Ambulance & Medical Support Services Ltd

Ambulance & Medical Support Services - Ambulance Station Sandhurst

Quality Report

Unit 22, Vulcan Way
Sandhurst
Berkshire
GU47 9DB
Tel:0843 289 8471
Website:www.amsservices.co.uk

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Ambulance and Medical Support Services (AMSS) is an independent medical transport provider based in Sandhurst, Berkshire. The service provides medical cover at events such as army boxing (in support of army medical staff), motocross and equine events, for both adults and children. Services are staffed by trained paramedics, emergency care technicians, ambulance care assistants and technicians

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 21 March 2017, along with an unannounced visit to the service on 31 March 2017.

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

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we do not rate

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

We found the following areas of good practice:

- All staff were passionate about their roles and providing excellent care.
- The provider had processes and practices in place to assess, monitor and improve quality and safety. Audits of the service were undertaken and learning took place. There was a system to ensure all incidents were recorded and monitored appropriately. There were daily debriefs for staff to learn from incidents and concerns.
- There were current, effective policies and guidelines to support staff to provide evidence based care and treatment.
- The service had a system for handling, managing and monitoring complaints and concerns.
- Risks were managed and there was a current formal risk register in place at the service.
- Selection and recruitment procedures ensured that staff appointed was suitable for the role.
- Systems and processes implemented the statutory obligations of Duty of Candour (DoC). Robust arrangements for safeguarding vulnerable adults and children were in place.
- Medicines were managed safely and securely.
- Records we checked confirmed that priority was given for mandatory ongoing training, which all staff had completed.
- There were systems to ensure staff received clinical supervision and a regular appraisal on their performance development needs.

Name of signatory

Edward Baker

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		Ambulance and Medical Support Services (AMSS) is an independent medical transport provider based in Sandhurst, Berkshire. The service provides adult and children medical cover at events such as boxing (in support of army medical staff), motocross and equine events. Services are staffed by trained paramedics, emergency care technicians, ambulance care assistants and technicians.

Ambulance & Medical Support Services - Ambulance Station Sandhurst

Detailed findings

Services we looked at
Emergency and urgent care.

Detailed findings

Contents

Background to Ambulance & Medical Support Services - Ambulance Station Sandhurst

Ambulance Station Sandhurst is operated by Ambulance and Medical Support Services (AMSS). The service was registered with the Care Quality Commission (CQC) in May 2011. It is an independent ambulance service based in Sandhurst, Berkshire. The service primarily serves the communities of Berkshire and Hampshire, but covers army boxing events in other counties.

The service has had a registered manager in post since 2012.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

The service was last inspected in January 2014 and was found to be compliant with the five outcomes inspected at that time.

We inspected this service using our comprehensive inspection methodology.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a specialist advisor who was a registered paramedic and a further CQC inspector. The inspection team was overseen by Leanne Wilson, Interim Head of Hospital Inspection.

How we carried out this inspection

We carried out an announced inspection on 21 March 2017and an unannounced visit on 31 March 2017. We inspected four ambulances, reviewed twelve sets of patient records and spoke with six members of staff, including the registered manager, and people who contract services from the provider.

Detailed findings

Facts and data about Ambulance & Medical Support Services - Ambulance Station Sandhurst

Ambulance and Medical Support Services (AMSS) is an independent medical transport provider based in Sandhurst, Berkshire. The service provides medical cover at events such as army boxing (in support of army medical staff), motocross and equine events. Services are staffed by trained paramedics, emergency care technicians, ambulance care assistants and technicians.

The service is registered to provide the following regulated activities:

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

Activity (April 2015 to March 2016)

- In the reporting period April 2015 to March 2016 there were 1,073 emergency and urgent care consultations of patients seen, treated or transferred. The majority of consultations were adults with a small number of children treated.

The service employs three registered paramedics, two paramedic technicians, a registered manager and a bank of temporary staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No reported Never events
- No serious injuries
- No complaints

During the inspection, we visited the ambulance station Sandhurst. We spoke with eight members of staff including; paramedics, emergency care technicians, ambulance care assistants and technicians and the registered manager. During our inspection, we reviewed 12 sets of patient records.

We were unable to speak with patients as part of this inspection because we did not travel with crews during our visit.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Ambulance and Medical Support Services (AMSS) is an independent medical transport provider based in Sandhurst, Berkshire. The service provides medical cover at events such as army boxing (in support of army medical staff), motocross and equine events. Services are staffed by trained paramedics, emergency care technicians, ambulance care assistants and technicians.

Summary of findings

Are services effective?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- The service had systems and processes to routinely monitor how the service was performing. The service completed local audits as a way of monitoring performance and making improvements.
- There were effective systems to ensure staff were suitably appraised and received clinical supervision. Staff were supported with their development and there was a clear recruitment induction process for new staff.
- There were robust policies and guidelines to support staff to provide evidence- based care and treatment.
- Staff were trained in the Mental Capacity Act 2005.
- Systems ensured the service used relevant and current evidence-based guidance, best practice and legislation to provide effective care.

Are services caring?

We found the following areas of good practice:

- All staff were passionate about their roles and providing excellent care for patients. Care records detailed how staff explained procedures and offered emotional support.
- Staff discussed privacy and dignity was an important aspect of care and gave examples of ensuring privacy in practice.

Emergency and urgent care services

- We saw thank-you cards and letters from patients and families praising staffs care actions and positive attitude.

However,

- The provider did not collect friends and family test data. There is no process to routinely telephone patients after treatment to listen to patient feedback and action future quality of care provided by the team

Are services responsive?

We found the following areas of good practice:

- Information about how to make a complaint was readily available in all vehicles we inspected. Staff and patients were aware of, and knew how to access, the service's complaints and compliments system.
- There was adequate provision made for patients who did not speak English or patients who had communication difficulties.
- The provider ensured travelling time was allocated for crew members to get to events on time and collected performance data regarding the service.

Are services well-led?

We found the following areas of good practice:

- There were effective governance arrangements to evaluate the quality of the service and improve its delivery.
- The service had a vision to provide a quality comprehensive emergency treatment response at high- risk sporting events.
- The registered manager demonstrated the necessary knowledge and skills to lead the service effectively. The registered manager understood the responsibilities of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to enable compliance.
- There were robust processes and systems for the identification of, recording, monitoring, or managing risks associated with the business.
- The registered manager ensured that correct management of medicines was a priority for ensuring safe and effective care.
- Audits ensured that quality and performance of services were assessed to ensure patients were not put at risk.
- Staff described the registered manager as highly visible and approachable. The service had low staff turnover.

However,

- The provider should address the sustainability plan to review business continuity around availability of senior staff.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- The service had a paper-based system for staff to report accidents, incidents and near misses (referred to as incidents for this report).All staff we spoke with were aware of their responsibility to report incidents and knew how to do this.The registered manager informed us there had been no clinical incidents recorded since January 2016. We noted incidents or concerns were not being reported or investigated because there was no documentary evidence. However, staff told us they always received feedback when they reported an incident or concern through email updates and face-to-face training. One member of staff told us how following a historical incident, staff received in-house training in how to manage distressed parents of children injured in horse-riding or motorbike-trials.
- The service had an incident reporting and investigating policy, updated February 2017. All staff had received training to complete documentation to the required standard. There had been no reported incidents of patient harm as a result of treatment by the service, from January 2016 to February 2017.
- The registered manager emailed safety alerts to all staff. They signed when collecting the ambulance to say they had read and were aware of changes they needed to make to their practice.
- The service had reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The service did not report any duty of candour concerns from February 2016 to February 2017. Both the manager and staff understood the serious incident procedure included the requirements of the duty of candour legislation. 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.

Cleanliness, infection control and hygiene

- The premises, vehicles and equipment were clean and ready for use.A staff member was responsible for ensuring all vehicles were cleaned and stocked on a daily basis. There were sufficient and appropriate cleaning materials and decontamination wipes available on all vehicles. Staff told us if vehicles were contaminated on site, they would call the registered manager to return to base to deep clean the vehicle.
- There was a schedule for deep cleaning of all vehicles. We saw that each vehicle had a record of deep cleaning, and when it had been cleaned and restocked after use. We saw cleaning schedules, which were dated, signed and monitored by the registered manager.
- The service had cleanliness and infection control policy, updated March 2017. Staff we spoke with confirmed awareness of the provider's infection control policy. Data confirmed all six staff members attended annual refresher training on infection control.
- There were hand-washing facilities at the ambulance station and vehicles were fitted with hand sanitising gel dispensers for hand disinfection.Staff were provided with adequate numbers of uniforms that they washed themselves.There was an expectation that staff would be properly attired when on duty.This was clearly laid out in the cleanliness and infection control policy, updated March 2017.
- There was sufficient personal protective equipment (PPE), such as gloves and aprons, for staff to use in all vehicles and on the premises.
- Compliance using PPE and hand sanitising gel was observed to be good. Hand hygiene and uniform cleanliness audits had been completed in February 2017 by a designated staff member and had reported 98% compliance.
- Staff told us the importance of cleaning relevant areas and pieces of equipment on vehicles between patient

contacts. Spare linen was provided on vehicles. A system was in place at all hospitals for dirty linen to be exchanged for clean.For event first aid work, disposable linen was used.

- Spills kits were provided on all vehicles, to minimise the hygiene risk until the vehicle could be cleaned.Disposable mop heads were used to clean vehicles at the end of a shift, to reduce the spread of infection.
- Containers for the disposal of clinical waste and sharps were in place on each vehicle.

Environment and equipment

- The ambulance station had a forecourt used for cleaning and restocking vehicles.We checked four vehicles. Two other vehicles were off road and were clearly marked 'out of service'. We saw defect books for all vehicles and a process for maintenance. There was a garage that was used for internal deep cleaning of vehicles and a secure room for storage of consumable items and medicines.
- Records showed that vehicles were compliant with Ministry of Transport (MoT) testing and vehicle servicing scheduling.There were also appropriate records of insurance and road tax. Vehicle keys were safely stored.
- Disposable single use equipment was stored correctly on the four ambulances we checked and in the store cupboard.All 26 items we checked were in date. Replenishment of vehicles was undertaken by staff at the ambulance station, as well as cleaning.
- There were suitable facilities at the premises for the disposal of clinical waste at the end of a shift.We saw service level agreements for the safe disposal of clinical waste.
- Staff carried hand-held airwave radios during working hours to contact colleagues or call for emergencies.
- Staff told us there was an effective and efficient system for reporting repairs and breakdowns of equipment. Staff told us there was spare equipment held at the station to ensure the vehicle could be back out on the road promptly.
- Moving and handling equipment was available on all vehicles to prevent injury. There were restraints for the safe use of wheelchairs in the vehicles. The provider treated a small number of children and paediatric harnesses were available if required. Staff told us they had been trained in how to safely use the different types of wheelchair restraints and available moving and handling equipment.
- The four pieces of medical equipment we inspected were serviced and labelled to show the last service date and when the next service was due.
- Each vehicle had relevant emergency equipment available for both adults and children, such as defibrillators, airway management equipment and transport boards.
- The service used a local garage for mechanical repairs of vehicles and MoT testing.
- Each vehicle was fitted with satellite navigation and tracking systems. This system also sent a message to the registered manager if the blue lights were activated.
- The registered manager kept an asset register of all clinical medical equipment. Medical equipment was checked and maintained by a contractor. We saw recent records of electrical testing of medical equipment. Faulty equipment was also managed through this contract to ensure there was sufficient equipment to cover events by the service.
- There was a training room for the teaching of emergency procedures. There was a beverage point for staff refreshments and an office on a mezzanine floor.

Medicines

- The service had a controlled drug policy, updated January 2017. The policy was signed by the medical director.
- All staff records we reviewed showed staff had received training and competencies in medicine management by March 2017.
- The service used a single supplier for medicines.The request to receipt of medicines was in place.
- Medicines were stored securely and appropriately in two double locked cupboards and access to them was controlled. Only the registered manager and two other nominated staff were able to access medicines.

- All CD and medicine stock levels were checked daily by two staff members, the registered manager or his deputy and another paramedic. There were clear records when controlled drugs were administered to patients with two staff signatures
- Six medicines checked were in date. Stock levels matched those on the stock control sheet, providing assurance that medicines were being safely managed and administered.
- Medicines were stored in drug kits. At the start of each shift, paramedics and technicians collected the appropriate packs from a central store at the ambulance station and the pack number recorded on a daily check sheet. Any medicines which were administered to patients were recorded on a patient record form (PRF). The packs were then returned to the store at the ambulance station after the end of each shift. We saw secure storage cabinets for medicines in all vehicles.
- The registered manager completed medicine management audits four times per year and spoke to individual staff members about improving documentation. The two audits and action plans we reviewed showed three minor documentation errors, most commonly times or dates not completed on paperwork.
- Staff could administer different medications depending on their role.Staff were clear which medications they could issue.
- A log was kept of medicines that had been disposed of, to ensure traceability and safe disposal.
- The patient report form (PRF) was used to record the administration of medicines. Details of any medicines administered were also verbally given to the emergency department staff during the handover of a patient.
- We saw the administration of medical gases policy, dated February 2017, signed off by the medical director. Records showed that staff had received training and competencies on administering medical gases.
- Medical gases, such as oxygen and Entonox (inhaled painkiller), were stored inside the front door of the garage building. This could pose a concern for opportunity theft of the medical gases, although storage was in an appropriate part of the building and the fire service were aware of the hazard. This concern was discussed with the registered manager on 21 March 2017. On the unannounced inspection, the registered manager had organised locked and secure storage of medical gases in upright positions with suitable holders.

Records

- There was a policy for the creation, storage, security and destruction of patient records.
- Staff completed duplicate paper record forms and gave a top copy of the paperwork to the patient.
- Patient and staff records were stored securely.There was both a secure box in the front of the ambulance and "post-box" at the station for crews to place their completed patient records of treatment generated after an event.The registered manager or his deputy was responsible for collecting and reviewing the records on the subsequent day and filing them in a locked cupboard.There was a secure storeroom for the archiving of records.
- We reviewed 12 sets of patient records; these were completed legibly and accurately. Patient assessments included a thorough examination of vital signs. The records included observations and a record of treatment and sign posting advice for patients if needed.
- The registered manager completed patient record form audits four times per year and spoke to individual staff members about improving documentation. . The two audits and action plans we reviewed showed three minor documentation errors, most commonly times or dates not completed on paperwork.

Safeguarding

- There were reliable systems, processes and practices in place to protect adults, children and young people from avoidable harm and abuse. The service had child protection and safeguarding adult's policy, updated February 2017. This included the identification of a vulnerable adult or child. Records showed staff signed when they had read the policy. The providers safeguarding policy said all staff should be trained to a minimum Level 2 for both adult and children. Staff had contracts of work in other hospitals and had received up to date level 3 safeguarding training for both adult and children. Training certificates were kept in individual staff personnel files.

- Six members of staff we spoke with could demonstrate knowledge of the correct way to report an adult or child safeguarding concern. The registered manager could describe the steps to be taken if staff had a safeguarding concern. Both the child protection and adults safeguarding policies contained up-to-date flow charts and telephone numbers to contact if concerned.
- The registered manager was the service lead, qualified to teach others and had recently attended an annual safeguarding of adults and children level 3 full days training (February 2017). We saw evidence of qualifications completed and in progress around children's safeguarding. Training records from all employed members of staff confirmed compliance of adult and children safeguarding level three training.
- There was a system in place to ensure the registered manager was made aware of any safeguarding concerns about a patient seen at an event. The registered manager was aware of the process to report a safeguarding concern to the local authority.

Mandatory training

- Mandatory training consisted of face-to-face basic and advanced life support (dependent on role and professional registration), safeguarding, moving and handling, health and safety, hygiene (including the use of personal protective equipment) and protection of information.
- We saw records that all staff had completed all the mandatory training by March 2017. There were some staff on an 'inactive list' as they were deployed abroad in military service and did not have an up-to-date record of training.
- Staff training records indicated that they had all completed Ambulance and Medical support Services (AMSS) standard training, this included driving and duties (for example, the correct cleaning and restocking of vehicles).
- All new staff attended induction training specific to company procedures and equipment.

Assessing and responding to patient risk

- Staff told us and records confirmed full risk assessments were completed by the registered manager or the deputy prior to the crew being sent to any public event. The registered manager or the deputy would look at how many people would be at the event, what the risk was, the number of paramedics required. This was based on based on organising previous similar events. Most events had a doctor in attendance which formed part of the risk assessment.
- Assessments for patients were carried out using a recognised model based on the Joint Royal Colleges Ambulance Liaison Committee Patient Assessment Model 2016. Documentation assisted staff in undertaking a rapid assessment and indicating when a patient should be transferred to hospital. Records we reviewed showed they were following the assessment process. We saw a series of monitoring observations such as blood pressure, pulse and respiration. Patients at events covered by the service were fit and healthy but undertaking high-risk sports such as boxing, motocross or equine events.
- Patients were monitored to allow for the early detection of deterioration while being assessed or conveyed to hospital. We saw in a patient notes who had fallen off her horse, 5 minute observations: blood pressure, pulse, respiration and signs of consciousness. Staff told us if they were concerned about the patients' medical condition they would immediately take the patient to the hospital emergency department and inform the registered manager.

Staffing

- Most staff that worked for AMSS had substantive contracts as paramedics or technicians with other institutions.Therefore, the rota was based on the availability of the part time staff.
- There was a validated staffing tool used to decide how much support was required at an event based on the expected number of public attendees.
- We saw eight staff files including the registered manager. All eight staff had references, photographic identification and employment history record checks. All eight staff had Disclosure and Barring Service (DBS) checks by the criminal records bureau overseen by the registered manager before treating members of the public.

Response to major incidents

Emergency and urgent care services

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services and would generally include the involvement, directly or indirectly, of large numbers of people.
- As an independent ambulance service, the provider was not part of the NHS major incident planning. However, the registered manager had supplies and vehicles that could be deployed in the event of a major incident at the request of the local ambulance service as part of the Joint Emergency Services Interoperability Programme (JESIP).
- The provider was part of the local resilience forum and had offered their services to which provide a coordinated response in an emergency.

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

Evidence-based care and treatment

- We saw policies and procedures followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. All policies and procedures were signed by the medical director.
- We observed all staff carrying a current copy of the JRCALC guidance and they told us they referred to it in their assessment and documentation of patient care. One paramedic discussed using 'the app' (software application that runs on a smartphone or tablet device) on his phone to check current guidance.
- NICE guidelines were circulated to staff through the clinical bulletin updates and service directives. We observed up-to-date clinical directives on display noticeboards for staff to read.

Assessment and planning of care

- We saw assessments of patients which followed the joint royal college's ambulance liaison committee (JRCALC) and health care professions council (HCPC) standards. There were pathways for assessing and responding to the risk of patients deteriorating. This included trauma cases and for patients suffering from chest and neck pain following event injury.
- Provider guidelines in the assessment documentation prompted staff to follow a set pathway when attending to patients, both adult and children. Staff explained that an increasing number of patients were treated at the scene ('see and treat') without needing conveyance to hospital. A review of the documentation demonstrated staff followed the pathway.
- If staff needed clinical advice, they contacted the registered manager who was a qualified paramedic (DipHE). Staff had the direct number for the local ambulance service help desk should this be required.

Response times and patient outcomes

- The service monitored response times for work undertaken. Data was recorded and compared for initial response time, on scene time and prompt turnaround time if a patient was taken to hospital.
- The registered manager routinely collected and monitored information on patient outcomes, such as the number of patients seen by the event first aid team, who were treated at the scene versus admitted to hospital. The team were proud of their treat on scene response, rather than admit to hospital. This information was discussed with all team members at debrief.
- The registered manager undertook a yearly assessment on driver training, including under" blue lights".

Competent staff

- The registered manager attended operational duties with all staff to check competencies and ensure there were good standards of care. One member of staff discussed an absence from working and how they were was given the full induction training and were subject to competency checks before being allowed back to work.
- Staff competencies were mostly maintained in their substantive employment; however the registered manager undertook checks of portfolios and continuous professional development with all staff that were employed.

- Paramedics revalidate their registration every two years, which includes clinical supervision. All staff were registered with the Health Professional Council and therefore had received appropriate clinical supervision for their revalidation requirement.
- Yearly refresher training was available to all staff. Records showed staff underwent emergency in-house training and drills to maintain competencies in February 2017.
- New staff attended induction training specific to the company procedures, specific roles and equipment.
- Appraisals were completed annually and we saw records of these.
- The registered manager kept a yearly record of Driver and Vehicle Licensing Agency (DVLA) checks.
- An army doctor we spoke with was complimentary about the service and said, "The staff really stepped up when required and knew what they were doing".

Coordination with other providers

- Patients were taken to the emergency department for continuation of their care, if this was required. Patients seen and treated at the scene were advised to seek medical attention from their general practitioner if symptoms persisted.
- The service was part of the local resilience forum, Joint Emergency Services Interoperability Programme (JESIP) which provided a coordinated response in an emergency, for example a major fire incident
- We spoke with an army doctor who regularly contracted work for boxing events who confirmed the service quality and timeliness of staff at all events.

Multi-disciplinary working

- The registered manager confirmed they had a good working relationship with local event providers such as motor sport, horse racing and boxing events for the army. There was no formal contract in place, but there was regular and on-going work for the business. The army doctor confirmed a regular booking was in place for events, as he said he was very pleased with the professionalism of the staff and service.
- If patients were conveyed to hospital, there was concise handover given to hospital staff.The patient record sheet contained details of the handover process as well as sign out.
- Staff would refer patients to other services if appropriate such as GP, minor injuries unit or army medical personnel following treatment.

Access to information

- Staff told us they were given clear reason for the calls they responded to and access to information on patient location.
- The service used satellite navigation systems. Vehicles were equipped with tracking devices to enable the registered manager to be aware of the location of all resources. Staff had mobile phones and radios for communication with the base, each other at events, and the NHS ambulance service if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they involved family and carers if they had not been able to obtain the consent of the patient. One staff member gave an example of discussing an action plan with the husband of a woman who had fallen from her horse and was unconscious.
- Verbal consent to treatment was recorded in the patients' records.For young children, consent was sought from the parent or guardian in line with national guidance.
- Records confirmed all staff had received training in the Mental Capacity Act (MCA) 2005 as part of their induction and mandatory training.
- All four ambulances carried a simple decision tool on capacity and consent. Staff understood that they could intervene with a person with mental health issues in order to provide 'a life-sustaining intervention' or to do a 'vital act to prevent a serious deterioration in their condition'.
- The registered manager told us they did not routinely convey patients with mental health problems.

Emergency and urgent care services

- The registered manager told us a do not attempt cardio–pulmonary resuscitation (DNACPR) patient situation would be rare. However, staff had received DNACPR training should the situation occur.

Are emergency and urgent care services caring?

Compassionate care

- We did not speak to any patients; however, frontline staff treated patients with respect. Staff told us that they would always ask the patient how they wanted to be addressed and each team member introduced themselves. They explained how they would involve and discuss treatment and care options in a way that patients understood.We were given examples of staff respecting patients' choices and preferences and being supportive of their culture, faith and background.
- All staff members we spoke with gave examples of ensuring privacy and dignity at all times. An example was shielding a young woman vomiting from public view, following a fall from her motor bike, to ensure her privacy and dignity.
- Staff gave examples of offering emotional and practical support to patients, their relatives and other people important to them. We were given an example of how they supported a person with possible mental health concerns through way of reassurance and calm interaction.

Understanding and involvement of patients and those close to them

- Patients and their relatives were involved in decisions about whether or not it was appropriate to take them to hospital. Patients were supported to manage their own health by using non-emergency services, such as their GP or local urgent care centre, when it was appropriate to do so.
- Staff explained the importance of involving carers to help with assessments and allow accompanying the patient to hospital if required. One set of clinical notes documented the father accompanying his 11 year old son to hospital following a fall from his motorbike.
- We saw seven thank-you letters/cards from patients and families praising staffs care actions and kind attitude.
- The provider did not however, collect friends and family test data. There is also no process to routinely telephone patients after treatment to listen to patient feedback and action future quality of care provided by the team.

Emotional support

- Staff explained the need to show empathy and consistently reassure patients and their families in a timely manner, and gave examples of the using distraction to assist with a patient's pain management.
- All staff completed emotional support training as part of their induction training, which enabled them to offer emotional support to families or patients who were distressed, anxious or confused.
- Staff discussed training they had received in the NHS hospital so could support patients experiencing a mental health crisis, but did not have regular experience of supporting this group of patients.
- Staff told us that they always spoke to the registered manager if they dealt with a difficult or upsetting situation at work.

Supporting people to manage their own health

- Staff gave examples of giving health advice to patients and family to manage minor injury symptoms such as pain, nausea and bleeding following equine or motor bike accidents. Staff gave patients and families written and verbal advice regarding when to call the GP or hospital if symptoms continued.

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

Service planning and delivery to meet the needs of local people

- The service had a number of contracts to provide event first aid, for local and national events within the area. At most events a doctor was present. A paramedic always attends every event. Senior staff told us a post event briefing was held with the organisers to review the

service provision at these events.This included whether people's needs were met and areas for improvement at future events, such as the number of staff needed to ensure a safe service.

- The provider allocates the right number of staff based on the risk assessment and from knowledge of managing events for many years. The provider knows in advance the number of people attending the event and the age range. The provider worked with the event organisers to identify potential needs.

Meeting people's individual needs

- All staff were issued with a simple multi-lingual pocket translation phrase book to help communicate with patients who spoke little English. This book contained pictures for common words and medical problems, such as level of pain, high temperature and part of the body affected, to support patients unable to communicate due to their medical condition. Staff said in practice, occasionally patient's families assisted with translation.
- Staff discussed the need to speak slowly and calmly when dealing with patients with complex needs, such as learning difficulties and dementia. Two staff members we spoke with discussed receiving recent dementia awareness training in NHS hospitals.
- The service had a 4x4 vehicle to get to some of the casualties in difficult places such as a motocross course. There was also a specialist vehicle and moving and handling equipment to safely care for bariatric (larger or heavier) patients.

Access and flow

- There was an administrator who booked events using the telephone. The events were overseen by the registered manager who assessed and booked sufficient staff to cover the event. Staff generally worked days, evenings and weekends. The service rarely worked at night.
- There was an up-to-date website, which gave full details of work undertaken by the service and included positive testimonials from members of the public.
- Ambulance crews had travelling time built into their shift, if they were due to start an event some distance from their base location.This ensured an efficient response could be provided to the event organiser. The provider collected performance data regarding the service.

Learning from complaints and concerns

- The service had a system for handling, managing and monitoring complaints and concerns
- Patients, carers and members of the public could provide feedback via the website, by email, letter or telephone.The website provided information on the complaints process and the expected response times to acknowledge a complaint and provide a written response within seven working days.
- The registered manager was the lead for the investigation of any complaint. A formal written response would be provided to the complainant, identifying the outcome and any actions taken.
- Complaints / comment cards were available on all vehicles.
- From March 2016 to March 2017, the provider had not received any complaints.

Are emergency and urgent care services well-led?

Leadership / culture of service related to this core service

- The registered manager, deputy and medical director met every three months to discuss governance and finance. There was however, no formal minutes from this meeting.
- The registered manager, a registered paramedic was also the managing director of the company and had responsibility for premises, equipment and staff. The registered manager provided staff training. A medical director oversaw clinical operations and policies.
- The registered manager and staff met every three months to receive training and time allocated to discuss safety concerns and strategy. There was however, no formal minutes from this meeting.

- Staff we spoke with described the process for raising concerns and there was a formal route for whistle blowing concerns.
- Staff we spoke with described the registered manager as highly visible and approachable.
- There was a caring and positive culture for staff that worked for the service; most staff had worked for the service for many years and there was very low staff turnover.

Vision and strategy for this this core service

- The service had a vision to provide a quality comprehensive emergency treatment response at high-risk sporting events. There was a written strategy in place for providing further fully equipped vehicles and to provide frontline emergency crews for the NHS within the next three years.
- All of the ambulance crews we spoke with demonstrated their passion and drive to provide of a high quality and safe service.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- Staff discussed governance and risks after each debrief. There was a 3 monthly routine governance meeting for staff, however minutes were not available for this meeting.
- One staff member was the lead for completing quality audits across a range of areas, including premises, equipment and medicines management.Action plans were developed and included completion and review dates.
- All polices we reviewed were dated and had a review date.However, some did not have a version number, to ensure an audit trail was available for any updates and so staff could ensure they were looking at the most up-to-date document and follow best practice. This was discussed with the registered manager. This action had been completed by the unannounced inspection and was therefore compliant.
- There was a local risk register, with controls in place to reduce each risk.Service risks were monitored at both regional and national level. The risk register included concerns raised by staff relating to moving and handling equipment. The risk was removed by the registered manager purchasing new, light weight equipment for staff to use, within two weeks of being raised.

Public and staff engagement (local and service level if this is the main core service)

- Staff engagement took place through face-to-face meetings when staff attended mandatory training updates and practical sessions on new equipment. Also during staff debriefs. The registered manager communicated with staff via emails, face-to-face or via mobile phone. All staff we spoke with said they felt engaged with the registered manager.
- Staff were invited to attend debriefs after events so staff could provide feedback and suggest changes for future events. One staff member discussed taking additional supplies of equipment and this was agreed by all staff.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The registered manager always had an informal debrief with staff if they dealt with a difficult or upsetting situation at work.
- Every staff member said they would talk through incidents and gave examples when the registered manager dropped everything to support the team in person. The service was committed to quality improvement and innovation. The registered manager told us that work volume had continued to increase. There was commitment to purchasing more equipment and vehicles to sustain the quality of the service.
- The provider had a nominated deputy who is available to cover for the registered manager in the event of their unavailability such as sickness or holidays. However, the nominated deputy also works in the NHS. There was a weakness in the service as the provider did not have a documented plan should both members of staff be unavailable.

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the hospital MUST take to improve

Action the hospital SHOULD take to improve

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.

This section is primarily information for the provider

Enforcement actions

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...