Criticare UK Ambulance Service

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Criticare UK Ambulance Service is an independent ambulance service. The service provides a patient transport service including high dependency transfers, medical cover at events and training.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 13 December 2017, along with an unannounced visit to the service on 21 December 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.

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Services we do not rate

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

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

- There were no formal governance arrangements . Whilst senior staff were able to describe systems and processes there was no formal record or evidence of these. This had a significant impact on many aspects of the service.
- There were no systems to monitor the safety or quality of the service. Audits were not undertaken and therefore learning did not take place from review of practices and procedures.
- The service did not have recruitment procedures to ensure all staff were subject to a robust check of their suitability and experience for the role. There was no evidence that the service consistently carried out pre-employment checks on staff.
- Staff did not consistently report incidents and the service did not have a clear system for identifying trends to implement learning from incidents.
- Staff did not consistently complete and record essential daily checks such as vehicle maintenance and equipment checks. The patient stretcher was not included on the essential checks prior to staff attending a patient transport request.
- The service did not have an effective robust understanding and governance processes for the use of restraint. Staff did not recognise that physically holding a patient to prevent them from harming themselves or others was restraint and staff did not receive training. The policy for the use of handcuffs did not outline a clear criteria where handcuffs could legally be used. The service had not followed its own governance procedures for the reporting of use of handcuffs.
- We found there was inconsistency over the documentation used for patient records and booking patient transport journeys. There was no clear process and staff could choose to use either paper or electronic patient records. Patients' medical records were not securely and there was a risk of unauthorised access.
- There was no formal process to triage or assess patients at the time of booking. This included assessment of patients' mental capacity. Staff did not always undertake risk assessment to monitor the individual risks to patients.
- Arrangements for safeguarding children were not adequate. Staff did not always have training appropriate to their role and the policy for safeguarding children did not reflect national guidelines or specify training requirements.

Summary of findings

- There were no formal systems to ensure staff received regular appraisals on their performance and development. There was no competency framework to assure the service that staff were competent to undertake their duties work in line with best practice guidelines. The service did not formally record the induction for new staff members.
- Not all staff had completed mandatory training appropriate to their role. Some training such as practical manual handling was not provided at all by the service.
- There were limited clinical policies and guidelines to support staff and provide evidence based care and treatment. Staff did not have access to the most up to date Joint Royal Colleges Ambulance Liaison Committee clinical guidelines.
- There was no provision on ambulance vehicles to support people who were unable to communicate verbally or for whom English was not their first language.
- Information for patients on how to make a complaint was not readily available in the vehicles or on the company website. The service did collect patient feedback.

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

- Vehicles were visibly clean and there was evidence staff had carried out deep cleans on the vehicles at regular intervals. There was access to personal protective equipment for staff and clinical waste facilities.
- Equipment on vehicles was well maintained and the service kept an asset register to ensure clear documentation of when equipment needed to be serviced.
- Staff were aware of how to report a safeguarding concern and there were examples of when they had done so. Senior staff could also demonstrate they had investigated and learnt lessons from safeguarding referrals made to the company.
- Staff demonstrated a good knowledge of their responsibilities in regard to the Mental Health Act (2005). There were several examples where staff gave examples of working in the best interests of patients.
- The service provided opportunities for staff to undertake additional training which was not mandatory to their role.
- There was evidence the service had investigated and learnt from complaints.
- Staff spoke highly of the senior leadership team and felt they were supportive and visible. Staff felt they could contact senior staff and any time for support and advice and concerns would be taken seriously.
- Staff enjoyed working for the service and were passionate about providing high quality care to patients. Staff told us there was a sense of teamwork amongst the staff.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice and took enforcement action against the provider. Details are at the end of the report.

Amanda Stanford

on behalf of the Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to Criticare UK Ambulance Service

Criticare UK Ambulance Service is operated by Criticare UK Ambulance Service limited. The service was registered on 6 April 2011. It is an independent ambulance service in Southampton, Hampshire. The service primarily serves the communities of Hampshire, Dorset and Oxfordshire.

The service has had a registered manager in post since 27 January 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

The service provides pre-planned patient transport services, including high dependency transfers for all age groups including from birth for private organisations and for some NHS trusts. During high dependency transfers from air ambulance services, a medical crew provided by the service who commissioned the transfer accompanies the ambulance crew. The medical team take responsibility for the clinical care of the patient and Criticare staff are employed to provide blue light ambulance transfer and support the medical team if needed.

The service also provides medical cover for some events including a small amount of conveyance. From December 2016 to December 2017, there was evidence the service had conveyed five patients from events to hospital.

Criticare UK Ambulance Service fleet consist of five vehicles: three ambulances and two response cars, one marked and one unmarked. However, only one car is used for occasional patient transport and the other is used for staff transport.

The leadership team for the service consist of a registered manager who has a clinical background as a paramedic, an operations manager who is a trained ambulance technician and a clinical oversight manager who is currently practising as a paramedic. The clinical oversight manager provides advice and support to staff and undertakes clinical duties when required. The service directly employs six staff including the registered manager and five self-employed staff who work on a regular basis. The registered manager and operations manager are responsible for accepting patient bookings and allocating these to staff. The service refers to this duty as 'control' and this is reflected throughout the report. The service also employs two paramedics and one additional technician who work as required on a self-employed basis. The service provides services seven days a week, over a 24-hour period for its patient transport service. All staff with the exception of the registered manager are employed on a zero hours contract on a shift-by-shift basis.

We inspected the patient transport service using our comprehensive methodology. We carried out an announced inspection on 13 December 2017, along with an unannounced visit to the service on 21 December 2017. We did not inspect urgent and emergency care provided by this service as all high dependency patient transport journeys were pre-planned and the organisation commissioning the transfer provided a medical team to take responsibility for the clinical care of the patient. Whilst the service did provide medical cover at events, this was exempt from our regulation. The service conveyed five patients from events to hospital which was a small proportion of their service and as such, it would not have been proportional to inspect this aspect of the service.

Our inspection team

Our inspection team was led by a CQC inspector, a second CQC inspector, and a specialist advisor with extensive knowledge and experience of emergency ambulance services and non-emergency patient transport services. The inspection team was overseen by Nick Mulholland, Head of Hospital Inspection.

Summary of this inspection

Information about Criticare UK Ambulance Service

At the time of our inspection the service was registered to provide the following regulated activities:

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

During our inspection, we visited the registered location and a separate location where two of the vehicles were held. We inspected two vehicles and accompanied the crew to an air ambulance transfer. We spoke with five staff including patient transport drivers and management. We were unable to speak with any patients or relatives during our inspection or review any patient feedback information. During our inspection, we reviewed 19 sets of patient records and nine patient transport booking forms. We reviewed 13 staff files in addition to vehicle registration and maintenance records.

During and following the inspection, we were sent additional information by the provider, which included policies and procedures relating to the management of the service.

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

Activity (April 2017 to September 2017)

- From April 2017 to September 2017 there were 722 patient transport journeys completed. This included non-urgent patient transport and pre planned high dependency transport journeys.
- From April 2017 to September 2017 the service provided first aid provision at 186 events.

The service was unable to submit data for a 12 month period. However, the registered manager told us this data would be similar to any six month period.

Two registered paramedics, five ambulance technicians, six Emergency Care Assistants and one Ambulance Care Assistant worked at the service.

Track record on safety

- No Never events
- Clinical incidents (the service measures incidents from negligible to high severity): No negligible severity, two low severity, no moderate harm, two significant severity and no high severity incidents.
- No serious injuries reported
- Four complaints recorded

Location

Safe	
Effective	
Caring	
Responsive	
Well-led	

Is the location safe?

Safe means the services protect you from abuse and avoidable harm.

Incidents

- The service had not reported any never events in the last 12 months. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The service had a paper-based incident system for staff to report incidents. From December 2016 to December 2017, staff had reported five incidents. These included incidents where the hospital ward had given incorrect information or the service had identified an unsafe patient discharge. The service graded incidents on a severity scale from negligible to high. Of the five incidents reported, two were rated as low severity and three were rated as significant severity.
- There was inconsistency in incident reporting and no formal, systematic process which reviewed and acted upon incidents. This could place patients at risk of harm if not all incidents are reviewed in the same way.
- The staff we spoke with knew how to report an incident and some could give examples of where they had done so. However, we found that not all incidents had been reported. For example, senior staff told us that one patient had been restrained using handcuffs; the company policy stated this must be reported as an incident but no incident report was completed. Similarly, an incident where a patient had to be physically restrained after assaulting a member of staff was not formally recorded in an incident report.
- The service told us they were experiencing some problems with one hospital providing incorrect information regarding patients with mental health conditions. For example, there had been incidents where they had not been informed patients were aggressive or detained under the Mental Health Act. Senior staff told us they contacted the duty manager when this prevented them for transporting a patient and were sometimes given an incident form to complete but this was not consistent practice. The service had not kept a record of all incidents where incorrect information was given and the action taken. Therefore, the service could not identify any themes or trends and address the concerns with the hospital.
- Discussions with the managers demonstrated the service had implemented learning following some incidents. For example, there had been repeated incidents where the control centre had not been given sufficient information about patients with mental health conditions. Staff told us there had been occasions when patients had exhibited unexpected aggressive behaviour to staff. To ensure the safety for both the patients and staff the service now scheduled three members of staff to transport patients with a diagnosis of a mental health illness. However, these incidents had not been formally reported and the decision to increase the number of staff documented anywhere.
- The service had recently launched a staff bulletin, which included sharing learning. For example, the December 2017 bulletin included information about ensuring patient and staff safety during the transfer of patients detained under the Mental Health Act.

Location

- The duty of candour (DoC) 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. Senior staff were aware of their responsibilities to apply DoC.. Senior staff told us if the service made a mistake they would apologise to the patient or relative and carry out a full investigation.
- The service had a policy for DoC which was updated in September 2017. However, this did not outline the incidents which would meet the criteria for DoC or the timescales to implement actions under the DoC regulations.
- The staff we spoke with were not always aware of DoC or policies about the need to be open and honest with patients if a mistake was made.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service did not have any systemsto monitor the safety of the service

Cleanliness, infection control and hygiene

- The two vehicles we inspected were uncluttered and visibly clean. However, on one vehicle we observed ripped material on the driver's seat. This posed a risk as the seat could not be thoroughly cleaned.
- Senior staff told us after each patient transport, the crew cleaned down any areas of equipment which the patient had come into contact with. We observed there were decontamination wipes available on the two vehicles we inspected. However, the daily cleaning was not recorded and therefore there was no assurance that the vehicles were decontaminated after each patient.
- Senior staff told us if the patient was known to be infectious, a deep clean would be carried out by staff. Staff told us that each property where the vehicles were stored had equipment to carry out deep cleans. This included colour coded buckets, brushes, colour coded cleaning clothes and a mop and bucket. Each vehicle also had a dustpan and brush available. We reviewed the deep cleaning records for one ambulance which had been deep cleaned in September 2017, October 2017 and December 2017.
- Both vehicles we inspected had access to clinical waste bags and containers for the safe disposal of needles. A clinical waste facility was available on the premises of a senior member of staff who lived in the road where the vehicles were parked. This was secure and the provider had a contract with a waste disposal company to collect waste on a regular basis.
- If staff required specialist advice regarding an infection control concern senior staff told us they contacted control for advice. If the control operator could not answer the question staff contacted the clinical oversight manager for support. The clinical oversight manager was a paramedic who was contracted by the company on a self-employed basis when required. Staff gave an example of when they had been asked to transport a patient with hepatitis B, hepatitis C and MRSA. Staff sought advice from the clinical oversight manager and accepted the transfer.
- Staff had access to personal protective equipment such as gloves and aprons to reduce the risk of the spread of infections between patients and staff.
- All of the staff we observed were bare below the elbow. We observed hand sanitiser gel dispensers in both of the ambulances we inspected. Clip on gel dispensers were available for staff if required.
- The vehicles we inspected contained spill kits to enable staff to safety deal with spillages of body fluids or chemicals.
- All the staff we observed wore visibly clean uniforms. Uniforms were provided by the service and designed to be washed at high temperatures. Staff were responsible for washing their own uniform. Staff told us they had spare uniforms if anything was spilt on their uniform during work. Senior staff told us they monitored staff presentation and adherence to the uniform policy. We reviewed the three completed appraisal documents, which all commented on staff presentation. However, as not all staff had a formal record of an appraisal, there was no evidence this was carried out for all staff.
- The service did not carry out any infection prevention and control audits or hand hygiene audits. This meant the provider could not be assured the staff were compliant with the policies and procedures to minimise the risk of cross infection between patients.

Location

Environment and equipment

- The service did not use radios but relied on staff members using their own mobile phones for communication and electronic access to the staff intranet and patient record application. The service provided chargers which could be used in all vehicles for staff to ensure their phones were charged. However, this posed a risk that staff may not be able to contact control if they were in an area without mobile phone signal. There was no risk assessment to assure us the provider had considered this risk.
- Staff checked the vehicle at the start of every shift. There was a checklist that staff completed which included red and green checks. The red checks were those which were essential to the immediate safety of the staff and patients for example, the defibrillator, and roadworthiness of the vehicle. Red checks had to be completed before the vehicle moved. Green checks were completed once daily and related to equipment such as oxygen therapy kit and suction unit. However, we noted the patient stretcher was included in the green checks. This meant it may not be checked directly before a patient transfer. This posed a potential risk the stretcher may not be in working order when required for patient use.

  We reviewed six vehicle checklists for one ambulance (vehicle one) and three for another (vehicle two) dated from 28 November 2017 to 12 December 2017. All checks had been completed, signed and dated. There was evidence defects had been reported to the senior staff for example, one checklist stated a headlight was loose. The registered manager repaired the headlight and it was recorded as repaired on the checklist. However, information provided by the service showed from 28 November to 12 December 2017 both vehicles had been active on 11 separate days. This meant there was no evidence of daily checks being completed on vehicle one on five occasions and on eight occasions for vehicle two. This posed a risk not all staff were carrying out essential checks prior to transporting patients. There was no audit of these forms to assess compliance with vehicle checks.
- The vehicles carried a kit bag which included clinical supplies such as bandages, wound dressings and oxygen masks. Both vehicles we inspected had access to equipment for basic life support for both children and adults. We found all equipment was within the expiry date. Two pieces of equipment were open and therefore were no longer sterile. We raised this to the registered manager at the time and both pieces of equipment were replaced immediately.
- The service did not carry equipment to transfer children on the vehicles. If the service was requested to transfer a neonate or child, the crew used equipment supplied by the company who requested the transfer, for example the air ambulance. The equipment provided could be secured into the ambulance easily.
- The service had a stair chair which could safely transfer a patient up to 318kg and a carry chair which could transfer a patient weighing up to 200kg. The stretchers in the vehicle were a standard width and therefore could not safely or comfortably transport patients who were clinically obese.
- The registered manager provided vehicle registration and insurance records for all vehicles. We checked tax and MOT records for all vehicles using the Driver and Vehicle Licensing Agency (DVLA) online service and all vehicles had valid tax and MOT certificates.
- There was a fleet vehicle breakdown policy which covered all the vehicles. Senior staff explained that in the case of a breakdown, staff assessed the risk to the patient, which could include arranging another vehicle in the fleet to retrieve the patient and continue the journey. Senior staff told us that if the patient was a high dependency patient, the crew would call the NHS ambulance service to continue the journey safely.

Medicines

- The service did not store or administer any medicines. However, ambulances were equipped with oxygen and nitrous oxide. Each ambulance carried a minimum of one large oxygen cylinder and two small cylinders. The service did not have a separate store for oxygen and nitrous oxide cylinders. Staff told us when oxygen was low they informed the registered manager who ordered replacement cylinders. Senior staff confirmed that oxygen could be ordered for same day delivery if required urgently. The cylinders we observed were all in date and were stored appropriately in a secured and upright position on both ambulances.

Location

- The inspection team reviewed one patient record which showed the crew had administered oxygen to the patient in a non-emergency situation without the direct supervision of a medical professional. However, there was no protocol to support oxygen administration or evidence that that the crew had followed any protocol or procedure. There was no evidence of competency assessment for staff to administer oxygen. There was also no protocol for the administration of nitrous oxide.
- Senior staff told us they relied the training staff had received on their professional qualifications from outside organisations. For example staff told us that the administration of medical gases was taught on the ambulance technician qualification. Therefore, the service assumed staff with this qualification were competent to administer it without any further formal competency assessment. This meant that the service did not have any assurance that staff followed best practice when administering medical gases.

Records

- Staff and patient records were not stored securely. We observed patient and staff records being held in plastic boxes or folders and stored in a room within the provider's home. There was no lockable storage facility for these records. In the vehicles, the inspection team observed patient records were stored in a folder with no method to lock. Some patient records were also held in the home of a senior member of staff. The member of staff told the inspection team these records were stored in a folder out of sight but were not secured in locked storage. This posed a risk of unauthorised access to both patient and staff records.
- There was no unified system for recording patient information. The registered manager told us paper records were available on the vehicles or staff could choose to use an electronic application accessible from any smart phone. The application was linked to the monitor and could transfer information without the need for an internet connection.
- Staff completed the patient record either using a paper record or electronic record on a phone application. If staff used the paper record, this was stored in a folder on the vehicle and the operations manager collected these on a daily basis and kept them in his home in a folder out of sight. The operations manager delivered the forms to the registered manager at frequent intervals. These were then stored with the booking form in a folder at the registered manager's house.
- If staff used the electronic application, they logged on to the secure system using a company username and password via their own mobile devices. Once the patient record was completed, the application was converted into a printable document and automatically emailed to the company's email address. The registered manager told us it was then printed out and placed alongside the booking form in a folder.
- We reviewed 19 patient records during our inspection. In one record we reviewed, staff had used the phone application to record the patient's clinical observations following a head injury. However, this was not printed off and placed with the booking form. This meant the registered manager had to log onto the application and find the clinical details for the patient and therefore the records were not readily available. There was no clear guidance for staff to follow to determine which patients should have had clinical details recorded for their journeys.
- The status of the crew was managed using an electronic messaging application. The application was secure and had end to end encryption when a message was sent. Staff sent messages to senior staff about their progress with a patient transport journey. For example, when they had arrived, were waiting or had completed a transport request.Staff used their own smart phones to send messages. This information was then added to a spreadsheet by the registered manager. Staff told us that confidential personal information was included on messages.
- The service did not carry out any audits on the quality of records and therefore could not be assured records were of a high quality.

Safeguarding

- The service had an up to date safeguarding adults and children policy which outlined the procedure for staff to follow if they had a safeguarding concern. This included calling the police if a child or adult were in immediate danger. However, the safeguarding policy

did not reference national guidelines or specify training requirements for staff. This meant staff may not be up to date with the latest training requirements or safeguarding information.

- Not all staff had safeguarding children training appropriate to their role. At the time of our inspection, out of 14 staff, two members of staff held safeguarding children level 1 training, one member of staff held level 2 training and two members of staff held level 3 training. Safeguarding Children: Roles and competencies for Health Care Staff. Intercollegiate Document (2014) outlines the following training requirements:
- Level 2: Minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers.
- Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- The service transported neonates, children and young people as part of their service. This posed a risk that not all staff would recognise and act on potential safeguarding children concerns.
- We raised our concerns to the registered manager at the time of our inspection. They told us they had sourced level three safeguarding children training and required all staff to complete this as part of their mandatory training. Information submitted by the provider on 3 January 2018 showed that six members of staff had completed this training since our inspection.
- The service provided safeguarding vulnerable adults training as part of mandatory training and 79% (11) of staff had completed this training.
- Staff were aware of how to report a safeguarding concern. During the night shift prior to our announced inspection the crew had raised a safeguarding concern. The crew correctly described the safeguarding process they had undertaken to ensure a patient was safe. Staff told us they had access to policies on the staff portal which was accessed through the company website.
- The service had recently undergone a section 42 enquiry led by the local authority. The Care Act 2014 (section 42) requires that each local authority must make enquiries if it believes an adult is experiencing or at risk of, abuse or neglect. The enquiry should investigate the facts about an incident or allegation and if any action is needed to stop neglect or abuse. The enquiry was prompted by a safeguarding referral to the local authority alleging Criticare staff used unlawful restraint. The registered manager was proactive in completing an internal investigation and suspended staff from carrying out transfers for patients with mental health conditions, until the investigation was complete. The enquiry concluded that the allegations were partly substantiated and made recommendations to the service including changes to handover and supervision and training of staff. There was evidence some of these changes had been implemented and were included in the December 2017 staff bulletin. There was recommendations regarding the supervision and training of staff involved in the incident. Senior staff told us this had been completed but there was no formal evidence to support this.

Mandatory training

- Mandatory training for staff was delivered by online learning modules by an external company. This included modules such as safeguarding vulnerable adults, basic life support, health and safety and infection control.
- Not all staff held training appropriate to their role. The overall compliance rate for all modules was 72% at the time of our inspection. However, out of seven modules, only one module (Basic life support) was completed by 100% of staff. Of the six remaining modules, one had a compliance rate of 86% and three had a compliance rate of 79%. The lowest compliance rate was for Deprivation of Liberty Safeguardsand health and safety where 71% (10) staff had completed the training. This posed a risk that not all staff were up to date with essential knowledge and training.

Location

- The service offered moving and handling theory training as part of their mandatory training programme and 79% (11) staff had completed this training at the time of our inspection. However, this did not provide practical moving and handling training or assessment. Guidance published by the Health and Safety Executiveon its website states that, 'ambulance crews sustain very high levels of reported musculoskeletal disorders, particularly from patient retrieval and moving/handling.' There was no evidence the service had assessed the moving and handling techniques of staff to ensure they were carrying out tasks safely. This posed a risk that staff may not use correct moving and handling techniques and injure themselves or patients.
- Information submitted by the service prior to our inspection showed six members of staff had completed emergency driver training. However, during our inspection the registered manager told us that seven members of staff undertook emergency driving. One of the six certificates expired had expired in March 2017. Whilst the other certificates did not have an expiry date, there was no evidence to show how the service had assessed or assured themselves of the continuing competency of staff. Therefore, the service may not be aware if a drivers practice was in accordance with their emergency driver training. This posed a risk to the safety of staff, patients and members of the public.

Assessing and responding to patient risk

- There was no evidence of formal assessment or triage of patients when booking. Senior staff told us they obtained information about patients' individual needs which included if they displayed aggressive behaviour at the point of booking. However, this was not formally recorded. On 13 December during our announced inspection, one crew attended a request to transport a patient from a local hospital. The crew were told by senior staff accepting the booking that the patient did not require any oxygen. However, when staff arrived the patient required 2 litres per minute of oxygen and a nebuliser. Staff had to delay the transfer of the patient while the nebuliser was given on the ward. Senior staff told us that they had asked the ward if the patient was on oxygen when the booking was taken and the ward staff had informed them the patient did not require oxygen, however there was no written evidence of this.
- The inspection team reviewed the booking form of a cardiac patient who required transport between two hospitals. There was no evidence that a formal needs or risk assessment had been undertaken for this patient. This posed a risk that the staff would not be aware of the patients' needs and therefore would not be able to provide appropriate care.
- There was appropriate equipment on board the ambulance vehicles we inspected which provided monitoring and assessment of patients, for example equipment to measure oxygen saturations, blood pressure and blood sugar level.
- Staff sought advice from a clinical oversight manager, the operations manager or registered manager if they required support. Staff told us they could always access a senior member of staff immediately.
- Staff undertaking high dependency patient transfers from air ambulances had completed a critical care transfer course which focused on the needs of transferring the critically ill patient.

Staffing

- The service directly employed six members of staff which included the registered manager. Five members of staff were self-employed. The service also had access to two paramedics and one additional technician who were contracted to work when required for specific jobs.
- The service provided a 24 hour service, seven days a week. However, all patient transport bookings were pre-planned or only accepted if the crew had capacity. All staff were employed on a zero hours bank contract or self-employed. The service had two shifts, the day shift from 8am to 8pm and the night shift from 8pm to 8am. There were normally two crews scheduled to be on call for each shift but if staff were not available then only one crew would be scheduled for the night shift.
- The service identified there was a higher risk to patients and staff with transporting some patients with mental health needs. As a result the service scheduled three members of staff for these transfers.

Location

- The service asked all staff for their availability and produced a rota one week in advance. If an additional crew member was needed the service tried to source an additional member of staff instead of merging two crews.
- It was evident that senior staff had a good understanding of each individual staff member's training and ability. For example, some staff were trained in particular areas such as high dependency transfers or emergency driving. Senior staff reviewed available staffing to ensure the correct skill mix was on each shift.
- Staff were contracted per patient journey and therefore there was no need to transfer care from one crew to another. Senior staff managed patient transport journeys to ensure staff were able to have regular breaks.

Response to major incidents

- 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, either directly or indirectly, of large numbers of people.
- As an independent provider the service was not part of the NHS major incident planning.
- The service had identified the adverse weather conditions could be a risk as some staff lived in rural locations. This had been identified on the risk register and staff had been advised to ensure vehicles were sheltered and anti-freeze levels were checked. Senior staff told us they would not provide a service in adverse weather conditions if they felt staff or patients would be at risk.

Is the location effective?
(for example, treatment is effective)

Effective means that your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.

Evidence-based care and treatment

- The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines were available on the staff portal which was accessed through the company's website. However, these were the 2013 clinical guidelines. The registered manager told us that every response bag had an current pocket book of JRCALC guidelines. We did not see enough staff during this inspection to assess if they had read these guidelines and there was no training record available.
- The service did not carry out any clinical audits to monitor adherence to JRCALC guidelines. This meant that the service could not provide assurance they were compliant with the guidelines or that staff were providing evidence based care and treatment.
- The service had some policies and procedures and all the policies we reviewed had been recently updated. The policies we reviewed were unpinned by evidence for example the resuscitation policy referenced UK resuscitation guidelines Staff accessed these policies and procedures on the staff portal. However, the service did not have policies or procedures for some key clinical interventions. For example, senior staff told us that staff followed JRCALC guidelines when administering oxygen. However, there was no policy for oxygen administration which detailed how to administer or what training and competencies were required.

Assessment and planning of care

- Senior staff took all bookings for patient transport journeys. Staff were informed of the crew booking via a message on an electronic messaging application or by telephone. Staff told us that the managers asked questions to ascertain the clinical needs and condition of the patient at the time of booking. However, this was not formally recorded.
- There was no assurance all patients were being assessed effectively to ensure the service met their individual needs and maintain their safety. The service transferred bariatric patients but did not have a robust assessment process to ensure patients' were suitable for transport using the equipment available to the service (bariatric patients are patients' with a body mass index over 40.) Senior staff told us they asked the patients height and weight when booking but the inspection team could not find any formal evidence of

this. The inspection team reviewed the booking form for a bariatric patient who was transferred using a stretcher. There was no evidence staff had completed a risk assessment for this patient.

The service carried out frequent transport journeys for patients with mental health conditions. Senior staff told us that they gained information at the time of booking to assess the most appropriate staff to attend the booking. However, this assessment was not formally recorded. Senior staff told us that some patient transport journeys had to be cancelled when the crew arrived due to incorrect information given by the ward. Staff told us this was particular concern at one hospital. However, as the service had not formally recorded the information they received, there was no evidence to support this. Senior staff told us that they had contacted the hospital on some occasions when this occurred but this was not consistent.

- Staff told us they did not transport patients if they felt they were not equipped to do so, or if the patient needed more specialist care. If the crew felt the patient was not fit for transport or discharge from hospital, they would raise this with the ward staff and control in the first instance. Staff gave an example of a patient who had attended the emergency department after sustaining a head wound during a fall at a care home. When the crew arrived to transport the patient back to the care home, they observed the patient's wound had not been closed appropriately. They raised this to staff in the department who closed the wound and the patient was transported.

Response times and patient outcomes

- From April 2017 to September 2017, there had been 722 patient transport journeys.
- The service did not have access to live time tracking for ambulances. The service monitored pick up times, arrival times and site departure by private messages on the electronic messaging application. The information was then transferred to a spreadsheet. This meant the tracking of vehicles was dependent on the crew inputting correct information into the electronic messaging application.
- There was no formal system to monitor the service's performance to ensure they were delivering an effective patient transport service. The service did not benchmark itself against other providers.
- We were unable to analyse how well the service performed in relation to patient outcomes because this information was not available.

Competent staff

- The service had a pre-employment and induction procedures policy which had been updated in February 2017. The policy outlined several pre-employment checks including the right to work in the UK, a satisfactory Disclosure and Baring Service (DBS) check, identity checks, two references and occupational health checks.
- During our inspection, we reviewed 13 staff files and found that no staff had completed all the required pre-employment checks. Of the 13 files reviewed, only eight members of staff had a record of employment history, no staff had a record of interview or occupational health checks and 11 members of staff did not have any references. Four members of staff had copies of their driving licence as evidence of identity but no staff had evidence of their passport or right to work in the UK. This was not in line with the service's pre-employment and induction policy.
- Of the 13 files we reviewed, three members of staff did not have an up to date DBS check, two members of staff did not have evidence of a DBS check on file and one member of staff had a basic disclosure from Scotland. None of the staff had had a DBS carried out by the service The services own pre-employment and induction procedures policy document updated in 2017 stated, 'the potential candidate must provide a recent Disclosure and Baring Service (DBS) check completed to enhanced standard should they wish for immediate employment, and whilst they wait for the company to commission a further DBS check, they will be placed on measures of supervision and observation'. This meant we could not be assured that all staff employed by the service were of good character and had the competency to carry out the role for which they had been employed. The company were also not compliant with their own policy. We

raised this as a serious concern to the provider who told us it had placed all staff without appropriate recruitment checks under supervision until these had been completed.

- The service contracted additional staff such as nurses and paramedics for work when required. During our inspection we reviewed two staff files for paramedics which were used when required by the service. The paramedics' folders did not demonstrate their ongoing professional practice as a paramedic. This posed a risk that the service did not seek assurance that staff had the correct skills and training to carry their role.
- Senior staff told us that staff received a formal appraisal every six months and informal clinical supervision more frequently. However, information submitted by the service showed that only 20% (3) of staff had received an appraisal from December 2016 to December 2017. One member of staff had also received a driving appraisal but was not consistent across the whole staff group. Staff told us they did receive appraisals but these were not formally recorded.
- Senior staff told us that the induction for new staff included outlining policies, showing the member of staff round vehicles and allowing them to become familiar with the equipment in the vehicle. This was in line with the service's induction policy. However, there was no written record or checklist that the induction had taken place. The induction staff received was not consistent and staff may not be suitably competent to carry out their duties.
- There were no records of competencies for staff to demonstrate they were suitably trained to use equipment such as defibrillators, chairs or oxygen. Senior staff told us that this was taught and assessed through professional qualifications obtained from an outside provider. However, this meant that staff had not been assessed as competent by the service and did not have assurance that staff were suitably competent to use equipment or undertake duties safely.
- Staff had the opportunity to undertake a critical care transfer course which focused on the needs of the critically ill patient during transfer. At the time of inspection 45% (5) members of staff had completed the course.
- Following our announced inspection, the registered manager reviewed the training requirements for staff. As a result the service had recently offered staff the opportunity to undertake the care certificate (a nationally recognised qualification designed to teach the knowledge, skills and behaviours to work in a health and social care role). At the time of our unannounced inspection three members of staff had started training towards completion of the certificate
- We saw evidence that Driver and Vehicle Licensing Agency (DVLA) checks were conducted at the start of employment. This was to ensure that staff had the correct licence to drive company vehicles and did not have any driving convictions.There was no evidence that the service had a process to regularly review DVLA checks for staff.

Coordination with other providers and multi-disciplinary working

- The service worked with a number of other healthcare providers including independent and NHS hospitals, air ambulances and community mental health staff.
- We observed the crew meeting an air ambulance to transfer the patient to hospital. The crew displayed good communication with air ambulance staff for example when moving the patient from the aircraft to the ambulance.

Access to information

- There was no consistency in the information obtained by senior staff prior to patient transport bookings. We reviewed nine patient booking forms. Of the nine booking forms, there were five different formats including three different forms. Two were from other organisations one was in email format and one was a screenshot. Each form or method of booking a patient journey contained different information for example some had only basic information such as the patient's

name, date of birth and date of transfer while others had detailed information such as the patient's infection status, clinical details and equipment required.

- Staff were notified verbally of patient transport bookings and details of the booking were shared on a group chat on an electronic messaging system. Senior staff obtained details about the patient at the point of booking but this was not always formally recorded. This posed a risk that staff did not always have robust information when attending patient transport requests.
- Senior staff told us that the presence of a Do Not Attempt Cardiopulmonary Resuscitation order would be discussed at the time of booking the patient journey. Crews would be informed of the order when at the time of being assigned to the patient transport journey and then verify the order once they arrived.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a Mental Health and Mental capacity guide which provided guidance for staff on obtaining consent from patients and considerations which should be made in regard to the Mental Health Act (1983).
- Senior staff and crew demonstrated they had a good knowledge of the principles outlined in the Mental Capacity Act (2005). Senior staff gave examples where crew had refused to transport patients as the patients were not under a formal section, had capacity to make their own decision and refused transport. However, there was no record that mental capacity was considered at the initial booking as part of each patient's health status or formally assessed by the crew. Mental capacity describes the ability of an individual to understand their care in order to make informed decisions. This posed a risk that staff would not always be able to act in the patients best interest and / or lead to delays and cancellation.
- We reviewed an incident form where staff had been asked to transport a patient from a ward to a psychiatric hospital. The patient was not detained under the Mental Health Act (1983). The crew informed staff at the hospital they would not be able to use force to restrain the patient as they had not been detained under the Mental Health Act. The hospital staff arranged to have an escort meet the ambulance at the psychiatric hospital where staff could detain the patient if needed. This demonstrated that staff were aware of the rights of patients and the legal frameworks used to protect patients.
- There was a lack of understanding regarding the use of restraint. The service did not recognise that physically holding patients to prevent them from harming themselves, staff or others was restraint. A safeguarding referral made by a local hospital to the local authority showed that physical restraint had been used but staff had not received training in restraint techniques to ensure patient safety was maintained. This meant that untrained staff could potentially cause harm to themselves or a patient by using incorrect techniques.
- Whilst there was a policy for the use of mechanical restraint (handcuffs), this did not provide a robust criteria for the situations that mechanical restraint could be used or a risk assessment to be carried out when mechanical restraint was used. This meant the service had not formally identified clear criteria for which patients and in which circumstances restraint could be used and safeguards which needed to be in place before using mechanical restraint. There was a risk that restraint could be used inappropriately or without adequate safeguards.
- The mechanical restraint policy states 'as a minimum, all managers and operational team leaders will be trained in the use of handcuffs'. One senior member of staff we spoke with stated they were not trained in the use of handcuffs and the company did not use restraint. This meant not all staff were aware of the company's restraint policy.
- Senior staff told us that if a patient had been restrained using handcuffs an incident form would be completed. This was supported by the company's own mechanical restraint policy. However, one patient had been restrained using handcuffs in the last 12 months but no incident form had been completed. The service was unable to locate the notes for this patient.
- Some staff did not have up to date training to ensure they were appropriately skilled to support vulnerable patients. The service provided training on Deprivation

of Liberty Safeguards (DoLS), consent and mental capacity as part of mandatory training. At the time of our inspection, the training compliance for mental capacity and consent was 79% (11) of staff. The training compliance for Deprivation of Liberty Safeguards training was 71% at the time of our inspection.

Is the location caring?

Caring means that staff involve and treat you with compassion, kindness, dignity and respect.

- Whilst we did not observe any interactions between patients and staff, staff told us they considered the emotional needs of patients on all journeys. This included allowing a relative or friend to escort the patient on the journey to provide comfort and reassurance.
- Staff were able to give examples of where they had managed to calm and reassure patients. For example, one patient wanted to go home to collect some belongings during a hospital to hospital transfer. Staff explained this was not possible because the patient was detained under the mental health act. Staff told us they explained this to the patient calmly. The patient then agreed to the transfer.

Is the location responsive to people's needs?
(for example, to feedback?)

Responsive services are organised so that they meet your needs.

Service planning and delivery to meet the needs of local people

- The service provided two types of patient transport service; pre-planned high dependency transport and non-emergency patient transport. The high dependency transport journeys were supported by clinical staffprovided by the air ambulance service who commissioned the transfer. Criticare staff provided staff to support the medical team and provide blue light transfer to the hospital. Non-emergency transport journeys included patients discharged from hospital wards and patients transferred between hospitals. The service also included transporting patients who were suffering from a mental health condition.
- All bookings were made through the service's telephone line or email. The registered manager and operations manager staffed the telephone lines 24 hours a day to ensure they responded promptly to requests for bookings. For on the day bookings, staff took the journey details and accepted the booking if a crew were available.

Meeting people's individual needs

- Ambulances had different points of entry, which included sliding door and tailgates so that people who were mobile or required a stretcher could enter safely.
- There was no coordinated training to enable staff to support patients living with dementia or with mental health conditions. This meant services delivered might not take account of the needs of patients living with dementia and their carers or patients with mental health conditions. . The service also did not provide any training for staff to raise awareness of patients with a learning disability.
- The service did not provide any specific equipment or aids to assist understanding for patients who were unable to speak due to their medical condition or who had complex needs. There was a potential risk of patients not being able to explain what was wrong or understand staff.
- For patient whose first language was not English, senior staff told us staff would use their own telephones to look up phases and words to help them communicate. However, there was a risk if the crew were in an area without mobile telephone signal they may not be able to communicate with patients. Staff also told ussome members of staff spoke multiple languages and may be able to translate for that patient. However, there was no evidence staff had received training to be a recognised interpreter which may pose a risk that the information is not translated correctly.

Access and flow

- The service operated 24 hours a day, seven days a week.

Location

- The majority of patient transport bookings were booked on the day of travel so staff assessed the resource requirements and capacity on an individual basis when needed.
- The operations manager and registered manager were responsible for taking patient transport bookings. The service advertised two numbers which were both linked to mobile phones. If the call was not answered within 60 seconds then it was diverted to the second member of control staff.
- When bookings were taken, the individual booking was given an estimated time of arrival depending on weather conditions, traffic and other journeys which had been booked.
- Senior staff told us that when crews met air ambulances they arrived before the flight's scheduled arrival time to ensure they were ready to transfer the patient.

Learning from complaints and concerns

- The service had received three complaints from December 2016 to December 2017. The service was able to demonstrate all of these complaints were formally logged and investigated. The outcome of each complaint was reported back to the complainant. There was evidence of learning from complaints where required, for example a hospital had made a complaint about the crew's treatment of a patient with mental health needs. As a result the service shared the complaint in the December staff bulletin and had reminded staff on key principles of care for mental health patients.
- Senior staff told us that if a formal complaint was received it would be fully investigated. The staff member gave an example of when a resident had complained that one of the ambulances had been parked inconsiderately. The staff member contacted the crew and asked them to move the vehicle. The service had then informed the complainant the vehicle had been moved.
- The service had a complaints guide for patients which had been updated in January 2017. The guide outlined how to make to make a complaint and the timescales by which the service would respond to the complaint. However, there was no information for patients on how to make a complaint in the vehicles or on the company website. This meant that patients may not be aware of how to complain to the service.

Is the location well-led?

Well-led means that the leadership, management and governance of the organisation make sure it provides high-quality care based on your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Leadership related to this core service

- The senior management team consisted of the registered manager and the operations manager. There was also a paramedic available for clinical oversight as required. The managers were responsible for the day-to-day management of the service, allocating journeys and policies and procedures. The managers also formed part of the clinical staff.
- The registered manager and operations manager demonstrated they had a good understanding of the service, the needs of individual patients and a desire to provide high quality care. Although we highlighted significant concerns about some aspects of the service at the time of our inspection, the management team took action to address these immediately.
- Managers were visible to staff working in the service and staff had confidence in the managers ability to lead the service. Staff told us they felt well supported by the leadership team and someone was always available if they needed advice or support. One member of staff gave an example of when they had transported a patient from hospital to a care home but the care home refused to accept the patient due to mobility concerns. The crew phoned the hospital but they also refused to take the patient. The crew contacted the clinical oversight manager who gave advice to admit the patient to the emergency department to ensure their safety.

Culture of the service

- Staff felt the service was a supportive place to work and there was a sense of teamwork amongst the staff.

Location

- The managers knew about their responsibility to be open and honest with patients if a mistake was made that caused harm to a patient. However, although the service had a duty of candour policy , staff were not aware of this. Staff had also not received training in duty of candour. However, they told us they would report any incidents directly to the managers who would then advise on what action they needed to take.

Vision and strategy for this this core service

- The service had a vision to provide safe, efficient, standardised and quality care. The service aimed to do this by supporting and developing staff, ensuring timely, quality care by the right staff and having equipment and vehicles which were fit for purpose.
- The staff we spoke with knew about the service vision and were passionate about providing a high quality care to patients.

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

- The governance arrangements were managed jointly between the registered manager and operations manager. The service also had access to a paramedic who was responsible for clinical oversight.
- We found significant concerns relating to the governance of the service. There were no robust systems or processes to monitor the service against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- There were no systemsto monitor the quality or safety of the service provided. The registered manager had not developed any clinical audit or similar arrangements to evaluate the service delivery. For example, staff had identified several occasions where the ward had not given accurate information about the patient and this led to the patient transfer either being delayed or cancelled. However, the service had not monitored or audited these concerns to identify any themes or trends. Therefore, they had not been able to address the issue. This meant the service was not evaluated to identify areas of risk and development.
- Although the registered manager told us they completed spot checks on staff, documentation and equipment, there was no formal evidence of this. The service did not carry out audits on documentation, infection control and prevention or any other areas.
- There was no robust recruitment process of checks for staff which posed a significant risk to patients. Out of 13 staff, no staff held all the required pre-employment recruitment checks such as references, identity checks and Disclosure and Barring Service (DBS) checks. We raised this to the registered manager at the time of inspection who commenced new recruitment checks on all members of staff. Staff without adequate recruitment checks were either supervised or suspended while the checks were taking place.
- The service did not provide evidence they had assured themselves of the training and competencies of staff prior to allowing them to work. For example, there was no record of staff's induction or competency. We also reviewed two paramedic's files, which did not contain documentation to prove their professional registration or qualification. This posed a risk that the service could employ staff who did not have the required training or competency to carry out the role. We raised this to the registered manager at the time of the inspection. The service then submitted an action plan stating they would design a competency framework for all staff.
- The operations manager and registered manager were responsible for populating the risk register. The risk register detailed risks such as adverse weather impacting the operation of vehicles, staffing levels and information technology risks. Nine risks were documented prior to our inspection. Of these nine risks, five were active and four had been closed. The service submitted an updated risk register after our inspection which showed eight risks had been added to the risk register which reflected the concerns raised during our inspections.

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

- The service had a website with information for the public on the services provided.

Location

- There was no formal systems for the service to engage with patients or gain feedback. The service did not have a patient satisfaction survey.
- The service had recently implemented a staff bulletin at the time of our inspection. This was emailed out to staff and placed on the staff portal. The bulletin included a variety of news for example the December 2017 staff bulletin included staff news and positive feedback from a patient in addition to policy updates and reminders.
- Whilst the service did not have regular team meetings, staff told us they frequently worked with managers and received updates from them via email and text messages.

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

- At the time of our inspection, the service did not have a formal action plan to identify any innovation or improvement to work towards. However, the managers discussed looking at new ways of working, for example making the patient records more robust and re-introducing the use of radios.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all staff have appropriate recruitment and Disclosure and Barring Service checks prior to commencing work with the service.
- The provider must ensure they comply with national guidelines for safeguarding children and this is reflected in the service's safeguarding policy and processes.
- The provider must ensure the safety and quality of the service is monitored.
- The provider must ensure essential checks for vehicle roadworthiness and equipment are carried by staff on a daily basis.
- The provider must ensure all incidents are formally recorded on an incident report.
- The provider must ensure there are clear guidelines for the use of restraint and staff are appropriately trained in restraint procedures if they are required to undertake this role.
- The provider must ensure patient and staff records are stored securely at all times.
- The provider must ensure all staff complete mandatory training including safeguarding appropriate to their role.
- The provider must ensure all staff are competent to carry out their role and use equipment provided by the service.
- The provider must ensure staff have access to current clinical guidelines and policies and procedures.
- The provider must ensure the needs of patients are assessed and recorded at the time of booking and this includes consideration of patients' mental capacity.

Action the provider SHOULD take to improve

- The provider should consider including patient transport equipment for example, the stretcher, in the primary checklist.
- The provider should consider the use of communication aids for patients with sensory loss, or patients living with dementia or learning disabilities.
- The provider should ensure that there is a robust risk assessment process to ensure they can safely meet the individual needs of patients for example, patients who are clinically obese.
- The service should ensure all patients are aware of how to make a complaint to the service.
- The provider should collect patient feedback and use this to design and improve services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Out of 13 staff files reviewed during our inspection, no staff had completed all their pre-employment checks including disclosure and baring service checks, references and proof of identity. The service must ensure all pre-employment checks are carried out for each member of staff. Regulation 19 (1)(a)(2)(3)(4)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014. Need for Consent How the regulation was not being met: There was a lack of understanding regarding the use of restraint There was no formal record of assessment of capacity for patients at the booking stage. Regulation 11 (1)(3)(4)

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Whilst there was a policy in place for the use of mechanical restraint, this did not provide a robust criteria for the situations that mechanical restraint could be used or a risk assessment to be carried out when mechanical restraint is used. Not all staff were aware of the restraint policy. There was no evidence the service completed robust risk assessments to ensure patients' safety was maintained. There was no formal record of staff competencies or induction programme. Not all staff received a regular appraisal. Not all staff had completed mandatory training.

This section is primarily information for the provider

Enforcement actions

service did not have assurance that staff contracted to work when required for certain events or transfers had the required qualifications or skills to carry out their duties safely. There was a lack of clinical guidelines for some clinical interventions such as oxygen administration.

Regulation 12 (2)(a)(c)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Not all staff had safeguarding children training appropriate to their role. The safeguarding children and young people's policy did not include reference to current national guidelines or specify training requirements for staff. **Regulation 13 (3)**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There were no systems in place to monitor the quality or safety of the service provided. The provider did not carry out audits on documentation, infection control or other any other areas. There was no record that the provider had carried out spot checks on the crew or vehicles. There was evidence that not all incidents had been reported.

This section is primarily information for the provider

Enforcement actions

Staff and patient records were not stored securely.

Regulation 17 (a)(c)(e)(f)