contemporaneous records for all patients.
- We raised concerns with the provider about the cleanliness of one of the three vehicles we inspected, as well as two pieces of equipment. We also raised concerns around three out-of-date oxygen cylinders we identified. The provider took immediate action to rectify these issues, and provided written confirmation of this to CQC.

However, we also identified the following areas of good practice:

- Staff spoke positively about the culture of the service and could approach the leadership team at any time if they wanted to raise a concern or needed support.
- The provider had systems to ensure vehicles were maintained to keep them roadworthy. We saw evidence of up-to-date tax, MOT, insurance and servicing for all vehicles used to carry out regulated activity.
- We saw evidence of effective pre-employment checks to assess the suitability of new staff. These included Disclosure and Barring Service (DBS) and reference checks, and evidence of professional registration.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- The service reported no never events in the twelve-month period before our inspection. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare services. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- Staff reported no incidents during the inspection reporting period (September 2016 – August 2017). This might have been indicative of a low incident reporting culture.
- However, the registered manager was able to show us details of an incident reported one month before the reporting period, in August 2016. A manager had logged this incident onto an electronic spreadsheet. The incident involved staff being unable to take a specific piece of equipment off an ambulance to move a patient. Another crew promptly brought the necessary equipment from their vehicle, and there was no harm to the patient. A duty manager investigated the incident. We saw the service had implemented learning from this incident by changing their practices so that crews assemble all equipment before an event begins. The duty manager observed this process to obtain assurances staff correctly assembled equipment at the start of each shift.
- The service had paper-based forms for staff to report incidents. The duty manager subsequently transferred incident details onto an electronic spreadsheet. We saw incident forms available on vehicles. The service required new staff to read the incident reporting policy in the staff handbook and sign to confirm they understood the policy and the expectation to report incidents. While the policy did not specifically state a requirement to report "near miss" incidents, it did prompt staff to report, "Any other incident, clinical or otherwise, that you feel may have compromised our service to, or the safety of, our service users - where such an incident could be avoided in future by proper reporting and investigation".
- We saw that the incident policy contained within the staff handbook did not cover the method for reporting incidents. However, we saw that the annual online appraisal completed by staff included a prompt to check staff knew how to report an incident.
- For the incident we reviewed that happened in August 2016, we noted from the electronic incident spreadsheet that staff had reported the incident by telephoning the duty manager. We asked the registered manager whether staff had also completed a paper incident form for this incident, and he confirmed that they had not. While it was clear that staff had promptly notified the duty manager of this incident, the failure to complete an incident report form may mean that not all details about an incident are captured and recorded to help identify learning outcomes.
- The duty of candour, Regulation 20 of the Health and Social Care Act 2008, relates to openness and transparency. This duty requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. While there were no incidents during the reporting period that triggered duty of candour, the registered manager demonstrated awareness and understanding of their regulatory duty of candour.

Cleanliness, infection control and hygiene

- We inspected three of the four ambulances used to carry out regulated activity that had been cleaned and were ready to be used for patient care and treatment. We raised concerns about the cleanliness of one of the vehicles. The inside of this vehicle was visibly dirty, and surface dirt readily lifted when wiped. We also saw a long-leg splint inside this vehicle, which was visibly soiled and discoloured. We raised our concerns about this vehicle with the provider. The provider told us this was an older vehicle that was due to be replaced with one of the newer vehicles waiting to be commissioned. Following our feedback, the provider immediately removed this vehicle and the long-leg splint from service.

- We also saw visibly dirty disposable splints and rust on the trolley wheels inside another vehicle. We informed the provider, who immediately began to research a method of individually wrapping disposable splints to prevent contamination.
- We saw dust and dirt inside containers holding consumables inside the equipment store. The floor in the stores was also visibly dirty.
- All vehicles received a deep clean every six months, or earlier if required, for example, after transporting a patient with diarrhoea and vomiting. The service kept a spreadsheet containing the dates staff carried out a deep clean of each ambulance. However, we found a lack of cleanliness audits to provide assurances around infection prevention and control. At the time of our visit, the provider confirmed they did not routinely carry out cleanliness audits. This meant the provider could not have been assured about the cleanliness of vehicles, equipment or the equipment stores.
- Following our feedback, the provider produced an audit tool to assess and monitor vehicle and equipment cleanliness. The provider shared a copy of the new audit tool with CQC within two weeks of our inspection visit. The provider told us they planned to carry out regular audits to gain assurances around cleanliness.
- At the time of our inspection, the registered manager confirmed that the service did not routinely carry out hand hygiene audits. This meant the provider could not be assured staff were compliant with hand hygiene policies and best practices to reduce the risk of infections.
- Following our feedback immediately after the inspection, the provider produced audit tools to assess and monitor hand hygiene and uniform practices. The provider shared a copy of the new audit tools with CQC within two weeks of our inspection visit. The provider told us they planned to carry out regular audits to gain assurances in these areas.
- We saw hand sanitising gel and personal protective equipment (PPE) such as gloves, goggles and overalls available on all three vehicles we inspected. However, as we were unable to observe direct patient care during our inspection, we were unable to observe staff cleaning their hands or using PPE.
- The service provided staff with uniforms. The service required staff to launder their own uniforms on a minimum 60°C wash after every shift to minimise the risk of infection. However, at the time of our visits, the provider did not carry out uniform audits to assure themselves of uniform cleanliness. The service kept replacement uniforms on the vehicles to allow crews to change their uniform during a shift if needed, for example, if it became contaminated with bodily fluids. Staff told us they would discard heavily contaminated uniform into clinical waste.
- We saw surface cleaner spray, paper towels and decontamination wipes available on vehicles so that staff could clean re-useable equipment between patients. However, as we were unable to observe direct patient care during our inspection, we were unable to observe staff cleaning equipment between patients.

Environment and equipment

- We reviewed completed "vehicle daily log sheets" covering a three-week period in October 2017. This covered checks of the vehicle and key equipment staff were required to carry out at the start of each shift. However, we saw gaps on some sheets where staff had not recorded checks such as vehicle critical checks including fuel and tyres. This meant the provider could not have assurances staff completed all checks at the start of every shift. Consequently, the provider could not be assured of the safety of all vehicles at the start of every shift.
- We saw that the harnesses on the trolley cots inside the ambulances we inspected had only two straps for securing adults during transport to hospital. It is best practice to fit trolley cots with a four-point harness together with one or two additional straps. These were not present on the three vehicles we inspected. The provider told us four-point harnesses would be fitted to the trollies supplied with three newer vehicles, which the provider had purchased. The provider had not yet commissioned these vehicles at the time of our visit but planned to do so over the coming winter.
- The service had adjustable five-point harnesses to secure children in their ambulances during transport to hospital. The manufacturer's instructions specified that

this equipment was suitable for the transport of young children and babies weighing 4.5kg and above. This meant the service had appropriate equipment to transport children of all ages.

- On the three ambulances we inspected, we saw a range of equipment, which was suitable for the treatment of children of all ages. This included resuscitation equipment such as paediatric defibrillator pads, bag valve masks, small cannulas and paediatric oxygen masks.
- Staff cleaned, restocked and made vehicles ready when they returned to the registered location at the end of a job. We spoke with an ambulance crew member, who told us they had never experienced any issues with a vehicle not being made ready before their shift.
- We saw evidence of up-to-date tax and MOT for all four ambulances the service used to provide regulated activity. We also saw evidence of annual servicing and maintenance for these vehicles. The service had vehicle breakdown cover for emergency assistance should a vehicle develop a fault. We checked the lights on all three vehicles we inspected and found that they were working correctly.
- The service kept an electronic vehicle maintenance tracker, which included the dates the next MOT, service and tax renewal were due. This helped the service ensure the timely maintenance of vehicles to keep them safe and in line with legal requirements.
- We saw the provider's equipment service logs. This provided evidence of servicing for all relevant re-usable or electrical equipment by an independent engineer within the last year. The service log also included a description of any maintenance action taken. The service log provided assurances all equipment had passed the engineer's inspection and testing.
- We saw the correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with Health Technical Memorandum 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. We saw that staff had labelled sharps bins and that no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks.
- The premises were appropriately secure. The provider's offices were located within a secure compound shared with other businesses. Visitors were required to sign in at the main reception after passing the security guard. The provider kept its ambulances inside the secure compound between uses.

Medicines

- We found two out-of-date oxygen cylinders on one of the ambulances we inspected. One cylinder had expired on 21/09/2013 and the other on 08/10/2009. We saw a further oxygen cylinder in the medical gases store, which had expired on 23/04/2016. We reported these issues to the provider on the day of our inspection, and they immediately removed the expired cylinders. The provider also sent information within two weeks of our visit confirming that an external contractor had audited all oxygen cylinders and removed any others that had expired or were close to expiry. The provider also introduced a daily check of oxygen cylinder dates as part of their daily vehicle checks to prevent this from happening again.
- We saw oxygen cylinders stored in a plastic tool cabinet in the medical gas storage area. We also saw cleaning fluids stored in this area. This did not meet Department of Health guidance set out in Medical Gases Health Technical Memorandum (2006). This states that gas cylinders should be "chained or clamped to prevent them from falling over, and stored when not in use in a well ventilated storage area or compound away from combustible material and separated from cylinders of flammable gas."
- The service used Morphine, an opioid pain-relieving medicine that is classed as a controlled drug (CD). CDs are medicines liable for misuse that require special management. At the time of our visit, the provider did not have a controlled drugs licence from the Home Office. Companies and individuals in England require a Home Office licence if they wish to produce, supply, possess, import or export CDs. However, the provider was able to show us evidence of their application for a CD licence, which they submitted in April 2017. We also saw evidence of emails the provider sent to chase their application in August 2017 due to the length of time

taken for their licence to come through. At the time of our visit, the provider had confirmation from the Home Office that they were on a case list, and they were waiting the processing of their licence.

- After our inspection, the provider reported that the Home Office Drugs Licensing and Compliance Unit visited them and issued their CD licence. The provider sent us a copy of their Home Office Licence, and we saw that this was issued on 13 December 2017.
- The service was able to provide evidence of a T-28 waste exemption certificate from the Environment Agency. Services that denature (inactivate) controlled drugs before disposing of them need to register an exemption to allow them to comply with the requirements of the Misuse of Drugs Regulations 2001. It is important that services denature any surplus CDs before disposing of them to prevent misuse.
- The service held denaturing kits for the safe disposal of CDs. A second staff member witnessed the disposal of CDs, and both staff members signed a register to confirm which drug and quantities they had disposed. We saw that the service's medicines management policy reflected these practices.
- The service stored Morphine inside a locked safe, within a locked cupboard on the ambulances. Only authorised staff had access to the CD safe to prevent inappropriate access to CDs.
- The service only carried 20 milligrams (two vials) of Morphine on each ambulance. This was in line with best practice. We saw that registered staff recorded Morphine usage on paperwork located with the drugs on the ambulance. Staff then transcribed this onto a central register held at the office.
- Registered staff visually checked the quantity of Morphine on the ambulance at the start of each shift and signed the "vehicle daily log sheet" to provide confirmation of this check. However, we saw no evidence of routine CD audits for the last year, and the registered manager confirmed the service did not routinely perform CD audits. This meant the provider might have lacked full assurances in this area. We fed this information back to the provider, who sent written confirmation within two weeks of our visit that they had introduced weekly CD audits.
- A member of make-ready staff restocked medicines bags with non-controlled drugs ready for each shift. Make-ready staff tagged the medicines bags to provide crews with assurances the bags were stocked and ready to use. We saw that crews checked the drugs bags at the start of each shift and signed the "vehicle daily log sheet" to provide confirmation of each check.

Records

- We reviewed seven patient report forms (PRFs). In five out of seven cases, we saw that patient observations such as respiratory rate, oxygen saturation and temperature were either not recorded or only recorded once for patients who were under the care of the service's staff for over an hour. There was no recorded evidence of a repeat set of observations in line with best practice.
- One of the five PRFs with missing documentation was for a patient who had lost consciousness for two minutes. We saw that staff had not documented the answers to vital questions. These included circulation, sweating, vomiting and fitting. The clinical lead thought there was a clinical referral form for this patient detailing these observations; however, they were unable to locate it.
- The service's clinical lead told us there may have been clinical referral forms for the five patients with missing observations if they had previously been seen at a treatment post at an event before transferring to hospital. The clinical lead told us the clinical referral forms might provide details of further observations supporting the PRF. However, the clinical referral forms were not part of an integrated record and the provider was unable to locate the relevant clinical referral forms for us. This meant the provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The provider was therefore in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.
- The leadership team told us they checked completed PRFs and fed back to staff any areas for improvement. However, there were no formal audits to provide

assurances around record keeping. The missing clinical observations we identified in the records we reviewed and the absence of record-keeping audits meant the provider lacked assurances around record keeping.

- We gave immediate feedback to the provider about our concerns around record keeping. The provider sent written confirmation within two weeks of our inspection that they had updated their clinical documentation policy and circulated to all staff. The provider shared a copy of their updated record-keeping policy with CQC. We saw that this required staff to record all information handed over if the patient had received care at an event treatment post before handover to the ambulance crew. The revised clinical documentation policy also made clear the requirement that, "Two complete sets of observations should be routinely be recorded for each patient, unless time in your care is under 20 minutes".
- The members of staff who had completed the records we raised concerns about also reflected on their performance and produced reflective statements. The provider shared these with CQC.
- Crews completed paper-based PRFs, which they transported back to the office and stored securely at the end of every shift. We saw that there were no completed PRFs left on the three ambulances we inspected.

Safeguarding

- The provider did not have assurances that all staff that treated children had the appropriate level of training to allow them to identify and respond to child safeguarding concerns. The service provided safeguarding children level two training to staff. However, the intercollegiate guidance document Safeguarding Children and Young People: roles and competences for health care staff (2014) states that, "All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should have level three training."
- We asked the provider how they ensured children were under the care of staff trained to safeguarding level three. The provider explained that most staff carrying out regulated activity also held a substantive post at an NHS ambulance trust and completed level three training there. However, the provider did not have evidence staff completed safeguarding children level three training elsewhere. This meant the provider could not be assured staff held the appropriate level of training.
- The service provided online safeguarding vulnerable adults and children level two training to all staff. Provider data showed 70% of staff (154 out of 220) had completed safeguarding level two training. However, there was no requirement for staff to update their training each year, and the data showed some staff that were recorded as being compliant with safeguarding training had completed the course more than two years ago. This meant staff might not have all held sufficiently up-to-date training to allow them to recognise and respond to safeguarding concerns.
- The provider told us only a small proportion of staff on this list carried out regulated activity, with most staff solely providing medical cover on event sites. This does not fall within CQC's regulatory remit. The provider also said some staff on this list had since left the company. However, the provider was unable to supply updated training data separating staff that carried out regulated activity.
- The medical director was the safeguarding lead for the service. The medical director held safeguarding vulnerable adults and children level four training, which was appropriate for their role as safeguarding lead. As the medical director was not a full-time employee of the service and was often off-site, the clinical lead also held level four safeguarding training. This meant staff had an appropriately trained point of contact involved with the day-to-day running of the service they could approach for safeguarding advice or to raise any concerns.
- There was a clear process for reporting safeguarding concerns. Staff reported safeguarding concerns on paper safeguarding referral forms. We saw safeguarding referral forms available to staff in the ambulances we inspected. The medical director or clinical lead subsequently reported safeguarding concerns to the relevant local safeguarding authority. We saw the service's "Safeguarding Policy Document" reflected this process.
- The service had not reported any safeguarding concerns in the inspection reporting period (September 2016 to

August 2017). An ambulance crew member we spoke with demonstrated awareness of adult and child safeguarding and knew the process for reporting concerns at Location Medical Services (LMS).

- We saw LMS's safeguarding policy, which the service updated in October 2017. We saw that the policy included practical guidance to staff and covered relevant areas including female genital mutilation (FGM) and human trafficking. The service had asked all staff to read the updated policy by 30 November 2017. At the time of our visit on 1 November 2017, the LMS online staff portal showed approximately 75% of staff had read the policy. This meant the service was on-track to ensuring all staff had familiarised themselves with the policy by 30 November 2017.

Mandatory training

- The provider assumed that staff working for an NHS trust completed mandatory training, but was unable to provide evidence they had completed this training. The provider confirmed they did not expect staff that held a substantive post at an NHS trust to provide them with formal evidence of training in key areas. Instead, the provider relied on staff to communicate any training needs in their online annual self-appraisal form. This meant the provider did not have assurances all staff providing regulated activity had appropriate and up-to-date mandatory training.
- We saw evidence of attendance at an annual training day in January 2017 for staff who did not hold a substantive post in an NHS trust. While the list of topics covered basic and advanced life support, and manual handling, it did not include other key areas of mandatory training such as infection prevention and control (IPC). This meant the provider did not have assurances staff had relevant and up-to-date training to help them prevent and control the spread of infections.
- Following feedback immediately after our inspection, the provider confirmed that they planned to add face-to-face IPC training to their list of annual mandatory training updates. The provider also confirmed they had begun writing to NHS ambulance trusts where staff held substantive posts to establish a pathway to share evidence of mandatory training and appraisal.

Assessing and responding to patient risk

- The service used the Glasgow Coma Scale (GCS) to monitor and detect deterioration in patients. GCS is a national tool used by ambulance crews to measure eye-opening response, verbal response and motor response following injury or trauma. The tool allowed calculation of a numerical score to enable crews to recognise any deterioration.
- We saw GCS observations in the records we reviewed. However, we saw there were no second set of observations documented in five of the seven patient records we reviewed. This meant the provider could not have had assurances staff always detected and responded appropriately to deterioration.
- Staff told us that as soon as they detected any deterioration, they would transfer the patient to the nearest NHS hospital emergency department under blue lights. Staff pre-alerted the receiving hospital about all patients they transferred under blue lights. This allowed the hospital to be prepared with some basic clinical details and ready to receive the patient. Staff also gave examples of times they had called the NHS ambulance service to request triage for the local air ambulance service when air ambulance was the most appropriate means of transfer for the patient.
- There was a clinical team leader on site at all events who staff could contact for immediate advice regarding escalation. Staff could also contact the duty manager for advice at any time using their mobile telephones.

Staffing

- The service had 12 core staff consisting of paramedics, ambulance technicians and registered nurses. These staff regularly worked for the service and provided both regulated and non-regulated activity. There was also a larger pool of approximately 100 additional staff that carried out irregular, non-regulated activity.
- The provider used the "Purple Guide to Health, Safety and Welfare at Music and Other Events" to determine safe staffing levels and skill mix for different events. The Purple Guide provided national guidance to help services plan safe staffing for events. This helped the service ensure there was a sufficient number and skill mix of staff on shift should the service need to transfer a patient to hospital and carry out regulated activity.

- The service had an online rota system where staff could record their availability. The service had a spreadsheet with details of each staff member so they could match staff with suitable jobs according to their skills and qualifications. For example, for events where children may attend, managers allocated registered staff that treated children as part of their day-to-day work within the NHS. Staff told us that as events were planned in advance, it was usually easy to allocate an appropriate number and skill mix of staff.

Anticipated resource and capacity risks

- The service did not have a written business continuity policy. However, the registered manager and clinical lead were able to give examples of situations when they had assessed risk and acted to ensure business continuity. This included assessing the risk to staff safety during travel to work in extreme weather. Another example was a time when an ambulance sustained a flat tyre on a film set. The duty manager assessed the risk of being unable to transport a patient and discussed this with the on-site safety team. The film crew subsequently agreed to delay high-risk stunt work until later on the same day when a mechanic had attended and replaced the flat tyre.

Response to major incidents

- Staff carried major incident packs on the ambulances when attending events where there may be a risk of mass casualties. The packs included blast dressings and a mass casualty triage system.
- The service participated in major incident table top exercises. This allowed staff to be prepared and understand their role should a major incident arise at an event. We also saw evidence a staff member had completed a major incident medical management course.

  The provider told us if they were the first ambulance on the scene of a major incident, then they would take control until the NHS ambulance service arrived and took over. The provider was able to give us an example of a time when they supported the NHS ambulance service when a major incident occurred at an event in the past.
- The provider told us they did not provide staff with conflict resolution training to help them respond to any violent or disturbed patients. However, they told us there were police officers on site at almost all the events they attended. Staff felt they could approach police at an event for any advice or assistance if they needed to. However, staff told us they rarely encountered violent or disturbed patients.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Evidence-based care and treatment

- At the time of our inspection, the service did not perform any audits to monitor staff compliance with policies and procedures. This meant the provider could not be assured staff followed the service's policies. We discussed this concern with the provider at the end of our inspection. The provider subsequently devised audit tools to monitor compliance in several areas, including hand hygiene, uniform and record keeping. We saw copies of the new audit tools; however, these were not yet in use during the inspection reporting period.
- The service had updated several policies shortly before our inspection, and we saw that they contained relevant, evidence-based guidance. For example, the provider's "Safeguarding Referral Process" contained an evidence-based tool for assessment of suicide risk based on the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. Policies had a version number; however, they did not include a review date. This meant the service might not have reviewed policies at regular pre-defined intervals to ensure they included the most up-to-date, evidence-based guidance.
- Staff followed JRCALC guidance to assist them with clinical decision-making. JRCALC provides evidence-based guidance to ambulance personnel, including general clinical guidance and detailed guidance covering a wide variety of areas including drug calculations and paediatrics.
- The provider told us that any policies that deviated from JRCALC guidance required approval from the medical director. We saw that the medical director had approved the use of Methoxyflurane for adult patients. Methoxyflurane was a prescription-only medicine that fell outside of the JRCALC guidance. Staff submitted an

audit form to the drug manufacturer every time they used Methoxyflurane. This allowed monitoring for any adverse reactions. The provider only used Methoxyflurane at remote event sites such as at off-road events and remote filming locations. They did not use this medicine in the context of ambulance transport or outside an event site, and therefore this activity was not within the scope of CQC regulation. However, this demonstrated the process for medical director approval following a deviation from JRCALC guidance.

Assessment and planning of care

- The service used a numerical scale of one to ten to assess and record patients' pain. However, in four out of seven patient records we reviewed, we saw staff had not recorded the patient's pain score. In one case, staff had given paracetamol for pain relief but not recorded a pain score. This meant the provider could not be assured staff always assessed patients' pain in line with national guidance.
- We raised the issue around inconsistencies in recording pain scores with the provider. The provider subsequently updated their clinical documentation policy, circulated this to all staff and shared with CQC within two weeks of our visit. We saw that the new policy explicitly set out the requirement for staff to record all relevant observations, including "Pain Score before and after any analgesia". The provider also asked the staff members who had not recorded pain scores appropriately to provide written reflection on this, which the provider shared with CQC.
- Where patients reported pain, we saw evidence in the PRFs showing staff had offered them pain relief.
- Staff did not transport a patient if they felt they were not best placed to do so. For example, if air ambulance transport was more appropriate, such as in certain trauma cases, staff arranged for helicopter emergency medical services to assist.

Response times and patient outcomes

- The ambulances had tracking devices, which linked to the service's monitoring system. The service could use this system to see when an ambulance left a site, its progression, and when the ambulance arrived at its destination. This meant the service could monitor the ambulance in real time and had the capability to monitor, record and audit response times.
- The monitoring system also allowed the provider to track blue light journeys and see vehicle speeds. This gave the provider assurances staff drove safely under blue lights and only used them when this was clinically necessary.
- Some event organisers set specific response times for ambulance staff to reach an injured patient. They required the provider to report their response times, which they measured from the time the call for help came in to the time the crew arrived on the scene. The provider's tracking system allowed them to monitor and produce this data.
- The provider did not participate in any national audits. This was because the volume of patients they treated when carrying out regulated activity was small. The provider also did not carry out any subcontracted 999 work for NHS ambulance services that are required to submit data to national audits.

Competent staff

- Staff did not receive a face-to-face appraisal. Instead, staff completed an online self-appraisal. We saw the service's online self-appraisal system, which relied entirely on staff to identify gaps in their skills and knowledge. This was therefore not a meaningful, two-way process between line manager and staff member. It meant the provider might not have had up-to-date assurances around the competencies of all staff carrying out regulated activity.
- The provider told us staff that carried out regulated activity had an annual appraisal at the NHS trust where they held a substantive post. However, other than asking staff for the date of their last appraisal and the employer name as part of the online self-appraisal, the provider had no evidence staff had completed an annual appraisal elsewhere or of the outcome. This meant the provider might not have had up-to-date assurances around the competencies and performance of all staff.
- The service carried out pre-employment checks to assess the suitability of new staff. We reviewed six staff

records and saw that the service performed Disclosure and Barring Service (DBS) and reference checks before employing staff. We also saw that the service checked the professional registration status of staff with the Health and Care Professions Council (HCPC) or Nursing and Midwifery Council (NMC). This ensured staff had the relevant qualifications and experience before they started working for the provider.

- All staff that drove the service's ambulances also performed this role as part of their substantive post within an NHS ambulance trust. The service required all staff that drove their ambulances to complete an accredited driving qualification that included training in driving under blue lights. We saw evidence of driving qualifications and copies of driving licences for relevant staff in the staff folders we reviewed. This meant the provider had assurances all staff driving their ambulances had the relevant training and qualifications to enable them to drive safely, including under blue lights.

Coordination with other providers

- The provider regularly coordinated with local NHS ambulance services. Staff told us examples of times they had done this. These included an occasion when they were unable to accommodate a patient's specialist wheelchair on their vehicles, and times when they had needed triage for air ambulance assistance. The provider also coordinated with air ambulance providers when a patient required transfer by air ambulance.

Multi-disciplinary working

- At events, crews coordinated with on-site doctors to provide care to patients. Staff gave us examples of times they had done this, including when dealing with cardiac arrests.
- Staff told us they handed over all relevant clinical information to hospital staff when they transferred a patient to hospital. However, we were unable to observe any handovers during our inspection.
- Staff had a daily team briefing at the start of each event. The team leader led the briefing. This ensured staff received all relevant information they needed for their shift.

Access to information

- Staff carried JRCALC "pocketbooks". They also had online access to JRCALC guidelines using their smartphones. This ensured they always had access to JRCALC guidance when on shift.
- We saw the online staff portal, which allowed staff to access the service's policies and procedures electronically using their smartphones. Staff told us they received an alert whenever the service added a new policy or updated an existing one. Staff then had to confirm via the portal that they had read the policy. This gave the provider assurances staff had received all relevant updates.
- The ambulances had satellite navigation systems. The provider told us the systems alerted them when the maps needed updating, and the provider arranged updates accordingly. Staff also had access to traffic monitoring systems on their smartphones, which they sometimes used to identify any traffic issues before setting off on a journey. This allowed them to better plan their route to avoid traffic.
- Staff carried smartphones, which they could use to contact the duty manager on call if they needed advice.
- Staff were also able to give us an example of a time when they supported the NHS ambulance service when a major incident occurred at an event in the past.
- Staff told us police officers were usually present at events they attended. Staff said they could approach police officers for advice and assistance if needed, for example, if a violent patient or relative presented.
- Staff gave an example of a time when the local hospital emergency department was not the most suitable place for a patient with an eye problem to be treated. Staff subsequently contacted a specialist eye hospital in London and transferred the patient there so they could receive specialist treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Registered staff carried out capacity assessments when there were concerns about mental capacity. A capacity assessment allowed healthcare professionals to identify patients who lacked capacity to make certain decisions about their care and treatment for themselves in line with the Mental Capacity Act 2005 (MCA). The provider told us staff carrying out regulated activity received

training in the MCA. A member of staff we spoke with told us they had received MCA training as part of their mandatory training at another provider where they held a substantive post. However, as with other mandatory training modules, the provider did not have evidence of MCA training for all staff that carried out regulated activity. This meant the provider could not be assured all staff had appropriate training to allow them to recognise capacity issues and assess mental capacity in line with the MCA.

- The provider told us approximately 5% of their activity involved providing care and treatment to children and young people. Staff told us parents accompanied any children under the age of 16 and were able to provide consent on their behalf if needed. Staff also told us they had treated children accompanied by a chaperone with written consent to treatment signed by someone with parental responsibility.
- Staff told us that only HCPC or NMC registered staff assessed Gillick Competence in children under the age of 16. Gillick Competence was the statutory process for assessing that children under the age of 16 were competent to make decisions about their own care and treatment. The provider told us registered staff assessing Gillick Competence received consent training in this area as part of their substantive role at an NHS trust. However, as with other areas of mandatory training, the provider did not have evidence of consent training for all staff that carried out regulated activity. The provider therefore could not be assured all registered staff had appropriate training to allow them to correctly assess Gillick Competence and take consent in line with the relevant legislation.
- Staff could contact the local NHS ambulance service to share additional patient information regarding do not attempt cardiopulmonary resuscitation (DNACPR) orders. Staff told us an example of a time when they had done this to establish that a patient had a valid DNACPR order after relatives told them the patient had one. This allowed them to provide appropriate care and treatment to the patient.
- The service had never conveyed a patient detained under Section 136 of the Mental Health Act 1983 or used restraint.

Are emergency and urgent care services caring?

Compassionate care

- We reviewed one patient comment card that a patient completed before our inspection. The patient described the member of staff that treated them as “very caring” and said, “I cannot fault her at all, she’s brilliant”! We also saw other feedback the provider received that described staff as, “Friendly, helpful [and] caring”, and “Very nice”. Although some of this feedback came from patients whose treatment did not fall within the scope of regulated activity, this demonstrated the compassionate care the service provided to patients.
- Staff described how they maintained patients’ privacy and dignity in public places by using screens at events and closing the ambulance doors when assessing patients.
- Staff told us about a patient they transferred to a specialist hospital, who stayed in touch with the service. Staff told us the patient regularly visited the service’s medical centre and updated staff on their progress.

Understanding and involvement of patients and those close to them

- The comment card we reviewed stated the member of staff caring for the patient had “explained everything” to them. This demonstrated that the member of staff had ensured the patient understood all aspects of their care and treatment.
- Staff told us an example of an occasion when they spent time liaising with the family of a patient who transferred to hospital. The family had been arguing, and staff spent time talking to the family and mediating with them. Staff subsequently managed to diffuse and resolve the situation.
- We saw evidence in patient records we reviewed that demonstrated staff involved patients in decisions about their care. For example, some patients had declined specific pain relief and staff had respected their decision and recorded this.

Emotional support

Emergency and urgent care services

- Staff told us about a time when they supported the relative of a patient who suffered a cardiac arrest at an event. An on-site doctor had broken the bad news that the patient had died, and the relative wanted to see the patient. A member of LMS staff subsequently escorted the family member to their relative and provided emotional support at this distressing time. Although this event related to non-regulated activity, it demonstrated the emotional support the service was able to provide.
- Staff told us about times they had provided emotional support to anxious patients who wanted someone to listen to them.

Supporting people to manage their own health

- Staff gave us an example of a time when they received a call from an event organiser after the team had finished their shift. A patient had sustained a minor injury during the event, but had only reported it after the event had finished. The crew subsequently returned to the event site to treat the patient and try to help them avoid a visit to hospital. After assessing the patient, the crew deemed a hospital transfer necessary and conveyed the patient to hospital with the patient's agreement.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- Clients, who were event organisers and production companies, privately funded all work the service carried out. As most events were planned well in advance, this allowed the provider sufficient time to plan ahead regarding vehicles, equipment and staffing.
- The service met and communicated with clients in advance to assess the types of services they needed. The provider encouraged clients to submit feedback questionnaires to help them improve the service they delivered, and we saw completed feedback.
- The service did not carry out any subcontracted work on behalf of an NHS ambulance trust. The service also did not provide any care and treatment commissioned by clinical commissioning groups (CCGs).
- To engage with the community and local charities, the provider told us they sometimes offered their services at no cost for local charity events.

Meeting people's individual needs

- The service rarely needed to use translators. This was because most patients they treated were able to understand and communicate in English. Staff told us they never used family members or friends to translate for patients. This was in line with best practice. Some staff spoke other languages and were able to communicate with patients who spoke limited English in their native language.
- The service did not have a service level agreement for professional translation services. However, staff were able to give examples of times they had accessed professional translation services for patients. In one instance, staff coordinated with a local NHS ambulance service, which provided a telephone translation service to the patient. Another situation involved a patient who did not speak sufficient English to be able to describe their medical history. As staff were unable to make clinical decisions without this information, they obtained consent from the patient for transfer to hospital. The patient spoke enough English to be able to understand and give informed consent to transfer. Staff subsequently contacted the receiving hospital before transporting the patient so they could book a translator.
- Due to the nature of the events and film sets the service attended, staff told us they did not routinely see patients living with dementia or other complex needs.

Access and flow

- Patients could access the service any time while at an event. Some patients with minor injuries attended a medical or first aid post for initial assessment before transferring to ambulance crews if they needed transport to hospital.
- At geographically larger sporting events, the service had specific response times to reach a patient. The service monitored response times using the tracking devices inside the ambulances. The service also used the tracking devices to identify where their ambulances

were at large events so they could send the nearest available crew for the quickest response. The service subsequently monitored journey times to hospital using the tracking devices.

Learning from complaints and concerns

- Data from the provider showed the service had not received any formal complaints with the reporting period (September 2016 – August 2017). Therefore, we were unable to review any complaints or the provider's response. Other than an email address given on the provider's website for patients to register a complaint, we saw no other information freely accessible to patients that were transported by the service informing them of the process for making a complaint. There was no patient information about how to make a complaint on the three vehicles we inspected. This meant patients may not have known how to make a complaint.
- The provider informed us after the inspection that medical rooms at events and mobile medical centres had posters displayed informing patients of the processes open to them for making complaints. However, we were unable to inspect these facilities during our visit because care and treatment provided on an event site does not fall within the scope of CQC regulation.
- We reviewed the provider's complaints procedure. The provider aimed to resolve all informal or verbal complaints as quickly as possible to prevent escalation. Patients could submit any formal complaints in writing to the managing director. The service aimed to provide a written response within seven days of receiving a complaint. As the service had not received any formal complaints within the reporting period, it was not possible to assess whether the provider met this target.
- The registered manager and clinical lead were able to give examples of times the service had resolved informal complaints and responded to feedback. This included liaising with event health and safety officers to improve the signage to a medical tent after patients informed staff they had difficulty finding it.

Are emergency and urgent care services well-led?

Leadership / culture of service related to this core service

- The managing director was also the registered manager. The leadership team also consisted of a clinical lead, who was a registered paramedic, a medical director, an operations manager and a fleet and equipment manager. These staff all reported directly to the managing director. Ambulance crew members reported to the operations manager, who had previously worked as a paramedic.
- Staff were positive about the culture. The leadership team told us they made themselves accessible to staff at all times and encouraged a culture of openness and transparency. They said, "Everyone knows each other" and described the culture as being like a "Family". The service valued its staff, and when we asked members of the leadership team what they were most proud of, they told us "Our staff". A crew member we spoke with told us they felt they could telephone the managing director or the operations manager at any time if they needed support. The crew member also described how the operations manager arranged cover if a shift was likely to run over so staff could finish their shift on time.

Vision and strategy for this this core service

- The leadership team told us they had a written set of values for the service. However, they had not committed the values to memory and were unable to share them with us. This meant the values could not have been widely shared and known amongst staff.
- The registered manager and clinical lead told us the vision and strategy was to continue to grow the service. Within this vision was a move to larger premises. The service had used a management consultant to review staffing, resourcing and systems to help the workload grow safely and at a manageable pace.

Governance, risk management and quality measurement

- The medical director was the service's governance lead. The service also used an external senior clinical advisor to provide governance oversight and support. The senior clinical advisor was a senior paramedic.
- The service did not have evidence of processes that allowed for appropriate governance of the service. We requested meeting minutes for any board, team or regional meetings as part of our pre-inspection data request. The service was unable to supply any. This meant there was no documented record of clinical governance meetings, or evidence of governance processes.
- The service did not have a risk register. We asked the registered manager and clinical lead what they thought the biggest clinical risks to the service were. They told us the biggest risk was the risk of a malpractice allegation against a member of staff. They said they mitigated this risk by ensuring staff attended training and made appropriate documentation. However, we found the service did not have robust assurance of mandatory training staff undertook with other providers. We also found missing information in patient report forms, as described in the 'Records' section of this report. This meant the provider had failed to sufficiently mitigate an identified risk.
- The registered manager and clinical lead said the second biggest clinical risk to the service was a medicines error. They felt that strong policies around medicines management mitigated this risk. However, found out-of-date medical oxygen cylinders on a vehicle and within the stores. This meant the provider had not sufficiently mitigated another identified risk.
- At the time of our inspection, there were no audits in place to monitor service quality. This meant the provider might not have had assurances around quality and performance in all areas. However, following feedback immediately after the inspection, the service introduced several audit tools and shared these with CQC. This included tools to audit cleanliness, hand hygiene and uniform. The provider also sent written confirmation that they planned to introduce weekly controlled drug audits to provide them with further assurances in this area.
- Client satisfaction questionnaires for the year before our visit demonstrated a high level of client satisfaction. Almost all clients rated the service as five out of a possible five for all areas assessed. The remaining ratings were four out of a possible five.

Public and staff engagement

- The service informally met with staff and listened to their ideas for innovation and improvement. The leadership team arranged meals out and events where all staff could attend to engage with staff.
- The service held debrief meetings with clients at the end of events and productions. This allowed them to discuss what went well and identify areas for improvement. The service also encouraged clients to submit satisfaction questionnaires to obtain their views.
- The service used client satisfaction questionnaires to assess the quality of services provided to their clients. The questionnaires sought clients' views on areas such as the quality of information provided, the behaviour of crews and the booking processes. However, there were no patient questionnaires to obtain detailed feedback from patients on the care and treatment they received.

Innovation, improvement and sustainability

- A crew member told the leadership team about a specific piece of equipment they used at the NHS trust they worked at to move patients who had suffered a near-drowning episode away from water. The leadership team listened to the staff member's idea and subsequently purchased the equipment to use at open-water events.
- Following feedback from crew members that response bags were too heavy to carry over longer distances, the service worked with a manufacturer to adapt a response bag to meet crews' needs. The service subsequently purchased and used the bags, which can be carried as a backpack for crew comfort.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that all staff carrying out regulated activity hold up-to-date mandatory training in key areas. These include infection prevention and control, and level three safeguarding children training for staff treating children and young people under the age of 18.
- The provider must ensure that all staff carrying out regulated activity have a meaningful annual appraisal.
- The provider must take action to ensure all vehicles and equipment are clean.
- The provider must take action to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- The provider must take appropriate action to monitor and mitigate all risks to the service.
- The provider must take action to use systems to assess, monitor and improve the quality and safety of the services provided and obtain assurances around service quality and safety.
- The provider must take action to put effective governance processes in place and keep records of these.

Action the hospital SHOULD take to improve

- The provider should ensure staff complete an incident report form to provide a full written account of all incidents, as well as reporting them verbally.
- The provider should ensure all policies and procedures have a planned review date.
- The provider should consider introducing a risk register to help them monitor, assess and mitigate risks to the service.
- The provider should ensure they have a documented record of all governance meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 (1) (a)** **How the provider was not meeting this regulation:** **We identified one vehicle and two pieces of equipment that were visibly dirty. We also saw dust and dirt inside containers holding consumables inside the equipment store.** **Although the provider took immediate action to remove the equipment and vehicle in question from service, as well as producing audit tools to monitor cleanliness, robust assurances of cleanliness in all areas were not yet in place within the inspection reporting period.**

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) (2) (a) (b) (c)** **How the provider was not meeting this regulation:** **Other than client satisfaction questionnaires, the provider was not yet using systems to assess, monitor and improve the quality and safety of the services provided.** **The provider took insufficient action to mitigate identified clinical risks.** **The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) (2) (a) How the provider was not meeting this regulation: The provider did not have assurances all staff carrying out regulated activity held up-to-date mandatory training in key areas. These include infection prevention and control, and level three safeguarding children training for staff treating children and young people under the age of 18. The provider did not have assurances all staff carrying out regulated activity had a meaningful annual appraisal.