Devon Freewheelers

Devon Freewheelers

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We carried out a comprehensive inspection of Devon Freewheelers on 29 & 30 April 2021 due to concerns raised. We inspected our five key questions: safe, effective, caring, responsive and well led.

This is the first inspection for this service since it was registered with CQC in February 2020. Before the inspection, we reviewed information we had about the provider, including information we had received and intelligence available.

Our inspection was unannounced to enable us to observe routine activity. We have rated the service at this inspection; however, we did not have sufficient evidence to rate caring.

Action we have taken against the provider of this service

We served an urgent suspension notice on the registration of Devon Freewheelers. This is because we believed that a person would or may be exposed to the risk of harm if we did not take this action.

We rated Devon Freewheelers as inadequate because:

The service was providing some regulated activities they were not registered for, and staff had no training to make sure they were safe to do this. Staff had no training in key skills, or understanding how to protect patients from abuse, and safety was not managed. Staff did not assess risks to patients, so any risks were not identified or acted on. Patients' records lacked details about their needs and no assessments were carried out to determine any risks during transfer. Equipment was not stored safely, and there were no warning signs to identify risks to staff and visitors. Patient transport vehicles and some of the equipment stored on them were not clean and they did not have valid insurance cover. The service had not reported an outbreak of COVID-19 to another regulatory body as required. Safety incidents were not managed well. Staff reports were incomplete, and these were not reviewed by senior staff to see if any lessons needed to be learned and shared with staff. Staff did not collect safety information to improve the service.

Managers did not monitor the effectiveness of the service. Staff were not appraised and did not have access to ongoing training programmes based on their need to develop their individual skills. There was no induction programme to guide staff and support them when starting work for this service. Staff were not assessed for their competency to undertake their role or to make sure they were competent. Staff did not have access to any guidance on how to support patients to make decisions about their care.

Staff did not consider patients' individual needs or provide any aids to assist them. There was no procedure or policy for patients or their family/carers to make a complaint about the service.

Leaders did not have the skills or knowledge to run their service. Information was not obtained to demonstrate the senior leadership team were fit and proper persons to oversee the running of the service. There were no reliable information systems to monitor the service provision or to identify risks and actions needed to address these. The service had no vision or values, and therefore no strategy to develop. The service did not have systems to engage with staff or patients to enable them to give feedback about the service.

However:

Summary of findings

The service had enough staff as they operated on an as when required basis. The service had implemented some systems to control infection risk. Restrictions had been introduced to minimise the risk of infection from COVID-19, but these were not always followed. Visitors to the location had to complete a questionnaire to check their risk of COVID-19 to prevent risks to their staff.

Whilst the service had no documented assessment to assess patients' food and drink requirements, staff offered water during long journeys. Patients were able to eat food provided to them by other sources during their transfer.

The service worked to the timescales given to them by the provider requesting the transport. But documented evidence was not maintained to demonstrate this.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Devon Freewheelers

Devon Freewheelers are based in Devon and are registered with the Care Quality Commission to provide a patient transport service. They have a mixture of volunteers and paid staff. The service operates 24 hours a day seven days a week.

This location is registered to provide the following regulated activity:

Transport services, triage and medical advice provided remotely.

Devon Freewheelers was registered with the CQC in February 2020. The registered manager has remained in post since the date of registration.

The service was not able to provide information about the number of patient transport journeys they have undertaken since they were registered.

This is the first inspection of this location since being registered with the CQC.

How we carried out this inspection

The team that inspected this location comprised of three CQC inspectors. During the inspection we spoke with the management team. We also reviewed documents and records kept by the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

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

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with eight legal requirements.

The service must ensure that senior staff with director level responsibilities are fit and proper to take on this role by obtaining and supplying documents to confirm their suitability. They must also have appropriate knowledge of the Health and Social Care Act 2008 (Regulated Activities) 2014 (part 3) and understand the consequences of failing to act on set requirements. 5 (1)(3)(a)(b)(d)(e)

The service must ensure staff receive appropriate support, training, supervision and appraisals to enable them to carry on their duties safely. 18(2)(a)

Summary of this inspection

The service must ensure patients who use the service are protected from abuse. Staff must receive safeguarding training that is relevant and suitable for their role. 13(1)(2)

The service must ensure the premises and equipment are safe to use and must be kept clean using the appropriate cleaning methods and materials. Staff must always follow COVID-19 guidance to prevent the risk of infecting others. All staff responsible for cleaning must have appropriate training. The storage of oxygen must be in line with legislation to reduce the risks to visitors to the location. Warning signs for oxygen must be visible on the building and vehicles to warn patients/staff and others of where it is stored. The storage of other hazardous materials and heat sources must not be located near to the oxygen storage. 12(2)(d)(e)(g)

The service must ensure risk assessments relating to health, safety and welfare of patients using the service are completed by staff who have the skills and knowledge to do this. Oxygen must only be administered in accordance with the prescribers' instructions to prevent any risks to the patient. Staff responsible for the management of emergency oxygen must be suitably trained and competent to do this and this must be kept under review. Policies and procedures for the management of oxygen must be in line with current legislation and guidance. 12(1)(2)(a)(b)(g)

The service must ensure information on how to complain is accessible to everyone and it should be available in other formats and languages. The service must have an effective complaints system to make sure all complaints are investigated without delay. Complaints must be monitored for trends and areas of risk that must be addressed. Records of all complaints, investigations and outcomes must be maintained. 16(2)

The service must devise a system to make sure they have oversight of and can assess and monitor their service provision. They must include for example, performance, incident monitoring, complaints and feedback. These systems must enable the service to identify any risks to the health, safety and welfare of patients who use the service. Records of these must be maintained. Records relating to patients who use the service must be kept and fit for purpose. All paper and electronic records must be kept in line with the requirements of the Data Protection Act 1998. 17(1)(2)(a)(c,d)

The service must ensure recruitment processes confirm that the information required for each new member of staff is obtained before they are employed. 19(2).

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

The service should ensure that the safeguarding policy includes details of the local council safeguarding team and how to contact them.

Senior staff should ensure all staff are always following COVID-19 guidance about social distancing and wearing of masks in the offices.

The service should consider devising vehicles checks for consumables to make sure they are all in date.

A system for staff to record their hours worked for other providers should be devised to help with planning of any transfer requests, so staff do not work excessive hours.

Summary of this inspection

As part of the transport referral process, the service should ask if patients have any special instruction for example, do not resuscitate orders.

The service should devise policies and procedures pertinent to patient transport services based on current legislation, guidance and best practice.

Patients' hydration and nutritional needs should be assessed prior to any journey to make sure they have access to food and drink to prevent any dehydration. Toilets stops should also be factored in and recorded on any long distant journeys.

The service should devise a feedback system for staff and minute staff meetings.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate

Are Patient transport services safe?

Inadequate

Our rating of safe is inadequate because:

Mandatory training

The service did not provide mandatory training in key skills to all staff. Patients were at risk of not having their needs met by untrained staff.

Staff did not receive effective training in safety systems, processes and practices. We reviewed five staff records and there was no evidence of training required for patient transport services. For example, safeguarding and manual handling. Patients could be exposed to the risk of harm if staff do not have the necessary training to perform their duties.

Records of staff training were incomplete, so managers would be unable to determine if staff had completed the necessary training to provide a safe service to patients. We were shown a list of mandatory training and details of how many staff had completed it. There was no safeguarding or manual handling training for staff which would be required training for a patient transport service. There were gaps throughout training records as not all staff had received training on infection prevention and control, health and safety and fire safety. On review of the training spreadsheet, we identified four of the five staff members were still working for this provider and one member of staff had left the service. Of the four remaining staff, we found two had a certificate to demonstrate completion of infection prevention and control training. We found no records of health and safety training for any of the four staff. Three out of four staff had no fire safety training. There was no record for medicines management (for the use of oxygen in an emergency) training. This was of concern, as we had observed oxygen cylinders in the vehicle we inspected, and a patient's record showed oxygen had been administered during a patient transport in January 2021. This could place patients at risk of being given oxygen when it could be detrimental to their health.

Patients were exposed to the risk of harm because there were no systems to ensure staff working for Devon Freewheelers had the necessary training. There was a risk patient would not be appropriately safeguarded or moved safely in the absence of training.

The provider was unable to offer any evidence that staff had received training to ensure they were able to meet the potential needs of patients with mental health conditions, learning disability, autism and dementia.

Safeguarding

Staff had access to a policy and procedure about safeguarding but this lacked guidance about abuse, how to protect patients from abuse and how to report it. Staff had not received training on how to recognise and report abuse placing patients at risk.

Staff did not receive effective training in safeguarding, processes and practices. We examined the training records for five staff and could not find evidence of any safeguarding training taking place. The providers safeguarding policy said a safeguarding lead from the board would be appointed but there was no evidence in the policy who this was and what training they had received to support staff.

There were no arrangements to safeguard adults and children from abuse and neglect that met relevant legislation and local requirements. The safeguarding policy had no details about the types of abuse, who to contact if staff suspected abuse, how to make a referral to the local council and nothing about the training staff should receive. There was a page labelled useful numbers, but it was blank. We were not assured staff had the information and guidance to protect adults and children from abuse.

Patients were at risk because adequate checks had not been completed on staff to ensure they were safe to work with patients. For example, Disclosure and Barring Service checks (DBS). The provider was unable to find evidence staff had DBS checks undertaken. The section on their record sheet for DBS numbers was blank for the five staff records we examined. These could not be provided when asked for evidence that these had been undertaken. We were informed there was a project being completed to review DBS checks, but we were not shown any evidence of this. The requirement for DBS checks was not included within the recruitment policy we reviewed during the inspection. We could not be assured staff providing regulated activities were safe to do so. Patients will or may be exposed to the risk of harm if DBS checks are not undertaken on staff who work for Devon Freewheelers.

As part of one of their service level agreements (SLA) with a local NHS trust for transfer of patients, the agreement stipulated all staff would be checked to an enhanced level of DBS to include vulnerable adults and children's register. As mentioned above this did not happen. The only member of staff we had evidence of a DBS was for the registered manager who had to have one completed as part of Care Quality Commissions (CQC) registration process. However, this member of staff had not been involved in the three transport journeys requested by this NHS trust.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Control measures had been devised to protect staff and others from the risk of COVID-19 infection, but these were not always followed. Equipment, vehicles and premises were not all visibly clean.

Patients were not always protected from the risk of infection. Although the service had some systems to reduce the risks of controlled infection, we found areas where improvements were needed.

Inadequate

Patient transport services

The service had an infection control and prevention policy which stated all staff would receive infection control training, which not been complied with. The operations director (the registered manager) was responsible for monitoring of infection control, auditing and annual reports. We requested to see evidence of these taking place, but they could not supply us with any records.

Standards of cleanliness and hygiene were maintained at their main location. This was to protect staff from the risks of cross infection. Cleaning schedules were not fully completed and did not provide assurance that all areas were suitably and regularly cleaned. We did not see any monitoring of the cleaning, for example, cleaning schedules to demonstrate when they had cleaned an area. We were told 'touch points' were cleaned several times a day by the member of cleaning staff, but no records were seen to support this. Touch points are identified areas which are touched frequently by several people and so need regular cleaning to reduce the risk of cross infection.

Cleaning staff used a system to reduce cross infection risks. For example, to reduce the risk of cross infection colour coded mops, brushes and buckets were used at this location. The colour of the mop indicated the area for use. During the inspection we observed the correct coloured equipment being used for the correct task. Mop heads were all single use and were disposed of after use. We saw stocks of these available to staff to ensure there was a reduced risk of re-use.

Vehicle deep cleaning of patient transport vehicles was undertaken to reduce the risks of cross infection, however issues with cleaning were identified. Due to limited patient transport services being undertaken, not all the three vehicles were ready for use. We inspected one patient transport vehicle and were shown the cleaning records to demonstrate deep cleaning of all patient transport vehicles was six weekly. These records stated the vehicle we inspected was clean and ready for use. We found this was mostly clean, but the suction machine had a dried substance on the top. There were also brown marks, possibly rust, on the side of stretcher trolley. Seating was torn on one of the side seats in the back of the vehicle. Patients will or may be at risk of infections if vehicles are not kept clean. This was particularly of importance in view of the current COVID-19 pandemic. Also, the record sheet recorded when vehicles had an unscheduled deep clean. We did not see any records of cleaning of the patient transport vehicles in between the deep cleans and after their use.

We saw in the patient transport vehicle we inspected staff had access to personal protective equipment (PPE) to keep themselves and others safe from the risk of cross infection. Staff also had access to PPE at the location.

Staff did not always follow COVID-19 safety guidance to reduce the risk of spreading infections. Face masks were required to be worn by all staff inside the buildings except when eating and drinking. However, we observed at times not all staff were wearing these. Staff at this location were required to maintain social distancing but we did observe in one office a number of staff had gathered which meant they could not safely distance from each other. Floor signs on entering the building indicated the distance staff and visitors needed to maintain for social distancing.

The provider had failed to follow all legal requirements when they had a COVID-19 outbreak in February 2021. An outbreak is described in healthcare-associated setting as two or more test-confirmed or clinically suspected cases of COVID-19 among individuals (for example patients, health care workers, other hospital staff) associated with a specific setting (for example bay, ward or shared space). This related to 14 staff at their location. This had not been reported to the Health and Safety Executive as required under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). At our inspection, the registered manager told us they had been able to identify the cause of their outbreak and had taken action to prevent it from happening again.

Systems had been introduced to help minimise the risks of COVID-19. Twice weekly COVID-19 lateral flow testing for staff had been introduced. Rapid lateral flow tests help to find cases in people who may have no symptoms but could still be infectious. The test provides a result in 30 minutes. We were shown records of all test results on a twice weekly basis and staff had to inform the registered manager if they tested positive. Staff were also being offered COVID-19 vaccinations. At the time of our inspection senior staff were not sure how many staff had received one or both vaccinations.

To minimise the risk of infection to and from visitors to the location, on arrival, a member of staff completed a questionnaire for each visitor about their COVID-19 status. This included asking if the person was displaying any signs and symptoms of COVID 19. Patients who required transport did not attend this base as they were collected from a designated location.

Environment and equipment

The premises and equipment were not safely managed and identified risks were not mitigated. Patients could be exposed to the risk of harm from unsafe equipment and staff were not trained to use all of it. There was no valid insurance cover for the patient transport vehicles. However, staff managed clinical waste well.

The use of facilities and premises did not always keep staff safe. We found oxygen cylinders and Entonox which were out of date in the cylinder storage cage. Entonox is a ready-to-use medical gas mixture consisting of 50% nitrous oxide and 50% oxygen for use in all situations where analgesia and sedation with rapid onset and offset is sought. Empty and full cylinders were also mixed in the storage area increasing the risk of an empty or low-level cylinders being taken for use by mistake. We found out of date oxygen in grab bags in the garage, for example one oxygen cylinder had expired 28 March 2020. Patients could be exposed to the risk of harm if processes to identify out of date medical gases and equipment are not used. There was no signage on the outside of the building to warn visitors and staff oxygen was being stored at this location.

Oxygen storage was unsafe and did not meet guidelines under the Health and Safety at Work Act 1974 and HTM02 guidelines and flammable risks were identified. Oxygen cylinders were stored within a short distance from a fuel tank, but there were no warning signs stating oxygen was close by. Above the cylinders was a small propane gas tank and an unsealed plastic box with spare fuel pumps, which had fuel in the bottom of the box. This was removed during the inspection as we raised concerns about fire safety risks. A vehicle was parked next to the oxygen and Entonox storage. This was very close to the storage area, carrying the risk the vehicle engine or hot exhaust could ignite the gas.

Staff were observed smoking within the vicinity of a patient transport vehicle storing oxygen. There was a smoking ash tray located very close to this vehicle which stored oxygen. No risk assessment for the storage of oxygen was provided. Oxygen warning signs were not on this vehicle although we were told by senior staff, they are due to be fitted shortly. We have not seen any evidence this has been completed. Fire safety risks had not been considered about smoking this close to stored oxygen. We were not shown any evidence of a formal processes to identify such risks and ensure these were mitigated. The smoking ash tray was removed during our inspection.

We saw evidence of maintenance of most equipment to keep patients safe. We saw stickers on most equipment to demonstrate they had been tested and when the next test was due. We were also sent a copy of a spreadsheet with dates of servicing of equipment on each of the three patient transport vehicles. We observed equipment including a defibrillator and suction machine on the patient transport vehicle we inspected, and these were in date for servicing. Senior staff told us these were not used. There was also a store of defibrillators in the garage area, but these were not up to date with servicing.

Inadequate

Patient transport services

The lack of training for some equipment placed patients at risk. There was no evidence staff had received the necessary training to use such the defibrillator or suction machine. The defibrillator was specialist equipment normally used by trained staff in advanced life support. Devon Freewheelers is only registered with the Care Quality Commission to provide patient transport services under the regulated activity of transport services, triage and medical advice provided remotely. The equipment available was unsuitable, due to lack of staff training and the regulated activity they were registered for. Patients could be exposed to the risk of harm if staff used this equipment on them, for which they haven't received training on and do not have the necessary competencies.

Staff were able to replenish the patient transport vehicles with supplies at the main location. However, we found an out of date paediatric oxygen mask on the patient transport vehicle we inspected which had expired in December 2019. This was removed.

Arrangements for managing waste kept patients safe. Clinical waste was managed safely to reduce risks to staff. An external contractor collected the waste on a regular basis depending on how much they had, due to limited transport. The clinical waste area was clean, and the bin closed and locked.

Patient transport vehicles were maintained and had the required legal test to demonstrate they were safe to drive. We saw records of service maintenance for patient transport vehicles. One patient transport vehicle was off the road due to a mechanical issue. We saw records of each patient transport vehicles to show they had MOT in date.

Six weekly safety inspections on each vehicle for patient transport service was required as part of one of their service level agreements (SLA) with a local NHS trust, however, they could not provide evidence these were taking place.

We checked the insurance certificate for one patient transport vehicle we inspected. We found the insurance certificate was in the name of another company and not Devon Freewheelers. This meant the vehicle was not properly insured. It also had an exclusion with the certificate for the use of paid transport, which would mean the insurance policy would not be valid for a patient transport vehicle. Following the inspection, the registered manager told us this was due to an error with the insurance company. However, we were concerned this had not been identified by the service until we pointed it out to them, and the vehicle had been used for patient transport.

Crews had access to up to date satellite navigation systems in the patient transport vehicles if needed to help them find their destinations.

The keys to the patient transport vehicles were stored securely with only staff with a door pass could access them.

Assessing and responding to patient risk

Staff did not complete risk assessments for patients to identify any risks. Staff had not received training to recognise patients at risk of deterioration and they provided treatment out of scope of their registration without training and checking the competency of staff.

We did not see any evidence that risk assessments had been carried out for patients using the service. Patients could be exposed to the risk of harm if risks to them were not assessed before being transported. Without risk assessments, the service could not demonstrate staff with the necessary skills, competence and experience would be transporting patients.

Inadequate

Patient transport services

Staff were able to recognise when a patient's condition changed but provided treatment out of their scope of registration. We saw in one patient record; staff had identified a change in the condition of the patient they were transporting and administered oxygen. However, Devon Freewheelers is not registered with the Care Quality Commission to provide monitoring services and treatment to patients. We did not see evidence that staff were trained and competent in the administration of oxygen. The service did not have a policy to provide staff with guidance on how to manage a deteriorating patient or provide staff with training.

Devon Freewheelers told us they did not provide transport services for patients with mental health needs.

Staffing

The service could not demonstrate staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. New staff were not provided with an induction programme to guide and support them in their new role.

Staff were not provided with permanent hour contract as Devon Freewheelers did not have a designated contract for patient transport, as it was undertaken on an adhoc basis. Staff were on zero-hour contracts and were contacted when a request for transport was received. At the time of our inspection, senior staff said they only had two staff who were undertaking patient transport. This was the registered manager and nominated individual. (The nominated individual is responsible for supervising the management of the regulated activity provided to meet the requirements of the Health and Social Care Act 2008).

Staff were not supported when starting work at Devon Freewheelers. We were not able to find evidence of induction arrangements for new staff. There were also no records of any induction programme or supervision of any staff. Patients were at risk of harm without systems to ensure staff had the training required to meet their needs. An induction programme is needed to provide staff with the skills needed and supervision to identify areas which staff may need help with, or further training.

There were no systems for staff to report hours worked elsewhere, therefore, Devon Freewheelers could not assure themselves that the staff working were safe to do so.

Records

Staff did not maintain detailed records of patients' care and treatment. Records lacked information about any risks identified and their management.

Patients individual care records were not written or managed in a way that kept them safe. We reviewed four records of patients who had been transported. Three were from a local NHS hospital and the other was a private transfer. The three hospital transfers each had some information from the hospital about the patients. For example, if they needed a wheelchair or stretcher and for one patient, who required oxygen during the journey, as they were receiving this prior to transfer.

There were limited details on the services patient record sheet, for example, no evidence of an assessment of the patient in relation to moving and handling, any risks, and limited details about the journey. We also saw documented in other patients record they had vomited during the journey, but no other details about this, or the condition of the patient had been recorded.

Patients records from the departing location travelled with them and were passed to the relevant care / health staff at a receiving provider. We did see this documented on one of the record sheets that a patient's hospital notes were handed to the staff at the receiving hospital.

Patients' records were not always clear, lacked details and were not completed with all information we would expect to see. For example, a more detailed account of the patient's journey. Records had dates on them, and one had times of observations checks but none were signed and dated by the member of staff completing them.

Regular audits of records were not undertaken, and changes were not made where necessary to ensure safety of patients.

Devon Freewheelers data protection policy stated they only kept personal data about their staff and volunteers. However, this was incorrect as they stored data about patients on their computer system.

The registered manager told us about the process for managing and disposing of confidential waste, which was to scan in all records and then destroy the paper copy safely. Their data protection policy did not set out the time scales for keeping patients records both electronic and paper form.

Medicines

The service had no systems and processes to safely administer, record and store medicines. The storage of oxygen was unsafe and placed patients at risk.

The process supporting the administration of oxygen in an emergency or if the patients were being discharged using oxygen was not clear for staff and had the potential to pose a risk to patients. The patient transport vehicles did not carry any medicines for emergency purposes, except for oxygen. The policy for medicines management made no reference to oxygen and its administration.

Staff were administering oxygen without training, competency checks and policies and procedure to support them. We saw in one patient records that oxygen was administered during a transfer due to a change in their condition. However, we could not find any evidence staff had been trained to use this, had their competencies checked or that the discharging hospital had granted permission for its use. There was no record on the information sent to the service about using oxygen during transfers and the service level agreement with this NHS trust also did not document the use of oxygen.

Another set of records regarding a patient who was transferred from an NHS hospital to another NHS hospital also stated staff administered oxygen to this patient throughout their journey as they had this in hospital. There was no record that this was prescribed by the departing hospital, or it had not been requested by them.

A senior member of staff told us they were trained in the use of oxygen following a training course. However, there was no record of oxygen administration being covered or that administering staff had their competencies checked.

We observed two cylinders of Entonox in the storage area. Entonox is a ready-to-use medical gas mixture consisting of 50% nitrous oxide and 50% oxygen for use in all situations where analgesia and sedation with rapid onset and offset is sought. We were not able to find any evidence staff were trained in its use or had their competencies checked. The medicine policy referred to Entonox as being self-administered but there was no guidance for staff on its use. This places patients at risk of unsafe administration of Entonox. One of these cylinders was also out of date.

Inadequate

Patient transport services

Incidents

The service did not manage patient safety incidents well. Staff had some recognition of incidents but did not report them in full as records were not completed. Managers did not investigate incidents so any lessons learned could be not be shared with staff.

Senior staff did not monitor their performance in relation to maintaining patient's safety. There were limited records of incidents and no evidence of any actions taken. We were not able to distinguish between incidents that were related to the regulated activity of patient transport services and those which were out of scope of regulation. This places patients at risk of harm if the service cannot review and learn from incidents.

Staff had some understanding about their responsibilities to record safety incidents as we saw records of these, but these were not completed in full, and it appeared this had not been followed up by senior staff.

There were limited arrangements for reviewing and investigating safety incidents. A spreadsheet had been devised but this lacked detail about the incident and any actions taken.

The management of incidents did not promote safety and learning. We saw that 26 incidents had been reported between 1 January 2019 and the date of inspection. The incidents were recorded collectively on a spreadsheet. The incidents were described in one brief summary line and did not include any actions taken. It was not clear from the record if these incidents related to the patient transport service. We requested the incident reports to see how they were reported and to provide clarity, but individual incident reports created by staff were not completed and so were not available.

We saw no evidence lessons were learned or themes identified from incidents and any action taken, as no investigations were carried out into incidents reported by staff. This meant staff and the service could not learn from or prevent any of them from happening again.

Senior staff lacked knowledge about their responsibilities in relation to duty of candour. The service sent us a copy of their Duty of Candour policy, but it referred to another company and not Devon Freewheelers. This policy mentioned monitoring of this policy was the responsibility of the board with all managers and the 'ambulance manager will provide an annual report'. We did not see any evidence of this. Duty of Candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.

Safety Performance

The service did not monitor results to improve safety. Staff did not collect safety information or made it publicly available.

The service was not able to demonstrate their safety performance over time. No system had been devised to review and monitor safety performance and benchmark this against other providers in their field. This is important for the service to demonstrate they are reducing risks to patients who use the service.

Are Patient transport services effective?

Inadequate

Patient transport services

Inadequate

We rated effective as inadequate because:

Evidence based care and treatment

The service did not provide care and treatment based on national guidance and evidence-based practice. Guidance for staff lacked detail or referred to treatments they were not able to provide.

Patients' records were very limited in detail and no risk assessments were undertaken. The provider was unable to provide any evidence that patient's physical, mental health and social needs had been assessed, or that their care and support had been delivered in line with legislation, standards and evidence-based guidance.

Guidance for staff in the form of policies and procedures was not effective at ensuing patients received the care they would need. Some of the policies referred to other legislation and guidance. For example, the capacity and consent policy referred to the Mental Capacity Act 2005 but provided little guidance for staff on how to implement parts of the Act relevant to their roles in patient transport.

Other policies referred to services that were out of their scope of their registration with the Care Quality Commission (CQC). For example, the clinical governance policy referred to clinicians, their development and clinical audits. The policy also stated, “Patient care is guided by the current best evidence of the effectiveness of particular treatments or drugs.” Devon Freewheelers is not registered to provide treatment to patients, only transport services. Policies and procedures must be pertinent to the role of the service to prevent patients from being placed at unnecessary risk.

Nutrition and Hydration

Staff did not assess patients’ food and drink requirements to meet their needs during a journey, but hydration was provided.

Patients were at risk because their nutrition and hydration needs, we not identified or monitored. We saw no reference to this on any patients’ records. However, we did see documented that one patient was provided with food to eat during the journey from the location they were leaving. The registered manager told us they took bottled water with them on each transfer for patients to have.

We did not see any evidence journeys were planned and carried out to account for patient’s hydration, feeding and toileting needs, during long journeys. There was no documentation to state if they stopped during these long journeys to provide patients with opportunity to use the toilet.

Response Times

Information about outcomes for patients and response times were not measured.

Information about the outcomes of patient's care and treatment were not routinely collected and monitored. Senior staff said they had not undertaken large numbers of patient transport and all their requests for this were adhoc

Inadequate

Patient transport services

There were no key performance indicators (KPIs) in the service level agreement (SLA) with the local NHS trust for monitoring the service provided to them. This meant the NHS trust would not be aware of how the service was performing.

Competent Staff

The service did not make sure staff were competent for their roles. Managers failed to appraise staff's work, performance and no supervision meetings were held with them to provide support and development.

Patients could be at risk because the provider could not evidence that staff had the right skills and knowledge to meet their assessed needs, preferences and choices. There was no evidence of induction, supervision or appraisals for staff in the five staff records we reviewed during the inspection. We requested supervision and appraisals documents for staff, along with the number of staff who had received them. We were sent a blank interview/appraisal record. There was no evidence provided to demonstrate appraisals had been carried out for staff. We were not assured staff were being supervised or receiving appraisals. Patients were at risk of harm from the lack of systems to ensure staff were being supervised to identify areas in which they may need help, or further training.

There were no processes to identify and manage poor or variable staff performance. The lack of supervision and appraisals meant senior staff had no process to monitor staff performance.

Training records made no reference to staff having receiving training in restraint, mental health or dementia. However, the provider told us they did not transport patients with mental health needs.

There was also no training for staff on how to recognise a deteriorating patient during transport and the action they should take. Patients may be exposed to the risk of harm if staff were not able to identify the signs of deterioration and act upon them. We could not be assured all staff would know what to do if a patient's condition deteriorated whilst they were being transported.

Multidisciplinary working

The service worked with other providers to make sure that patients were transferred in a timely way. Important information about patient's wishes or instructions were not documented.

Relevant services and organisations were informed when patients were discharged from another provider. Discharge was undertaken at an appropriate time of day. In the four patients records of transfer, we reviewed the NHS trust had contacted the service to arrange the transport at a time directed by them. The NHS trust also liaised with the receiving provider. For the private transfer, it was not clear who liaised with each location about the transfer.

Staff transferring patients would not know how to respond if an emergency was to have happened in meeting the patient's wishes and instructions. It was not clear how the service worked with external organisations and providers to make sure they were aware of special notes. For example, advanced care plans / directives and do not attempt cardiopulmonary resuscitation (DNACPR). There was one entry in a patient record we reviewed, and it stated, 'resuscitation status full treatment and escalation plan (TEP),' but there was no further information about what was on this plan. The other patients' records made no reference to special notes.

Consent and Mental Capacity Act

Inadequate

Patient transport services

Staff were not supported by the service to understand consent or other relevant legislation or guidance.

We were not assured staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and other relevant national standards and guidance. The policy called 'capacity and consent' made limited reference to the Mental Capacity Act 2005, but mostly cited the Gillick competence. Gillick competence refers to children under the age of 16 consenting to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them. We did not see any evidence the service was transporting younger adults between the age of 16 to 18 years. There was no guidance for staff on how to do a best interest decision, just a checklist.

The provider was unable to supply us with any evidence staff had been offered training in consent, Mental Capacity Act 2005 or any other national guidance around this subject.

There was no process for monitoring the seeking of consent or evidence it had been reviewed to ensure it met legal requirements and followed relevant national guidance. The service was not able to demonstrate staff asked patients for consent as part of the transport process.

The service promoted supportive practice that avoided the need for physical restraint. Senior staff told us they do not use restraint. In the four patients records we examined we did not see any evidence that restraint was needed to be used.

Are Patient transport services caring?

Insufficient evidence to rate

We were not able to rate caring as the service was not able to tell us how much patient transport services, they had undertaken and had limited feedback to share with us. We had also not received enough feedback about the service for this section.

Rating for caring is not rated due to insufficient evidence.

Compassionate Care

Not enough evidence to rate this section.

Emotional Support

Not enough evidence to rate this section.

Understanding and involvement of patients and those close to them

Not enough evidence to rate this section.

Inadequate

Patient transport services

Are Patient transport services responsive?

Inadequate

We rated responsive as inadequate because:

Service Delivery to meet the needs of local people

The provider had planned services to meet the needs of local the communities it served. It also worked with others in the wider system and local organisations to plan care but was not meeting all the terms of their contract.

Devon Freewheelers is a registered with the Care Quality Commission to provide patient transport service. This was run on an adhoc basis when they were contacted by another provider.

The facilities and premises were appropriate for the services that were delivered. The premises were shared with other non-regulated services they provided. We found some concerns with the safety of the premises as previously mentioned under safe.

The service was not always managed to meet the commissioning agreements. Devon Freewheelers had two service level agreements with two local NHS trusts. We saw they were not meeting all the required criteria. For example, checking of all staff by applying for an enhanced Disclosure and Barring Scheme check (DBS).

Meeting peoples individual needs

The service was not able to identify patients' individual needs and preferences. Patients were at risk of not having their needs met.

The registered manager was not able to show us how they identified and met the information and communication needs of patients with a disability or sensory loss. Some patient's physical needs would be met because the patient transport vehicles had a step at the side door to help less mobile patients access the vehicle. At the rear of the vehicle, a winch used alongside the tail lift helped staff lift and guide the stretcher into the back of the vehicle. From the records we reviewed, we did not see any evidence of a moving and handling assessment to provide staff with the information needed to safely move each person. We also were not provided with any evidence of staff being trained to use this winch or tail lift safely.

We did not see any communication aids in the patient transport vehicle we inspected. For example, any picture boards to help aid communication for patients who were not able to communicate verbally. There was also no information about translation services for staff to access in case they transferred a patient whose first language was not English.

There was no degree of continuity of staff for the patient transport service as they did not have a contract for frequent transfers of the same patients.

Staff were not equipped to deal with violent or aggressive patients as they had not received training in this area.

Inadequate

Patient transport services

Can people access care and treatment in a timely way?

Patients could access the service when they needed it and received their transport in a timely way.

The service operated its patient transport service on an adhoc basis. They were contacted by a local NHS trust when they required patients to be transferred or a patient who required a private transfer. All transport was booked in advance to enable Devon Freewheelers to find staff who could undertake the transfer.

Bookings were managed by contacting the service in advance of any transfer requests. We saw one of the local NHS trusts had sent details to the service about when they required the transport and the patients they would be transferring. Devon Freewheelers would then contact staff to arrange cover for the transfer and then inform the NHS trust. Senior staff told us they would agree to the time set by the NHS trust for the transport.

The service had not monitored if their journeys ran on time, therefore we were not able to tell if they kept patients informed of disruption.

Learning from complaints and concerns

It was not easy for patients to give feedback and raise concerns about the transport they received. The service did not treat concerns and complaints seriously and there was no information provided on how to make a complaint.

There was no effective process for handling complaints. We could not gauge how patients, or their family/friends could make a complaint or raise concerns. There was no information on the patient transport vehicle we inspected on how to do this. The Devon Freewheelers website also did not have information on how to complain about their service. The registered manager told us they had not received any complaints about their patient transport services.

The complaints and grievance policy contained no information on how to make a complaint. It was about grievances from staff and volunteers. No procedure for the management of complaints was included. With no policy to describe how they planned to manage complaints, any patient who complained would not get a timely response or be aware of what to expect. We saw a complaints audit form, but it was blank as they had not received any complaints.

There were no arrangements for an independent review of complaints once their internal process had been completed. In the service level agreements (SLAs) with the two local NHS trusts, there was no mention of who would lead the investigation into any complaints received about the service provided by Devon Freewheelers.

Are Patient transport services well-led?

Inadequate

We rated well led as inadequate because:

Leadership of the service

Inadequate

Patient transport services

Leaders did not have the skills and abilities to run the service and they did not fully understand their legal responsibilities. They did not identify the actions needed to address shortfalls in the service management.

The nominated individual and the registered manager were visible and accessible but lacked the knowledge and managerial skills to ensure the service was run safely. They were responsible for supervising the management of the regulated activity provided. They were unclear about the scope of the regulated activity of the service and had merged the service with another unregistered service. This caused some regulated activities to be provided when they did not have the legal registration with the Care Quality Commission (CQC) to do so.

The registered manager and nominated individual were not clear about the regulations they were required to meet. The failings we have identified throughout this report have evidenced the registered manager and nominated individual had little understanding of the practical application of the Health & Social Care Act 2008. We found staff employed by a company not registered with the CQC had undertaken patient transport services for Devon Freewheelers without the required recruitment checks taking place.

The registered manager and nominated individual did not fully understand their legal responsibilities for overseeing the service they provided. They had employed another party to set up their service without ensuring enough oversight to assure themselves of their ongoing legal responsibility.

The leadership of the service lacked enough oversight to ensure that the systems and strategies implemented were completed and reviewed. They did not ensure enough monitoring of the service to confirm a quality service was being provided.

The provider could not evidence the staff with directorship responsibilities for the service were fit and proper persons to oversee the running of Devon Freewheelers. The nominated individual and registered manager could not produce when requested the documents required under Schedule 3 of the Health and Social Act 2008. For example, Disclosing and Barring Scheme (DBS) check and a full employment history with gaps in employment explored. They also needed to demonstrate appropriate knowledge of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). The nominated individual was one of the staff with directorship responsibilities but could not demonstrate knowledge of this Act.

Vision and strategy for this service

The service did not have a clear vision or set of values, with quality and sustainability as the top priorities. Leaders did not understand the need for a strategy for delivering good quality sustainable care.

The registered manager and nominated individual had not set out a clear vision for the service. There were no values identified for the patient transfer service.

It was evident from the inspection that there was no realistic documented and formulated strategy to develop the service. There was no formal structure or short or long-term business plan with agreed timescales to work towards development of the service. The nominated individual advised us that they planned to develop the service and had purchased more vehicles. However, this action had not been because of a contractual agreement.

Culture within the service

The culture of the service did not respect or consider the safety and wellbeing of the staff.

The service lacked the mechanism and structure to enable staff to raise concerns or promote the development of themselves and the service. There was no evidence that staff meetings were conducted and no other evidence that staff views were sought or listened to. There was no evidence that staff received the support needed to develop their skills and that appraisal and monitoring were used to monitor staff skills and wellbeing.

Leaders did not understand the importance of staff being able to raise concerns without fear of retribution, and appropriate actions had not always been taken when incidents occurred.

Learning and action was not always taken in relation to concerns raised. The registered manager explained that learning was sometimes transferred by emails to staff. There was also an informal social media group, but this was not a Devon Freewheelers patient transport group and not all staff used the site, so this was not a consistent and inclusive means to share information.

Governance

Leaders did not operate an effective governance process. There were not enough effective structures, processes and systems of accountability to support the delivery of good quality, sustainable services. Those available were not regularly used, reviewed and improved.

Staff were not clear about their roles and did not understand what they were accountable for, and to whom. There was an absence of policies and procedures that would guide staff in this respect.

The governance procedures for managing and monitoring any service level agreements the provider had with third parties did not provide assurance that all parties were clear about the service being provided and by which company. Services were provided to local trusts and independent health providers. Service level agreements were not available for all services being provided; therefore, enough oversight could not be seen. The agreements seen were not clear in describing the legal entity providing the services. Feedback from the services who used Devon Freewheels was not requested by the provider.

Further service level agreements were not available to confirm the agreement with trusts to supply personal protective equipment. The provider told us that the stock was provided by the trust, but this would change in the future.

There was a lack of evidence that audit and governance systems were used to monitor the service. Documents had been created to record the monitoring and auditing of how the service was being provided however, these documents had not all been used. For example, the documentation monitoring form, service feedback monitoring form, the staff monitoring form, the station infection control monitoring form, the stock monitoring form, the training monitoring form, the policy and standard operating monitoring form and the observation practice form were all blank and not completed in line with their planned use.

The assurance systems to manage current and future performance such as incidents and complaints were not used to develop learning and improve the quality of the service.

There were audit tools available however, the data needed to complete the audits was not being gathered and staff confirmed that plans to gather and monitor data had not been completed.

Staff recruitment records were not completed, reviewed or audited. This could place patients using the service at risk of being cared for by unsuitable staff. Recruitment was not being completed in line with the requirements of Schedule 3 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Relevant employment checks were not completed, and their recruitment policy did not cover all areas relevant to Schedule 3. There was no evidence disclosure and barring service checks (DBS) were completed. These could not be provided when asked. We were informed there was a project being completed to review DBS. The requirement for DBS checks was not included within the recruitment policy sent to the CQC. We could not be assured staff providing regulated activities were safe to do so. Patients will or may be exposed to the risk of harm if DBS checks are not undertaken on staff. A deputy manager was recruited on 11 September 2020 and had not had a DBS check before employment was confirmed. They told us during inspection they had recently requested their DBS, but at the time of inspection, had no evidence of a DBS and we were not supplied with evidence it was requested. We reviewed five staff records for staff identified as providing regulated activity. Employment checks were incomplete. For example, there was no evidence of professional references having been obtained for all five staff. This was not in line with their recruitment policy. For two staff, there was no records of employment history, and for three staff there were gaps in the employment history. Photograph identification checks could not be located on two staff records. The requirements for employment history and photo identification checks were not outlined in their recruitment policy.

Staff training records were incomplete which meant staff may not all had the appropriate training and skills needed to provide the service. The service had a safeguarding auditing form where any safeguarding incidents were to be recorded. The form stated that all safeguarding's recorded were to be reviewed monthly and checked on a quarterly basis as part of an audit system. This form was blank as they had not received any safeguarding incidents.

Audits of staff skills and practice were not maintained. The observational practice form had not been updated and there was no evidence of observational monitoring of staff ever having been undertaken. The staff monitoring form created in May 2018 was noted to be blank.

Monitoring of staff driving had not been recorded. The registered manager told us that annual checks were completed to establish if staff had any driving convictions. In between these times the registered manager told us that staff were expected to inform him of any driving violations. There were no instructions for staff and no contractual obligation or signed agreement with staff to be forthcoming with this information. This meant that the service provider could not be assured that staff were legally safe to drive.

We saw further examples where the service had no process to monitor or have oversight of aspects of the business. For example, this included, the stock monitoring form did not include the stock management of oxygen, with cylinders seen to be out of date and stored in an unsafe manner. The registered manager confirmed that the audit of oxygen was his responsibility, but it had not been completed. Stocks of equipment were seen which were not appropriate for the regulated activity the provider was registered for. The registered manager advised that these pieces of equipment had been purchased for the ambulances but were not currently in use.

A clinical engineering report showed that equipment for use on the patient transport vehicles was last checked in September 2019. A clinical engineer completed those checks but a contract or agreement for the checks was not available.

Cleaning audits were undertaken but were not clearly recorded to enable a consistent audit trail of vehicle hygiene. We looked at one vehicle which was not clean and ready for use, despite records stating the vehicle had a deep clean in April 2021.

There was an absence of policies and procedures when requested. Policies for the patient transport service were not all available and those available were not completed to a good standard and did not reflect the services being provided.

The provider had a policy and standard operating procedure monitoring form available developed in May 2018. This document noted that this audit must be completed on a quarterly basis. This was to ensure that the highest standard of care was provided to all patients. The form was to be checked on a six-monthly basis as part of the providers audit system. The form was blank and so no assurances were possible that any policies and standard operating procedures were audited or monitored.

Staff were not clear about their roles and did not understand what they were accountable for, and to whom. Staff were unclear of their role in both Devon Freewheelers and the further business created at the location. Staff members were also not clear about what they were accountable for within their roles and as part of their registration with the Care Quality Commission.

Staff were not clear which company was able to provide which service. Staff were employed and paid by another company, but they also worked for Devon Freewheelers. There was no service level agreement available to record the arrangements to use staff from this other company at Devon Freewheelers. As a result, actions were undertaken by some staff which were outside of their role which created risks to both patients and staff. For example, records seen demonstrated that a patient's blood oxygen levels had been monitored and oxygen administered by staff during a patient transfer. Devon Freewheelers was not legally registered to complete this treatment.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. Assurance systems were not fully formed, and policies were not followed when incidents and performance issues arose. Learning from incidents and performance issues were not used to develop the service.

The arrangements for identifying, recording and managing risks, issues and mitigating actions were not clear and did not provide a clear system to monitor and manage risk safely. Two risk registers were seen which identified risks to the business and the service. One was developed in 2018 and the other in 2019, neither had been updated since they were written.

Each risk register lacked dates of when the issues had been identified and when the issues and actions were to be reviewed. Risks were not allocated to any specific person to managed or be accountable for. There was no evidence that staff had been involved in the development of the risk register or included in the risks identified. For example, in the 2019, there was one risk on the risk register described as "an inability to occupy premises or use interior equipment." All actions were to be completed by the responsible person, but that person or role was not identified. No updates or renewal dates were identified. The risk actions included, "invoke the disaster recovery/business continuity plan." We requested these plans, but they were not available.

A further risk was "loss of HCPC employees". HCPC stands for Health and Care Professions Council. The Health and Care Professions Council is a statutory regulator of over 280,000 professionals from 15 health and care professions in the United Kingdom. The Council reports its main purpose is to protect the public. The action advised that the organisation succession plan was to be used. We requested this plan, but it was not available. Devon Freewheelers does not employ professionals who register with this organisation as they are not registered with the Care Quality Commission to provide treatment.

The 2018 risk register noted a risk of medicines management and recorded actions to include "management systems in place, comprehensive medicine recording system in place and training provided on induction." None of these systems were available and medicines were not provided as part of the regulated activity of this service.

Risk assessments were not used to identify any areas of risk or challenge for staff. There were no risk assessments for the environment and for staff employed at the service.

Some areas of risk management had been completed, for example, risk assessments for fire safety and COVID-19. However, these were the only risk assessments in use. A fire risk assessment had been completed by an external contractor and had been updated in 2021. The risk assessment did not identify the oxygen cylinders as a flammable substance hazardous to firefighters and no external signage was used to inform firefighters that oxygen cylinders were stored inside. The risk assessment noted that flammable and hazardous substances would be kept within the main warehouse in a fume cupboard with spill lipped shelving. This was not seen to be available. The lack of risk assessments placed staff at risk.

Risk assessments for fire safety had not been updated to reflect all aspects of the service. For example, the fire risk assessment referred to the providers business continuity plan, the provider did not have this plan completed or available.

Staff confirmed there was no system available which took learning from performance data or performance incidents and then used this to create service learning and development.

Information Management

The information systems used were secure. However, the service did not collect reliable data and did not use analysis of information to develop the service and to inform decisions and improvements.

The computer information systems used were password protected and accessible only by permitted staff.

As the service was booked on an as required basis, performance measures were not used as a basis for staff to be included in discussions about service improvement.

There was no evidence that notification of external bodies was undertaken. For example, the Care Quality Commission, local authority safeguarding, and the health and safety executive were not informed when issues occurred. For example, notifying the health and safety executive about the outbreak of COVID-19.

There was no evidence that third parties were involved in the development of Devon Freewheelers. There was no evidence that feedback from external organisations involved in service level agreements with Devon Freewheelers were contacted and their views requested.

Public and staff engagement

Leaders did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They did not collaborate with partner organisations to help improve services for patients.

There was no evidence that staff were involved in the development of Devon Freewheelers. There were no records of staff's views being requested or surveyed. There was no evidence of team meetings having been convened or any other forums for formal or informal staff discussion. The management of the service told us that staff meetings took place, but no meetings minutes were available and there was no date available for the last meeting.

Inadequate

Patient transport services

There was no evidence that operational changes were discussed with staff, or that risk assessments were considered to include staff. There was no evidence of staff being involved in the development of the risk register or included in the risks identified.

Patients were not given feedback forms to gather their views of using the service. We found some feedback forms, but it was unclear if these were for Devon Freewheelers, or the other organisation run from the service's location. There was no means to identify if any of the forms related to the patient transport services. We cross referenced the names with the dates the patient transport service had been used and found none could be attributed. There was no evidence the information gathered from patients' feedback would be used to develop or improve the service.

Innovation, improvement and sustainability

Staff had no understanding of how to continually learn and improve their services. They had no understanding of quality improvement methods or the skills to use them.

Leaders had limited understanding of quality improvement methods as mentioned above and they could not demonstrate they had the skills to use them. There was no evidence that leaders encouraged innovation and participation in research.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The service had no information on how to complain which was must be accessible to everyone and it should be available in other formats and languages. An effective complaints system had not been devised to make sure all complaints would be investigated without delay. Complaints must be monitored for trends and areas of risk that must be addressed. Records of all complaints, investigations and outcomes must be maintained.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service had no system to make sure they had oversight of and could assess and monitor their service provision. The system must include for example, performance, incident monitoring, complaints and feedback. These systems must enable the service to identify any risks to the health, safety and welfare of patients who use the service. Records of these must be maintained. Records relating to patients who use the service must be kept and fit for purpose. All paper and electronic records must be kept in line with the requirements of the Data Protection Act 1998.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Requirement notices

The service had no recruitment processes to confirm the information required for each new member of staff was obtained before they are employed.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not receiving appropriate support, training, supervision and appraisals to enable them to carry on their duties safely.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors The service could not demonstrate senior staff with director level responsibilities were fit and proper to take on this role by obtaining and supplying documents to confirm their suitability. They must also have appropriate knowledge of the Health and Social Care Act 2008 (Regulated Activities) 2014 (part 3) and understand the consequences of failing to act on set requirements.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments relating to health, safety and welfare of patients using the service were not completed. These must be completed by staff who have the skills and knowledge to do this. Oxygen must only be administered in accordance with the prescribers' instructions to prevent any risks to the patient. There was no evidence

This section is primarily information for the provider

Requirement notices

staff responsible for the management of emergency oxygen were suitably trained and competent to do this. Policies and procedures for the management of oxygen were not in line with current legislation and guidance.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service could not ensure patients who used the service were protected from abuse. Staff had not receive safeguarding training that was relevant and suitable for their role.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The service did not ensure the premises and equipment were safe to use and they were kept clean using the appropriate cleaning methods and materials. Staff were not always follow COVID-19 guidance to prevent the risk of infecting others. All staff responsible for cleaning did not have appropriate training. The storage of oxygen was not in line with legislation to reduce the risks to visitors to the location. There were no warning signs for oxygen on the building and vehicles to warn patients/staff and others of where it was stored. The storage of other hazardous materials and heat sources was located near to the oxygen storage.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff were not receiving appropriate support, training, supervision and appraisals to enable them to carry on their duties safely.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Premises and equipment were not being safely maintained and any risks identified and mitigated. Patients will or may be exposed to the risk of harm from unsafe equipment and systems not operating effectively for infection control.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The service had no recruitment processes to confirm the information required for each new member of staff was obtained before they are employed.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The service had no system to make sure they had oversight of and could assess and monitor their service provision. The system must include for example, performance, incident monitoring, complaints and feedback. These systems must enable the service to identify any risks to the health, safety and welfare of patients who use the service. Records of these must be maintained.