Special Ambulance Transfer Services Limited

Special Ambulance Transfer Service

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Special Ambulance Transfer Service (SATS) was founded in 2006 and is an independent ambulance service providing a range of different patient transport services based in north west London. This includes the transfer of high dependency and critical care patients, non-emergency transfers, repatriations and event medical cover such as sporting events.

The service has contracted work with both NHS and independent hospitals. Journeys are made to various locations within London and longer journeys occurred on a regular basis. The service also occasionally transfers patients from international European locations back to the UK. The service has vehicles operated by emergency care assistants, emergency medical technicians and nurses.

We carried out this inspection as part of our comprehensive independent health inspection programme. The announced inspection took place between the 13-14 July 2016.

We saw areas of good and outstanding practice including:

- Staff adhered to good infection prevention and control practice.
- Vehicles were maintained to a high level of cleanliness.
- There were good systems in place for checking drugs on ambulances.
- Patient record forms were stored appropriately and audited to ensure good completion by staff.
- There was good coordination with other providers.
- We saw staff treating and caring for patients with compassion, dignity and respect.
- Staff felt valued and proud to work for the service.
- Staff feedback was collected and used in service development.

However, there were also areas of poor practice where the service needs to make improvements:

- There was no formal documented log of all incidents and staff were unable to show us how to access the incident reporting form. Therefore, we was not assured all incidents were being reported.
- Staff were not trained to the recommended level of safeguarding training, as per national guidance.
- The safeguarding policy was out of date and did not include updated relevant national guidance.
- There were no hand hygiene audits.
- Oxygen canisters were not being stored appropriately, which put people at risk.
- Medications were not stored appropriately.
- Some equipment was not safety checked and maintained.
- Staff had no training in information governance.
- We saw no evidence of early warning scores being used during the transportation of patients.
- We found limited evidence that complaints and low level concerns were being documented.

Importantly, the service must ensure:

- Staff are appropriately trained in safeguarding adults and children. All staff should be trained to level two in safeguarding and the safeguarding lead should be trained to level four. The service needs to establish systems and processes to effectively respond to any safeguarding concerns raised and prevent abuse and improper treatment of service users.
- The safeguarding policy is up to date and incorporates relevant national guidance.
- Oxygen and medications are stored safely and securely and do not pose a risk to others.
- All staff receive information governance training.
- All staff receive training on duty of candour and understand their role with regards to the regulation. Duty of candour must be incorporated into the serious incident investigation process.
- Equipment is serviced and safety checked on a regular basis and staff know how to check equipment appropriately.

Summary of findings

- That any serious incidents are appropriately investigated and the duty of candour is applied. The manager will need to ensure a written record is kept, investigation reports are documented and patients receive a written apology.

In addition, the provider should ensure:

- The incident reporting policy is adhered to and a log is kept of incidents reported in order to identify themes and appropriate learning identified.
- Early warning scores are used to assess for deteriorating patients during journeys.
- All staff have a Disclosure and Barring Service (DBS) check completed by the service to ensure staff are suitable to work with vulnerable people.
- They establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users. Any complaints received must be investigated and necessary and proportionate action taken. The service should ensure responses to complaints are recorded.

The above list is not exhaustive and the service should examine the report in detail to identify all opportunities for improvement when determining its improvement action plan.

Professor Sir Mike Richards
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		There was no formal log for incidents and low level complaints, which limited the services ability to look for themes and change practice as a result. Staffs' understanding of safeguarding adults and children was varied, and training was not to the recommended level. We found oxygen canisters and medication was inappropriately stored. However, we found staff were compassionate and caring and respected patients dignity. The vehicles we inspected were clean and observed excellent practice with regards to hand hygiene and infection control.

Special Ambulance Transfer Service

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

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Background to Special Ambulance Transfer Service

Special Ambulance Transfer Service (SATS) was founded in 2006 and is an independent ambulance service providing a range of different patient transport services based in north west London. This includes the transfer of high dependency and critical care patients, non-emergency transfers, repatriations and event medical cover such as sporting events.

The service has contracted work with both NHS and independent hospitals. Journeys are made to various locations within London and longer journeys occurred on a regular basis. The service also occasionally transfers patients from international European locations back to the UK. The service has vehicles operated by emergency care assistants, emergency medical technicians and nurses

Our inspection team

Our inspection team was led by:

Two CQC inspectors, a clinical team leader and senior paramedic and a retired ambulance service manager.

How we carried out this inspection

We visited the ambulance service for a two day announced inspection on the 13 and 14 July 2016 and gathered further information from data provided by the service.

During the inspection, we spoke with 15 members of staff including the financial director, operations manager, clinical lead, emergency medical technicians, emergency care assistants, nurses and administrators. We also spoke with seven members of staff at hospitals for which services were provided including doctors and nurses, and two patients. We also inspected eight vehicles and observed ambulance crews transporting patients.

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

Our key findings are:

- There was no formal documented log of all incidents which limited the service's ability to monitor incidents for any themes and use this for staff training and service development. Staff had no understanding of what would constitute a near miss and did not report incidents that were low or no harm.
- The safeguarding policy was published in 2010 and therefore did not incorporate new national guidance and recommendations. Staff's awareness of safeguarding processes and procedures was mixed and we could not ascertain what level of safeguarding staff had been trained to. All staff should be trained to level two safeguarding training and the safeguarding lead to level four.
- There was no evidence of infection prevention and control or hand hygiene audits. However, the service had a vehicle cleaning audit in place.
- We inspected a number of ambulances and found some equipment was not appropriately and regularly safety tested. Staff had not received any training on the use of some equipment. Some staff were unable to show us how they would test equipment each day to ensure it was working properly.
- Oxygen canisters were not being stored appropriately which was putting people at risk. We raised this concern with the manager on the day and were informed immediate measures were being taken to improve this.
- Emergency medicines were kept in an unlocked cupboard in the staff office. During the inspection we

were able to access the office and the medications whilst no one was around. This concern was raised with the manager on the day and a lockable cupboard was purchased for the office.
- Staff were not aware that new Joint Royal Colleges Ambulance Liaison Committee Clinical Practice Guidelines (JRCALC) had been re-published in 2016 and were referring to the 2013 guidelines.
- Disclosure and Barring Service (DBS) checks were variable and some staff had no DBS check conducted by SATS. The managers were relying on previous DBS checks by other services and therefore had no assurances that staff were able to safely work with patients. DBS checks are checks of an employee's criminal record, which are required for jobs within healthcare.
- Awareness of the Mental Capacity Act and consent was variable amongst staff and at the time of the inspection most staff had received no training in this area.
- Telephone complaints and concerns were not always being documented which limited the services ability to see trends.
- Some bank staff had full time jobs outside of SATS and, there was no process to monitor working hours. We had some concerns some staff may be working excessive hours.

However

- Ambulances were clean and we observed excellent practice with regards to infection control and hygiene.
- There were good systems in place for checking drugs on ambulances.
- Patient Care Records (PCR) forms were kept for all patients. These were stored appropriately and kept out of view during transport. PCR forms were audited to ensure staff were completing these appropriately and any issues were raised with staff immediately.
- The service was achieving its key performance indicator (KPI) target around arrival on scene times.
- Hospital staff were very positive about the service and the crews. They were described as 'professional and caring'.

- We observed very positive, compassionate and caring interactions between crews and patients and their relatives. Staff acted in a professional and courteous manner at all times.
- Staff felt valued by their peers and supported and listened to by their manager. Staff enjoyed their work and felt proud to work for the service.

Emergency and urgent care services

Are emergency and urgent care services safe?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- We found there was an underreporting of incidents and no records were kept for incidents that were low risk, no harm and near misses.
- Safeguarding training was not to the recommended level as per national guidance. All staff should be trained to level two safeguarding training and the safeguarding lead to level four. The safeguarding policy and training pack was written in 2010 and therefore did not incorporate relevant national guidance.
- Oxygen canisters were not being stored in a safe and secure way. We found oxygen canisters were not stored upright. They were stored in the same cage as petrol canisters and some were leaning against the cage and could be tampered with. This was raised with the manager who informed us immediate action was taken to order a new cage for the separate storage of oxygen.
- Some staff could not show us how they would test equipment appropriately. This included one staff member not taking equipment away from the power source to check the battery was functioning correctly.
- We found some equipment was not safety tested and there were no records to show this was done on a regular basis. One piece of equipment had a sticker that said “Do not use after September 2015”. However, this was still on one of the vehicles. Following the inspection we was told this piece of equipment did not belong to the service.
- Medications were stored in an unlocked cupboard in the office. During the inspection we were able to access the office and the medication cupboard whilst no staff were around. This was raised with the manager and a lockable cupboard was purchased.
- Staffs understanding of duty of candour was variable and this had not been incorporated into a serious incident investigation process.

However:

- We observed excellent infection prevention and control practice and hand hygiene amongst staff when transporting patients.
- All vehicles were kept clean, free from dust and well maintained.
- Patient record forms were stored appropriately during transport and were audited to ensure good completion by staff.

Incidents

- The incident reporting policy said staff should complete incident forms and pass these to their line manager who would then forward it to the operations director. The operations director should then record this on the services computer system and keep it on file for seven years. If an incident involved an injury the form should be completed and sent directly to the operations director.
- However, staff told us if an incident occurred, they would contact the control room and ask for advice.
- At the time of the inspection staff were not able to show us the formal incident reporting form when we asked how to access it. Therefore, we were not assured staff were reporting all incidents. Following the inspection we were provided with a copy of a blank incident reporting form.
- We found the service kept a log of incidents recorded which only included one incident of a flat tyre. However, there was no formal log which contained all incidents including low harm and near misses. The manager told us this was because it would take too much time and resource to do this. This limits the services ability to monitor incidents for any themes and use this for learning and service development.
- We found there was an under reporting of incidents across the service. There were no formal records kept for incidents that were low risk or no harm and near misses. Most of the staff we spoke with did not know what a near miss was. We inspected one vehicle and found a laryngoscope light source was defective as the bulb had

fallen out. For a staff member to be able to intubate a patient successfully it is vital the larynx can be seen. A failure in light source is therefore a significant risk and could result in staff being unable to maintain a patient's airway. Staff should have reported this as a near miss incident with no harm but this was not done.

- We found no evidence that learning from incidents was fed back to staff. A lack of documentation meant there were no action plans and learning from incidents.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We found that when we questioned staff about the principles of duty of candour, this was not well understood by most of them. The senior staff were aware of duty of candour and had emailed some information out to staff on the staff portal. However, this was done just before our inspection took place and was not well integrated into practice.

Mandatory training

- Managers told us Emergency Care Assistants (ECAs) must have First Person on the Scene (FPOS) Intermediate training or equivalent. The service used an external provider to ensure ECAs were trained and reported 100% of ECA were trained in FPOS.
- The service recommends Emergency Medical Technicians (EMTs) should have completed the Institute of Health Care (IHCD) EMT course. 100% of full time EMTs were IHCD qualified and 60% of bank staff.
- All registered nurses require a current NMC registration and should have completed Advanced Life Support (ALS) training. The service users an external training provider for ALS and the service reported 100% of full time nurses had ALS training. The service did not train bank staff in this. However, bank staff had to provide a valid ALS certificate at the recruitment stage.
- One of the registered nurses had been trained in Paediatric Immediate Life Support (PILS) and Advanced Paediatric Life Support (APLS). This was required for neonatal and paediatric transfers. However, we were told this would be stopping and all staff would just receive Basic Life Support (BLS) training as all paediatric transfers would require hospital staff to travel with them. We asked the service to provide us with information regarding the number of paediatric transfers; however they were unable to provide this information.
- Some staff told us training included manual handling, fire safety, safeguarding adults, child protection, health and safety, infection control, managing violence and aggression and equality and diversity. Training records provided by the service indicated that this had been completed by all staff.
- The service had recently added training for the mental capacity act which had been completed by two members of staff.
- The staff portal held the e-learning for mandatory training. These were mainly PowerPoint slides or documents that were written in-house. There was no method for reviewing these training packages.
- Training records indicated all staff had been trained between August 2015 and June 2016 and staff had completed all training modules on the same day.
- Some staff could not recall when they had received mandatory training and couldn't remember what training they had done.
- Some bank staff members had never completed mandatory training with SATS and had only provided certificates of mandatory training obtained in their other roles outside the organisation. This means the service could not be assured that bank staff had received appropriate updated training.
- There was no formal training around the use of equipment in ambulances, information governance or medications management.

Safeguarding

- The manager told us all crews were required to obtain a handover prior to transferring a patient. This enabled the staff to ascertain important information about the patient including any safeguarding issues. Crews were required to inform control of any anomalies to ensure each patient was transferred safely. In any event of uncertainty, a registered nurse from the hospital should be requested to accompany the crew and handover appropriately at the receiving hospital.

Emergency and urgent care services

- The safeguarding policy was published in 2010 and had not been revised since. This meant the policy did not incorporate new national guidance. The policy quoted Working Together to Safeguard Children 2006 and London Child Protection Procedure 2007. Both these documents had since been updated in 2015 and 2016 respectively. Therefore, the service was not practicing against up to date relevant national guidance.
- Safeguarding vulnerable adults and child protection were part of mandatory training. All staff had completed this training between August 2015 and June 2016. The child protection training was dated as being written in 2009 and had been designed in-house.The service had not revised this since 2009 so it included no information about Female Genital Mutilation (FGM) or Prevent.
- Safeguarding training was generic training and we could not ascertain the level of safeguarding staff were trained to. National guidance from the Intercollegiate Document for Healthcare Staff (2014) recommends that all ambulance staff including communication staff should be trained to level two. This applies to all clinical and non-clinical staff that have contact with children/ young people and parents/carers. The service was not meeting this requirement.
- The operations manager who was the services safeguarding lead was not trained to level four safeguarding as per national guidance.
- Awareness of safeguarding processes and procedures was variable among staff. Some staff were able to describe what would constitute a safeguarding concern. However some staff were clearly unfamiliar with the term and commented things such as “Safeguarding is treating all patients equally”, “Safeguarding means respecting confidentiality”, “Does it mean looking after yourself first then the patient”, “safeguarding is to do with property of the patients”.
- At the time of the inspection staff were unable to show us specific paper work for recording safeguarding concerns. Therefore, we had no assurance all safeguarding concerns were being reported. However, following the inspection we were shown a copy of the ‘children and vulnerable adult referral form’.

Cleanliness, infection control and hygiene

- We found good levels of cleanliness, infection control and hygiene across all the vehicles we inspected. Vehicles were visibly clean and free from dust.
- All staff had received training in infection control and had a good understanding of their roles with regards to infection control.
- There was an infection control lead within the service that staff could access for advice and information.
- The staff assigned to each vehicle completed the day to day cleaning. At the start of each shift staff were given 30 minutes to complete a Vehicle Daily Inspection (VDI) form. This included checking for appropriate cleaning supplies and an infection control internal clean checklist. This prompted the staff to clean the ambulance and equipment.
- Additional deep cleaning was completed by staff as and when required.
- The fleet manager inspected the vehicles once a week and sanitised each vehicle with a handheld sanitiser.
- We observed staff following infection control procedures, including washing their hands or using alcohol gel after patient contact.
- We observed staff adhering to the principle of ‘bare below the elbow’ as a way of minimising the spread of hospital-acquired infection.
- Staff had access to personal protective equipment (PPE) such as gloves and aprons and we observed staff wearing both when in contact with patients.
- We noted access to mop handles with disposable mop heads, cleaning products, chlorine release agents and wipes in each of the vehicles.
- We observed staff disposing of clinical waste appropriately and cleaning equipment between each patient contact.
- The services base had no facilities for the safe disposal of clinical waste. Staff told us clinical waste would be disposed of at hospitals throughout the day.
- Sharp bins were closed and not overfull, however they were not signed and dated.

- The service had developed a new cleaning log for one of the contracted hospitals (clients) to improve the way they can evidence infection prevention and control systems.
- We saw no evidence of hand hygiene or infection prevention and control audits. We were told this was something the service planned to do in the future. However, we saw the service had a vehicle cleaning audit in place.

Environment and equipment

- There were four different makes of vehicle used for the ambulance service. The oldest vehicle in the fleet was 2009 and the newest was purchased in 2016. We were told vehicles were replaced for a number of reasons including too many mechanical issues, complaints or specific clauses in contracts regarding the age of vehicles.
- Vehicle MOTs and servicing checks were monitored via an Outlook calendar.
- All vehicles within the fleet were B vehicles, which is vehicles up to 3500kg. All driving licenses were checked to ensure staff were licensed to drive this class of vehicle. Driving licenses were checked via the Driver and Vehicle Licensing Agency (DVLA) at six monthly intervals. Drivers were requested to send an authorisation code which allowed managers to view their driving license in detail including any recent convictions.
- The fleet manager conducted weekly checks on tyre pressure, tread wear, fluid levels and bulb checks.
- Staff completed daily Vehicle Daily Inspection (VDI) checks on vehicles where equipment should be checked and tested. The VDI checks covered a range of things that needed to be checked in the vehicle, such as cleanliness and oxygen levels.
- The service used lap belt restraint on stretchers and wheelchair restraints to ensure patients were safe during transit.
- For neonatal transfers the service used an incubator which was designed for the safe transfer of neonates. The incubator had safety crossover belts and a vacuum mattress.
- We found one out of date neonatal nasal cannula on one of the vehicles.
- We found a number of large oxygen cylinders were in the 'red' indicating it needed to be changed. We were initially told this vehicle was ready to go but were told a VDI check would have highlighted the oxygen needed changing prior to departure.
- We found a syringe driver which had a sticker that said "do not use after September 2015" was still on a vehicle. Following the inspection we were told by the manager that the syringe driver belonged to a hospital, and was not something staff used.
- We found a faulty laryngoscope whose bulb had fallen out within a sealed bag. If staff had required this in an emergency situation it could have prevented staff from being able to see the larynx whilst trying to intubate a patient.
- We asked managers how medical devices were maintained and we were shown the asset register. We found suction units and stretchers received preventative maintenance only. There is a requirement under work equipment and machinery (PUWER) legislation that requires comprehensive maintenance on a regular basis, often annually in line with manufacturers advice. The service was not doing this.
- We asked about training provided in testing the Laerdal Suction Unit (LSU). The manufacturer recommends a four stage test which is set out in the manufactures user handbook. The service was not following this.
- Staff had no specific training on the use of equipment. Some of the staff could not show us how to conduct proper tests on some of the equipment within the ambulance. For example, one staff member did not know how to test a suction unit and completed no checks to ensure the battery was functioning effectively away from the power source.
- The service did not provide high visibility jackets for staff. This was a risk because staff wore dark blue uniforms and collected patients during the dark and from airports.
- We reviewed servicing records and found one ventilator had last been serviced in May 2013 and was not serviced again for 21 months till February 2015. The manager told us any device overdue its 12 month service was removed from service.

- We observed inappropriate storage of oxygen canisters. Oxygen was stored in an external cage within the car park. We observed electric fans in the cage with a number of petrol canisters stored on top of them. Storing oxygen in an area where patrol canisters are sat on top of an ignition source is unsafe. Oxygen supports combustion and will significantly worsen any fire and therefore should be stored away from ignition sources and any accelerants. In addition, large cylinders containing compressed oxygen and Entonox were leaned against a wall and the fence and were not secured. These cylinders can weigh up to 19kg and have the potential to cause significant harm if they fall onto anyone. Some were also leaning against the fence and we were able to reach through the fence to touch the canisters. This was a risk because it meant someone could tamper with them. We raised these concerns with the manager on the day of the inspection. When we returned the following day the canisters had been removed from the cage. A new cage had been ordered so the canisters could be stored on their own and more securely. We asked to see where the canisters had been moved to and were shown they had been moved to a shed in the meantime. The shed had a keypad code to gain access. We were told the shed belonged to one of the other companies within the building who also knew the code. We were told these would be moved to the new cage as soon as it arrived. Due to the risk we said this should be added to the risk register. We were sent an updated risk register following the inspection and this had been added. We were sent an additional update from the provider to state the new cage had been placed in a secure area.

Medicines

- We observed good systems in place for checking drugs on ambulances. Each bag was sealed with a tamper evident seal and the numbers were recorded within a drugs folder in the office. If drugs were used staff were required to record this as part of the VDI checks and replace the seal with a new one and update this in the office.
- Emergency drugs were kept in sealed packs in a cupboard within the office (accessible by a keypad to employees). These were predominantly for use by a doctor on a transfer if required. No nurses were prescribers and the service did not use Patient Group Directions (PGD). EMTs can administer drugs to their competencies under JRCALC prescription only medicine exemptions. ECAs can only administer medical gasses.
- The service did not store any controlled drugs.
- We were told by the clinical lead that if a patient travels with a doctor the doctor would bring any medications needed on route and provide it.
- For transfers without a doctor the nurse attending would ensure that patient has had analgesia or anti-sickness medication as required prior to travel.
- For long transfers with no doctor where medication may need to be given SATS would provide the doctor with a form to sign. This form recorded the name of the patient and the drug, dose, and route of administration for the drug. This acted as a prescription and the SATS nurse would then be able to administer the drug to the patient. The clinical lead said this was rare and unused medications would be returned to the origin hospital.
- One staff member showed us the drugs protocol which had a review date of January 2016, so was six months out of date.
- Drugs were stored in an unlocked cupboard in the office. Staff told us there was always someone present in the office otherwise it was locked. During the inspection we went into the office and no member of staff was present. We were able to access the drugs from the drug cupboard. We raised this concern with the manager who ordered a lockable cupboard for the drugs to be stored in going forward. Following the inspection we were told by the provider that lockable storage was now in place.

Records

- Completed Patient Record Forms (PRF) were kept in the ambulances before being transferred for storage in the office. PRF were scanned into the system then kept in the office for up to 12 months. Following the 12 month period they are moved to archive which was reported to be a secure garage.
- We saw patient information and PRFs were kept within metal folders and were never visible in vehicles. We observed good vehicle security and locking of vehicles when staff were leaving them.

- A PRF audit was completed each month to ensure staff were completing them properly. The service had a target of 95% compliance. We were told if this fell below 95% then staff would be spoken to about making improvements. We reviewed a number of PRF audits for various staff and found compliance was mainly over 95%.
- The service did not provide information governance training for the staff. The commercial third parties information governance toolkit published by the Department of Health says all staff should have training on information governance requirements; the service was not meeting this recommendation.
- Staff were alerted by hospital staff if a patient they were transporting had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place. Staff told us they asked for an original copy of the DNACPR prior to transportation. Managers told us staff sometimes had difficulties in obtaining the original copies from hospitals. When this occurred staff would call the office and report to control they had seen the original copy and record this within the PRF. At the time of the inspection the service was reviewing the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing 'Decisions relating to cardiopulmonary resuscitation' document prior to updating their policies on this.

Assessing and responding to patient risk

- Early Warning Scores (EWS) enable early identification of deteriorating patients. Staff did not use the National Early Warning Score (NEWS) or Paediatric Early Warning Scores (PEWS) during journeys. This could prevent them from identifying when a patient is deteriorating.
- Staff used the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach to assess patients. There was a good comprehensive reminder sheet and clear guidance on how to escalate if staff were unsure or worried.
- In the event of a patient condition changing or deteriorating systems and processes were in place for staff to seek support from the control and either call 999 or take the patient to the nearest accident and emergency department (A&E).

Staffing

- The service consisted of two directors and an IT systems security maintenance and control manager who were not based in the office. An operations manager, clinical lead, assistant administrator and an assistance and event coordinator worked full time at the service.
- There were 20 full time employees, 17 bank employees and three self-employed employees.
- Staff told us they did a ride out shift when they first arrived at the service, this involved them shadowing other staff members for the day.
- There were six registered nurses, nine EMTs and 20 ECA's. Some staff held dual roles. For example, one of the registered nurses was the clinical lead and a second was the infection control and clinical audit lead. One of the ECAs managed the fleet and a second was the assistance and events coordinator.
- Managers told us crews were allocated to certain ambulances depending on their skills. For example, registered nurses would be allocated to the intensive care ambulances and sent to jobs requiring this level of care.
- The majority of staff said they got breaks during the course of the day. This involved two 15 minutes breaks and a 30 minute lunch break.

Anticipated resource and capacity risks

- There was an adverse weather policy in place which advised staff what to do in the event of severe weathers conditions such as snow. If staff were unable to make it into work then they would not be paid.
- SATS had one contract with a London hospital and managers said they have enough staff to meet the work load for this contract. Additional work will only be booked if the service has capacity. The manager said the service would only turn work down during high periods of activity to avoid the service overstretching themselves.

Response to major incidents

- The manager told us SATS would not be involved in a major incident. We were told the service could expect a high volume of transfers in the event of a major incident. However, they would only provide resources if they had the capacity to do so.

Emergency and urgent care services

- The service were not contracted to provide support in the event of a major incident. Therefore, there was no major incident policy in place.

Are emergency and urgent care services effective?
(for example, treatment is effective)

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- There were no copies of the Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines stored on vehicles. When we spoke to staff about the guidelines they were not aware a new version had been published in 2016.
- The service had not completed DBS checks for a number of their staff. Managers were relying on DBS checks completed by other organisations and therefore there was no assurances it was safe for staff to work with patients.
- Staffs understanding of the Mental Capacity Act and consent was varied. At the time of the inspection most staff had received no training on these topics.

However:

- There was good coordination with other providers and hospital staff were very positive about the service.
- We observed staff had good access to information about patients before transport. Staff were proactive in asking questions during the handover at the hospital.

Evidence-based care and treatment

- We observed some staff were carrying personal copies of guidelines published by the Joint Royal College Ambulance Liaison Committee (JRCALC). However, no copies of this were stored on the vehicles. Staff referred to the 2013 version of JRCALC and had no awareness that a new set of guidelines was published in 2016.
- We were told by the nursing staff that they kept up to date with relevant national guidelines and evidence based practice via the Royal College of Nursing. However, we did not see any critical care transfers so we were unable to assess whether national guidelines were being followed or not.
- Staff were following the Guidelines for the provision of Intensive Care Services (2015) and the Resuscitation Council (UK) guidance. The service was in the process of reviewing a new cardiopulmonary resuscitation document to inform practice.

Assessment and planning of care

- SATS provided one ambulance for two professional football clubs. This ambulance was provided for player transport and staff were provided for pitch rescue. For one of these clubs the ambulance was provided by SATS and the crew of a paramedic and Technician was sub-contracted from a limited company. For the other club the ambulance and either ECA or EMT was provided by SATs and a freelance paramedic was employed. In both cases the equipment was provided by the club and any additional paramedic equipment or drugs was provided by the paramedic.
- The same ECA and EMTs were used for the football clubs and we were told they were familiar with the event and ground and any actions they would have to undertake in the event of a major incident. No additional major incident training was provided by SATS. We were told that SATS checked that the paramedic was registered on the HCPC register but no additional checks were completed to assess competency.
- Staff told us the service does not provide food and drinks for patients. If patients require food and drinks during long transfers then the service would stop at a service station for them. One patient told us the staff stopped and bought them a bottle of water when they were thirsty.
- Staff told us they would ask patients to rate their pain on a scale of one to ten prior to the journey. This allowed the patient to access pain medication from the hospital. If a patient was in pain during the journey they were offered gas and air to help reduce their pain.

Response times and patient outcomes

- The service had one Key performance indicators (KPIs) which was on the scene arrival time. This was monitored for their contracted service and a report was sent across

each month. Between January 2016 and May 2016 the service achieved this for an average for 96% of journeys. The remaining journeys were between five and 30 minutes late.

- The service monitored the same KPI for all transfers and between January 2016 and September 2016 the service achieved 80.9%. We was told this was against a target of 75%.
- Staff told us if they were running late they would call the control, who would then inform the hospital.
- Standards and expectations of the service were outlined in the Service Level Agreement (SLA).
- We were shown no evidence that on scene arrival times were monitored for other patient journeys outside the contracted ones.
- The service asked for feedback from patients regarding their experience of using the service. This was recorded within a database to monitor positive and negative feedback.

Competent staff

- Staff told us the induction involved them shadowing an ambulance crew for the day. There was no training around the use of equipment within the ambulance. When we asked staff to show us how to test certain equipment, they were unable to show us how to do this properly.
- The clinical lead told us new starters were supervised and received one to one sessions throughout the year. However, we found no formal documented supervision records and no evidence supervision was undertaken for nurses once competencies were signed off.
- The manager reported the appraisal rate to be 75% for registered nurses and 48% for ECA and EMT.
- We were told all staff had Disclosure Baring Service (DBS) checks. DBS checks help employers make sure they recruit suitable people to work with vulnerable groups including children. During the inspection, we reviewed 12 DBS records covering both full time and bank staff. We found eight of the 12 records were not DBS checks completed by SATS. The manager told us the service accepted pre-existing DBS checks from other employers. Some of these checks were done a number of years ago. It is inappropriate to use pre-existing checks as the service could not be assured staff were suitable to work with vulnerable people. This meant patients were at risk.
- There was no training in place to prepare staff to support a patient experiencing a mental health crisis.
- The SATS website said all critical care nurses held post-graduate qualifications. During the inspection we found this was not the case. We raised this with the manager who had this removed from the website.
- The SATS website also said they provided bariatric and airport trained staff. However, during the inspection the manager told us this was not the case and the website needed to be updated.

Coordination with other providers

- The service regularly got feedback from the contracted hospital and used this to make changes. For example, the booking form had been updated to make it more user friendly.
- Staff said they have good relationships with staff at the different hospitals they visit.
- We observed good interactions between the Patient Transport Service (PTS) and nursing staff at the hospital when moving patients. PTS staff ensured they received detailed handovers from hospital staff.
- Hospital staff told us they had very good relationships with SATS staff. They told us having an ITU nurse as part of the crew was a big selling point as it saved the hospital having to send a nurse with the crew.

Multidisciplinary working

- Staff told us there were no team meetings as it was difficult getting everyone together in the office.
- The service employed nurses, emergency healthcare assistants (ECA) and emergency medical technicians (EMT). Staff reported good multidisciplinary working between each of the professions and sharing of knowledge.

Access to information

- Ambulance crews had access to special notes including DNACPR orders before they arrived to pick up the patient.

Emergency and urgent care services

- General information for staff was accessed through the staff portal. All staff had log in details to the portal. The staff portal stored a range of information including policies and training information booklets.
- The managers sent out staff announcements via the portal including company news and any feedback about the service such as complaints. The portal was accessible to employees from home and at work. Announcements were also sent out via email. However there was no guarantee that staff had read the information.
- Company policies were also stored on the portal but there was no system in place for reviewing them and some of them did not have review dates. Some staff told us they did not know how to access the policies and one staff member told us they had never looked at them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Some staff understood the principles of consent and said they would seek advice if anyone was refusing any sort of treatment.
- Some staff said they would always ask patients for consent before they carried out any treatment and if the patient was unconscious would act in their best interests.
- However, a number of staff we spoke with had no awareness of the mental capacity act or consent. They did not know what Fraser or Gillick competency was and had had no training around this.

Are emergency and urgent care services caring?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- During our inspection, all observations of care provided by the ambulance service showed patient dignity being maintained.
- Patients were treated kindly and compassionately. We observed positive and courteous interactions between staff and patients.
- Staff we spoke with were passionate about their roles and dedicated to providing the service.

Compassionate care

- We witnessed positive interactions between staff and patients, which were caring, compassionate and responsive.
- We observed patients being treated with respect by ambulance staff throughout our inspection. Ambulance staff consistently showed patience and sensitivity to the needs of patients.
- We heard ambulance staff speaking to patients in a kind and supportive manner while moving them on and off vehicles. Staff clearly explained what was going to happen and asked patients for permission before carrying anything out.
- All staff we spoke with were passionate about their roles and were dedicated to the service.
- We spoke with two patients during the inspection and both were happy with the service they received. Comments included “I am happy with the staff and transfer” “I have no complaints it was fine”.
- We spoke to seven hospital staff who said things like “they are always polite and courteous”, “the crews are always smiling”, and “the crew are very professional”.
- We observed one interaction between a staff member and a member of the public who was passing by and asked for directions for an appointment within the hospital. The staff member accompanied the patient to their appointment to show them where to go. This was going above and beyond their role.
- The service manager recorded a list of comments received by service users in a database. However, there was no formal auditing of patient feedback so the service could learn from it.

Understanding and involvement of patients and those close to

- We observed during handovers from hospital to ambulance that patients were engaged in the conversation.

- Carers were asked to help and were able to accompany the patient on the transfer.
- The service sent feedback cards out to patients and all the feedback was recorded on a database within the office. We looked through the feedback and found the majority of comments were positive. Comments included things like "excellent professional service', 'what an amazing service' and 'staff were professional, friendly and reassuring'.

Emotional support

- We observed staff constantly reassuring patients during the journey and asking them and relatives questions.
- There were no formal debriefs for staff following any distressing patient transfers.

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

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- The booking process was straightforward and a specific booking form had been developed for the main contracted hospital to ease booking.
- Each vehicle had satellite navigation which enabled staff to travel effectively between locations.
- Each vehicle stored complaint forms for patients and relatives.

However

- No support was available during journeys for patients with communication difficulties or who did not speak English.
- Telephone complaints and concerns were not formally recorded on a log which limited the services ability to look for themes and change practice to make improvements.
- There was no staff training around mental health, learning disabilities and dementia for staff.

Service planning and delivery to meet the needs of local people

- The service tracked the locations of its ambulances which helped identify who had finished jobs and was nearest for the next transfer pickup.
- The control desk in the office had a permanent member of staff which meant bookings could be responded to fairly quickly. Each booking would come via telephone followed by an online booking form submission. If the control desk did not answer calls were diverted to one of the mobile phones within the office.
- The service took a mixture of advance and on the day bookings and workloads were planned around this. Hospital staff told us the service was good at responding, even on short notice bookings.
- Staff told us their workload was variable, sometimes picking up two patients a day and sometimes this could be many more.
- A local hospital had requested the service to do an aortic balloon pump transfer, which is a device that assists patients in cardiac disease. In response to this the service has ordered new equipment for two of the vehicles and was in the process of developing a policy for this type of transfer.
- Hospital staff told us the fact the service had its own registered nurses was very helpful. It meant they did not have to send one of their own nurses on the transfer with the patient.
- As the service undertook a number of neonatal transfers. They provided warming blankets on the vehicles. This is a piece of equipment that helps to keep babies warm and could be used for both patient transfers and repatriations.

Meeting people's individual needs

- Booking forms requested various patient information to ensure individual needs could be met. For example, drop off and pick up locations, weight, mobility, infection and an area for special alerts such as DNACPR orders. This information was printed and provided to crews at the start of each shift.

- Some of the vehicles had built in satellite navigation system to enable them to travel efficiently between their destinations. All crews had phones which had access to maps and there were three European satellite navigation systems available on a sign in/sign out basis.
- The service added additional seats into some of the ambulances to accommodate additional family members accompanying patients.
- Staff told us the service transported a high number of patients whose first language was not English. However, the service has no access to interpreters and staff would rely on their ability to speak a second language or used hand signals to communicate. Relatives were allowed to travel with patients to aid communication.
- There was no access to support for people with hearing loss and/or speech impairment access.
- There was no training provided about people with mental health conditions, learning disabilities or for people living with dementia.

Access and flow

- The service operated within the core hours of 6am to midnight. The service was currently drawing together a contract with a local hospital which would require the service to be available 24 hours a day.
- Hospital staff were happy with the way bookings were made. They told us they called the control to make the booking and followed this up with the booking form. All key information about the patient was recorded on this.
- The service had a current contract with one hospital and monitored the response time to each job. This information was collated in a report and sent to the hospital each month.
- Staff told us due to the way the mobile phone system works sometimes calls regarding bookings will be diverted to the crews out in ambulances. They would then have to forward this call back to the office which could be time consuming.

Learning from complaints and concerns

- Each vehicle had a number of complaint forms in self-addressed envelopes available for patients to take if they had any concerns.
- The service also sent out feedback forms to patients and recorded all the responses within a database in the office. Any negative feedback was highlighted in orange so the manager could see if anything was consistently being brought up.
- We reviewed the complaints database and there were only two complaints documented on this. This recorded what the complaint was about and what changes the service had made in response to this. For example, one vehicle had been taken off the road due to a complaint about the vehicles suspension and a bumpy journey.
- For serious complaints the manager would send out an announcement over the staff portal to give feedback. However, there was no mechanism in place to know whether staff had read this announcement or not.
- We found limited evidence that complaints and low level concerns were being documented. The manager told us a number of concerns will be raised over the telephone and due to the size of the service there wasn't time to record each of these. This could limit the services ability to see trends from concerns and complaints and use this to inform changes in practice and service development.

Are emergency and urgent care services well-led?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- The service had no formal strategy. Managers told us there was a vision, however staff had no awareness of this.
- We had some concerns about the management of bank staff working hours and whether this was breaching working time regulations.
- At the time of the inspection the risk register did not incorporate anything about vehicles. This was raised with the management and added to the register.
- There was a lack of structure and formal processes in place regarding the investigation of incidents and

complaints. This prevented the service from learning when things go wrong and making changes to ensure it does not happen again. Staff had no understanding of the duty of candour at the time of the inspection.

- Disclosure and Barring Services (DBS) checks were not being completed appropriately and there were no assurances staff were safe to work with vulnerable groups.
- The service incorporated patient safety as part of its vision. However, there were a number of concerns we found during the inspection that meant patients were not always being looked after safely. For example, safeguarding training was not to the required levels, early warning scores were not being used to assess deteriorating patients and staff were not always aware of how to conduct appropriate equipment checks.

However;

- Staff felt valued and supported and said their morale was good. Staff said they felt proud working for the service and liked that it was a family run business.
- Staff were asked for feedback about the service and there was evidence some changes had been made as a result of this. For example, the booking form had been updated to add in a section regarding information about the patient's home.
- The financial director told us the service had funds to be able to develop and grow the service should they require.

Leadership of service

- The operations manager and clinical lead were responsible for overseeing the day to day management of the service. There was a staff member assigned to infection control and auditing of patient care records.
- Staff told us they saw the senior management team on a regular basis.
- Staff spoke very positively about the management team who they felt able to approach if they had any questions or concerns.
- General feedback regarding the management team was very positive, with some comments including: "It feels like a family here", "The management are supportive and approachable", "The management are friendly and always available", "I can call my manager for any advice, it's very open here"

Vision and strategy for this service

- The manager and clinical lead told us the service was evolving so there was no formal strategy for the service.
- The senior team told us they would like to be a leading ITU transfer service in London. However, due to the size of the service they were unlikely to win any NHS contracts. The service was exploring how they could influence critical care transfers. However we were told this was more of a aspiration rather than a formal strategy.
- We were told the service vision was "to provide a first class service with ultimate patient care by trained registered nursing professionals in a well-equipped, safe and clean environment". However, staff we spoke with did not know what the vision for the service was. There were no clear plans behind the vision and how they would achieve it. For example, the service wanted to provide a safe service for patients. However, we found a number of safety concerns during the inspection, such as incident investigations, safeguarding and equipment checks. The service also did not complete DBS checks appropriately so there was no assurances staff were safe to work with vulnerable people.

Governance, risk management and quality measurement

- We observed no evidence of operational or governance meetings taking place. Staff told us they did not have team meetings. There was a named clinical advisor (ad-hoc) who the service would contact for support and advice as required. However, there was no formal meeting schedule and agenda in place.
- At the time of the inspection the services risk register had nothing about vehicles and plans to mitigate risk to ambulances. We raised this with the manager during the inspection and the risk register was updated to include this. However, the risk register did not reflect the risks we found during the inspection. For example, we found staff were not appropriately trained in safeguarding, and this was not on the services risk register.

- The service was doing a number of audits such as the patient care record audit and the fleet vehicle audit. However, there was no comprehensive clinical audit activity such as infection, prevention and control and hand hygiene. We were told by the manager that there was a plan for these audits to start in the future.
- Although incident reporting was centralised there was no formal log of incidents or near misses. This meant the service had no overview of incident trends locally and therefore limited the services ability to learn from incidents and near misses.
- During the inspection we had some concerns around the management of working time directives. Some bank staff had secondary employment and provided shift rotas for their core work. We spoke with the manager regarding Working Time Regulations (WTR). There was an understanding of the need to have adequate rest breaks between shifts but no awareness of the need for a weekly rest period. WTR requires a weekly rest period of 48 hours in each 14 day period. We had concerns some staff were breaching the WTR.
- Performance around arrival on scene times for the contracted hospital was monitored on a monthly basis. The service Key Performance Indicators (KPIs) were for time booked and time picked up. We reviewed the services performance report and saw the service achieved 96% of their vehicles arriving on time between January 2016 and May 2016.
- Ambulances were sometimes left unattended, but locked while staff collected and moved patients. We checked a number of ambulances and found these were kept locked, doors were shut and medications were kept out of view.
- The service had a lone working policy in place to ensure the safety and welfare of staff whilst at work.

Culture within the service

- Staff told us they felt proud to work for SATS and they felt valued and morale was good.
- Staff said it was a very family orientated company and everyone was supportive and friendly,
- Staff said there was no bullying or harassment within the service.
- The manager told us there were plans to educate staff around duty of candour. An announcement had been sent out on the staff portal to raise awareness.

Public and staff engagement

- The service sends out patient questionnaires to those who have used the service. The responses are all kept in a database in the office. The manager told us the comments are colour coded either green for positive comments or oranges for negative comments. All comments are fed back to staff and for any outstanding comments staff will be nominated for the employee of the month award.
- Prior to our inspection the manager asked staff to rate the services and collected comments from staff. One staff member highlighted the need to know more information about patients homes, such as how many steps there were or if there was a front path. As a result of this feedback the patient information forms were updated to include a section for this.

Innovation, improvement and sustainability

- We spoke with the financial director of the service who said the service had no financial deficit. There were funds available to expand the service as and when required. The manager said they wanted to continue to find the right type of staff before expanding the company.
- Managers told us they were looking for a new office space which would have an area for storing of clinical waste.
- We were told the service has built a good relationship with an infection control company that produces antimicrobial products and had since introduced the chlorine releasing wipes and sanitiser unit to enhance infection prevention and control compliance and minimise the risk of healthcare acquired infection.
- Managers told us they had added driving assessments to the recruitment processes to assess this for new employees. They believed this has reduced the accident rates.
- The service has introduced a new database to enable a better understanding of data and transfer of information. The patient booking process, KPI and invoicing is all recorded using this system.

Emergency and urgent care services

- The service introduced stretcher vehicles with the a power load stretcher which reduced manual handling and allows for one crew operation.These vehicles are predominately used for flight repatriation and include additional seats for relatives and medical teams.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Staff are appropriately trained in safeguarding adults and children. All staff should be trained to level two in safeguarding and the safeguarding lead should be trained to level four. The service needs to establish systems and processes to effectively respond to any safeguarding concerns raised and prevent abuse and improper treatment of service users.
- The safeguarding policy is up to date and incorporates relevant national guidance.
- Oxygen and medications are stored safely and securely and do not pose a risk to others
- All staff receive information governance training.
- All staff receive training on duty of candour and understand their role with regards to the regulation. Duty of candour must be incorporated into the serious incident investigation process.
- Equipment is serviced and safety checked on a regular basis and staff know how to check equipment appropriately.
- That any serious incidents are appropriately investigated and the duty of candour is applied. The manager will need to ensure a written record is kept, investigation reports are documented and patients receive a written apology.

Action the hospital SHOULD take to improve

- The incident reporting policy is adhered to and a log is kept of incidents reported in order to identify themes and appropriate learning identified.
- Staff are appropriately trained to use and test equipment.
- Early warning scores are used to assess for deteriorating patients during journeys.
- All staff have a Disclosure and Barring Service (DBS) checks completed by the service to ensure staff are suitable to work with vulnerable people.
- Establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users. Any complaints received must be investigated and necessary and proportionate action taken. The service should ensure responses to complaints are recorded.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems and processes were not established and operating effectively to investigate immediately upon becoming aware, of any allegation or evidence of abuse because:** • Staff were not trained to the appropriate level of safeguarding. • Training slides were not up to date with relevant guidance and we couldn't ascertain if guidance was being followed effectively. • Staff could not demonstrate a clear understanding of safeguarding or their responsibility in protecting people from abuse or improper treatment. • Your safeguarding policy did not take into account current national guidance. **This was a breach of regulation 13 (1) (2) (3)**

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 HSCA (RA) Regulations 2014 Good Governance

This section is primarily information for the provider

Requirement notices

Your systems and processes were not established or operated effectively to ensure that you were able to assess, monitor and improve the quality and safety of the services provided because:

- Your oxygen canisters were not stored in a way that kept people safe.
- Medication was not stored in accordance with National guidance.
- Equipment was not safety checked and maintained.
- The quality of incident reporting and recording of low level and near miss incidents was not always completed. Therefore, you was unable to effectively assess and monitor quality and safety due to the lack of detail in incidents reported.
- You did not perform audit on infection, prevention and control or hand hygiene.

This was a breach of regulation 17 (1) (2) (a)