Inter-County Paramedic Ltd

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Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service learned lessons from issues. Staff collected safety information and used it to improve the service.
- The service promoted using best practice clinical interventions to support better patient outcomes over and above what was required for the service. Staff provided good care and treatment and gave patients pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged with staff and stakeholders to plan and manage services. The service demonstrated innovative practice supported by skilled clinicians.
- The service demonstrated aspects of outstanding practice when adopting advanced ways of managing trauma patients.

However:

- Not all patient records were fully secured at the time of our visit.
- Patient record forms reviewed were not always completed fully for the patient consent section or handover to NHS staff section.
- The service used third party providers and used CQC registration and ratings to select these. However, the service did not routinely document all due diligence checks.
- The service did not document certain governance processes such as clinical governance meetings; or ongoing checks of Health and Care Professionals Council (HCPC) registrations for paramedics.
- Two provider policies had not been reviewed for some time.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Good	

Summary of findings

Contents

Summary of this inspection

Background to Inter-County Paramedic Ltd

Inter-County Paramedic Riverside Park is operated by Inter-County Paramedic Ltd.

It is an independent ambulance service which is registered for two core services:

- Urgent and emergency care
- Patient transport services

At the time of our inspection the service had not undertaken any patient transport services for over 12 months therefore we did not inspect this core service.

We inspected the urgent and emergency care core service.

The service provides medical cover for events including sporting events. This includes medical care and treatment on the event site (this activity is not regulated and therefore is not included in this report) and conveyance to hospital for patients that require ongoing care and treatment. The care and treatment provided during conveyance to hospital is regulated and is the focus of this inspection. From August 2021 to August 2022, the service conveyed 105 patients to hospital.

We inspected this service using our comprehensive inspection methodology. We carried an unannounced inspection on 18 August 2022. We also conducted staff interviews remotely after the site inspection.

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?

The service was last inspected under a different address in 2017. The service was not rated at this previous inspection. No breaches of regulation were identified at the previous inspection however some areas for improvement were identified. These were:

- The service did not have a Home Office licence in place for the management of controlled drugs.
- The service did not have a system in place to regularly receive medicine and medical device alerts.
- There was no risk register in place to give an overview of all known risks.
- Staff were unaware whether there was a vision and strategy for the service.
- There were limited systems in place to measure quality and service improvement.
- There was an appraisal process in place, however at the time of our inspection, only 39% of staff had received one.
- Not all staff had completed mandatory training. At the time of our inspection, compliance with mandatory training was between 54% and 88%.

How we carried out this inspection

The team that inspected the service was led by CQC inspector, who was accompanied by one specialist advisor.

During the inspection we checked two ambulances, 10 patient records and spoke with six staff including the registered manager, paramedics and technicians. Due to the nature of the service, we did not speak with any patients.

Summary of this inspection

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

Outstanding practice

We found the following outstanding practice:

- The service had implemented the use of antibiotics for open fractures following an evidence review. This meant patients were better protected against potential infections from these injuries.
- Paramedics at the service used advanced drugs such as ketamine which is used for pain relief after severe traumatic injury and Methoxyflurane which is a non-opioid emergency analgesic. These were supported by the medical director.
- The service used different colour syringes for morphine, and labelled vials of medicine which looked similar, to reduce the risk of administering the wrong drug.
- Staff had access to a Lund University Cardiopulmonary Assist System (LUCAS) mechanical chest compression-decompression system which enabled automated and continuous closed chest compression, without limiting other procedures.

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that governance is strengthened to support documenting essential processes. This includes documenting governance meetings.
- The service must ensure records are secured, when not in use.

Action the service SHOULD take to improve:

- The service should ensure there is a formal process for ongoing HCPC registration checks for applicable staff.
- The service should ensure patient records are consistently completed to contain all relevant information including consent and details of when staff hand a patient over to another healthcare provider.
- The service should ensure due diligence checks are strengthened when subcontracting to third party providers.
- The service should ensure mandatory training levels reach the provider target.
- The service should ensure any used mop heads are disposed of immediately after use in line with local and national best practice guidance.
- The service should ensure the IPC policy is reviewed and updated in line with current national guidance.
- The service should ensure all continuation pages within the controlled drug ledger have the name and strength of the medicine dose recorded at the top.
- The service should consider reviewing the incident reporting and management policy to ensure the contents still align with current national guidance.
- The service should consider ways to engage more staff in the appraisal process.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	Good	Good	Requires Improvement	Good
Overall	Good	Good	Good	Good	Requires Improvement	Good

Good

Emergency and urgent care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Emergency and urgent care safe?

Good

We rated it as good.

Mandatory training

The service provided mandatory training in key to all staff.

Staff received mandatory training. This was a combination of electronic learning and face to face competency skills updates. The mandatory training was comprehensive and met the needs of patients and staff. The service used a third-party online training portal to deliver electronic mandatory training modules. As this had only recently been rolled out, at the time of our inspection compliance with this was between 60% and 70% for all staff. The duty of candour training module had been newly introduced; therefore 50% of staff had completed this. However, all staff we spoke with had a good understanding of the duty of candour.

Where staff held a substantive post elsewhere and completed equivalent mandatory training in that role; those staff could provide certificates instead of completing the service mandatory training modules to demonstrate compliance.

All staff were checked prior to employment to ensure they were trained to drive on 'blue lights' and qualified to meet requirements under Section 19 of the Road Safety Act (2006). The service had future plans to deliver blue light training using in house qualified staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. This was included in the mandatory training modules required of all staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were sent reminders if they were not complaint with mandatory training. All staff we spoke with told us they were 100% compliant.

Safeguarding

Not all staff had up to date training on how to recognise and report abuse but staff knew how to protect patients from abuse and the service worked well with other agencies to do so.

Staff received training specific for their role on how to recognise and report abuse. Compliance with training at level two for safeguarding adults and children was 78%; 50% of staff were trained to level 3.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Several of the event venues staff worked at regularly had their own safeguarding team, processes and policies. Where this applied; staff worked in line with these policies to safeguard vulnerable patients.

All staff we spoke with were knowledgeable about safeguarding and were clear on the process to follow if required.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to a safeguarding lead who was trained to level four in children and adults safeguarding. If the safeguarding lead was not available; staff could contact the on-call manager for advice and support.

Staff had access to paper-based safeguarding referral form on all vehicles which they could complete if required.

There had been no safeguarding referrals made within the 12 months prior to our inspection.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff mostly used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. During the inspection we checked two ambulances. We found both to be clean and in good condition both externally and internally.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Decontamination wipes were available to wipe down equipment and ambulances in between patients at events.

Where vehicles became contaminated with bodily fluids after seeing a patient, specialist cleaning services were called to decontaminate these.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service generally performed well for cleanliness. The service used third party provider to undertake quarterly deep cleans of the ambulances. This included pre-and post-cleaning swapping audits to check effectiveness. We saw a report which showed a low microbial count after a deep clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). Each vehicle we checked had a good supply of PPE. Staff used face masks when working in close contact with patients as part of Covid-19 risk assessments.

Staff described the process to maintain good infection prevention and control when working with patients such as maintaining hand hygiene, using PPE and cleaning vehicle and equipment after patients had used these.

Staff at the service had access to single use mop heads to clean vehicle floors at the end of the shift. However, staff did not always remove and dispose of the dirty mop heads when finished therefore there was a risk that another member of staff may use the same mop-head. The manager discussed this during the inspection and stated they would re-issue further messages to staff about this.

Good

Emergency and urgent care

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the ambulances followed national guidance. The service had 11 vehicles in total of which eight were being actively used to treat and transport patients. Vehicles which were off the road were clearly indicated. The service also had a trailer which they use for events which required a mobile medical unit.

Staff carried out daily safety checks of specialist equipment. Staff were required to complete a daily vehicle log on every occasion they took an ambulance to an event. These logs required staff to note mileage start and finish, fuel, equipment checks such as the defibrillator, the quantity of medical gas cylinders remaining, and how many cleans staff had done throughout the shift. We checked four daily vehicle logs and saw in the main these were completed fully. However, two of the four logs did not have a vehicle clean recorded throughout the shift. This was due to the staff on those shifts not seeing any patients.

Staff completed a vehicle defect and missing/used kit sheet to report any problems with vehicles or stock on ambulances. We reviewed four completed forms and saw these were marked as completed when problems had been rectified.

The service employed a third-party provider to undertake yearly maintenance checks. We saw all equipment had been serviced as of June 2022.

Where equipment was not to be used; for example, if out of date or faulty; this was clearly tagged and the equipment was moved to a different part of the unit.

The service used an online tracking system to monitor the ambulance MOT and tax renewal dates. We checked a sample of two vehicles and found both had an in-date MOT and tax.

Ambulance tail lifts were tested every six months under Lifting Operations and Lifting Equipment Regulations (LOLER) by third party provider.

Breakdown cover was in place for service vehicles.

The service had enough suitable equipment to help them to safely care for patients. The service had good systems for stock control and replacement after use. Sets of equipment for specific emergency resuscitation use were stored in grab bags or pouches on the ambulance. These were tagged to indicate they were fully stocked. Where staff opened these for any reason, such as to use with a patient or to check stock expiry dates, the bags were re-stocked and re-tagged.

Staff were required to check stock levels on the vehicle before leaving the base unit to ensure they had sufficient equipment.

Staff wore a uniform provided by the service. These were laundered at home by staff. Staff were aware to wash these at least 60 degrees.

Staff used paediatric equipment as necessary when working with and transporting children.

Staff had access to Lund University Cardiopulmonary Assist System (LUCAS) mechanical chest compression-decompression systems which enabled automated and continuous closed chest compression, without limiting other procedures.

Staff disposed of clinical waste safely. Sharps boxes and clinical waste bags were available on ambulances. The service had an agreement with the local city council to dispose of clinical waste there.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Whilst reviewing patient records, we saw staff undertook clinical observations in line with the National Early Warning Score (*NEWS2*) and completed a Glasgow Coma Scale (GCS) assessment for each patient for every patient. Staff completed risk assessments for each patient on, using a recognised tool, and reviewed this regularly. Where indicated, staff undertook a Facial drooping, Arm weakness, Speech difficulties and Time (FAST) assessment to identify potential strokes.

Staff took a medical history of the patient to support their clinical decision making.

The service had 24-hour access to mental health support through emergency departments if staff were concerned about a patient's mental health. Staff worked with patients who were experiencing acute mental distress, or under the influence of alcohol or other substances.

Where patients became a risk to themselves or others; staff contacted the police to take action.

Staff shared key information to keep patients safe when handing over their care to others. When conveying patients to hospital, staff completed a handover with NHS staff receiving the patient. A copy of the patient record was given to the hospital. Patients could also be given a copy of their patient record on request.

Staff working together met at the beginning of most shifts to discuss which local hospitals and units were available in case of any major trauma of medical emergency.

Staff liaised with a variety of clinical staff to assess risk and act quickly when patients were deteriorating. At the regularly worked event venues, staff had access to doctors, nurses and x-ray technicians. Where medical support was not immediately available on scene, if required staff could speak with consultants at emergency departments for clinical advice.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough staff to keep patients safe. Service had approximately 70 staff at the time of our inspection however not all of these were regular shifts. Permanent full-time staff comprised the registered manager, an administrative manager, and an emergency care assistant who oversaw vehicle cleaning, restocking and administration

relating to this. Two paramedics worked full time hours; one of whom was self-employed. The additional clinical leads were employed on a part time basis. The remaining staff were on a zero hours contract therefore could self-select shifts they wanted to work when these appeared on the electronic scheduling system. Approximately 60% of the zero hours staff were paramedics. The remaining staff were ambulance technicians or emergency care assistants.

Managers reviewed paramedics fitness to practice by checking on the Health and Care Professions Council (HCPC) at the recruitment stage. There was no formal process for ongoing checks that a member of staff was still registered with the HCPC after initial employment, although staff were checked when they renewed their HCPC registration. Instead, the registered manager did ad hoc checks and relied upon staff to inform them if they were under investigation within another role. Following the inspection, the registered manager explored the possibility of getting automated updates from the HCPC; however found this was not possible. Therefore they set an action to produce a manual process. Disclosure and Barring Service (DBS) checks were renewed in line with the provider policy.

Managers accurately calculated and reviewed the number and grade of paramedics, technicians or emergency care assistants needed for each shift in accordance with national guidance. The manager overstaffed bigger events to cover last minute sickness or other staff shortages.

Where the service was unable to provide staffing or vehicles to meet the demands of contracted work; the service subcontracted to three independent health ambulance services which also offered urgent emergency care for events. The registered manager had reviewed the CQC ratings for these services prior to working with them. Two of the three were rated 'good' and one was newly registered. The registered manager checked the HCPC register and DBS certificates, and specifically requested staff with required skills and competence levels. The staff from third party providers worked alongside staff from this service to ensure oversight and safe practice.

Records

Staff mostly kept detailed records of patients' care and treatment. Records were clear, up to date. Not all records were stored securely.

During the inspection we reviewed 10 patient records.

Patient notes were comprehensive. Patient records were paper-based and were structured in such a way that staff could safely record relevant information about the care and treatment received. We saw staff had completed the clinical information sections fully in all 10 records. However, we saw some areas where staff had not fully completed the patient record. For example, in six out of ten records the consent to treatment box had not been ticked to indicate the patient had given their consent. However, we acknowledged that the narrative recorded by the staff onto records clearly identified if consent had been given or not to proceed with treatment. We saw one patient record where the patient was conveyed to hospital. However, the time the patient was handed over at hospital was not recorded, nor was the section of the hospital's complete indicating they had received that patient completed.

The registered manager reviewed all patient records to audit the quality of these. Whilst there was no formal tool used for this; areas for improvement were addressed. We saw the registered manager had already identified the areas for improvement which we found on inspection and had displayed an information bulletin to alert staff to these areas. Where a theme was identified; all staff were updated with information on how to improve record keeping. If an individual persistently made errors; this was addressed with that staff member.

Not all records were stored securely in line with the General Data Protection Regulation. Patient records were completed at events and securely transported back to the site in a locked box. They were then kept within a locked office. However,

at the unit we saw that a small number of patient records had been left out on a desk within this room although no patient details were identifiable to anyone outside the room. Although we acknowledge this room was locked when not in use; it may have been possible for people, such as staff, to access the records when not authorised to do so when the room was unlocked during the working day.

Medicines

The service mostly used systems and processes to safely prescribe, administer, record and store medicines. However, we noted some areas of medicine management which could be improved.

Staff followed systems and processes to prescribe and administer medicines safely. The service had a medical director and pharmacist who oversaw medicines which could be used for patients and completed prescriptions for paramedics to administer medicine in line with patient group directions (PGD). PGDs were stored electronically. We saw all PGDs had named staff who were identified as competent to administer each prescription medicine within set parameters. We saw PGDs were updated to reflect changes in national guidance.

At the time of our inspection we saw there was not a PGD in place for Methoxyflurane however this was rectified shortly after the inspection. Although the PGD was not previously in place, we were assured the staff who administered this were trained, competent and aware of when they could administer this.

Staff reviewed each patient's medicines. Staff did this when taking a medical history from patients. Staffed checked for any known drug allergies.

Staff completed medicines records accurately. Staff clearly recorded on the patient record form which medicines had been administered and in what quantity.

Staff stored and managed all medicines safely. Medicines were stored at the base unit in locked cabinets. Controlled drugs were kept separately from none controlled drugs. The controlled drug ledger was up to date, legible and clearly documented stock left. However, some continuation pages did not have the name and strength of the medicine dose recorded at the top.

Paramedics collected general drug bags, cardiac arrest drug bags and controlled drugs when arriving on site to collect the ambulance they would be using each shift. The staff taking out the medicines signed a record to document what was taken and used.

All drugs bags were tagged; a log was kept when any tag was broken and re-sealed.

The service had a process in place to write the closest drug expiry date on the tag to ensure these were easily identifiable. However, this was not recorded on every tag. The registered manager addressed this by sending reminders on the electronic app used by all staff.

A sample check of two drugs bags, the drug cabinet, and the controlled drug cabinet identified that all medicines were within their expiry date, neatly ordered and stored safely. We check this the lockable medicine cabinet on two ambulances and found these were safe.

Medical gas storage both on and off vehicles complied with the British Compressed Gasses Association code of practice.

We did not see evidence of formal stock checks for medicines; however, stock was checked on a daily basis by staff collecting medicine required for events.

The service did not use medicines which required refrigeration.

Staff followed national practice to check patients had the correct medicines for their condition. Paramedics used Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance to administer medicines for patients including paediatrics.

Staff learned from safety alerts and incidents to improve practice. The registered manager had signed up to the Medicines and Healthcare products Regulatory Agency (MHRA) to receive timely safety alerts. These were shared with staff where relevant to the service they were delivering.

We saw an example of learning from an incident which occurred with a medical practitioner from a different service. The incident involved a near miss of administration of intravenous medicine. As a result, managers at this service implemented the use of different coloured syringes for morphine and ketamine to reduce the risk of the wrong medicine being administered.

Out of date medicines were given to a local teaching hospital to be used as part of medical training programmes.

At our last inspection in 2017 we found the service did not have a controlled drugs licence. This had been rectified shortly after that inspection and the service had a controlled drugs licence in place at the time of the current inspection.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff had access to paper-based incident reporting forms and the incident reporting policy on board vehicles. The policy was comprehensive and clearly specified what should be reported as an incident; although we noted the date on the policy indicated it had not been reviewed since 2011.

At the time of our inspection there had been no clinical incidents reported formally for the previous 12 months. Staff did raise non-clinical incidents through other methods such as filling out daily vehicle check forms, sharing messages on the shift rostering app or speaking with the managers directly.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The service had a duty of candour policy in place and staff clearly understood how and when to apply the duty of candour.

Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence that changes had been made as a result of feedback. Staff told us of changes in practice following incidents; such as a new process following occasions where batteries for specific equipment were repeatedly going flat due to staff not plugging these in at the end of their shift.

Good

Emergency and urgent care

Managers ensured that actions from patient safety alerts were implemented and monitored. Changes were made following an external incident regarding medicines. This led to the service adopting the use of coloured syringes for different controlled drugs.

Staff met to discuss the feedback and look at improvements to patient care. Managers debriefed and supported staff after any serious incident. Debriefs were held after every major trauma or medical emergency which included staff involved from both this service and the event staff.

Are Emergency and urgent care effective?

Good

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Paramedics followed the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance when working with patients including paediatrics. Staff had access to this guidance either electronically or in hard copy.

Staff had access to an app which was used to schedule shifts. Staff could also access all of the service's policies and procedures through this app; therefore, having the most recent version available at all times. Managers monitored which staff had read messages shared through this app.

Updates around clinical practice, for example from the Resuscitation Council UK, were shared with staff via the shift scheduling app. These were also displayed on the site base.

The service worked to implement more advanced evidence-based ways of working to support patient outcomes. For example, the service had implemented the use of antibiotics for open fractures following an evidence review. This meant patients were better protected against potential infections from these injuries immediately rather than waiting until arrival at a hospital.

The service had implemented the use of using pre drawn flushes instead of drawing up flush from plastic ampoules; this promoted better infection prevention and control and patient experience. This was promoted to staff to use as the preferred way to flush a line. Where staff were noted to be using the previous method; managers re-shared the learning and evidence base for this practice until all staff were consistently working in the same way.

Leaders at the service supported the safe use of advanced drugs and equipment to ensure patients received treatment more quickly than if they waited for further NHS support.

The service had 10 Lund University Cardiopulmonary Assist System (LUCAS) mechanical chest compression-decompression systems which enabled staff to provide automated and continuous closed chest compression, without limiting other procedures.

Some of the improved practices had not been widely adopted by either the NHS or private sector ambulance serviced and demonstrated a proactive approach to using up to date evidence-based practice. In particular, the service focused upon improving care and treatment for trauma patients due to much of the event work being undertaken in high risk sports.

Staff routinely referred to the psychological and emotional needs of patients. Staff supported patients experiencing symptoms of mental health conditions. For example, staff supported patients to do breathing exercises to reduce anxiety and to manage panic attacks whilst at events.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Within 10 patient records reviewed, we saw in all relevant cases staff asked about and recorded pain scores.

Patients received pain relief soon after it was identified they needed it, or they requested it. Patient records clearly indicated what painkiller had been provided to patients if they indicated they required this.

Staff prescribed, administered and recorded pain relief accurately within patient records.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

The service monitored the numbers of patients from contracted events to maintain oversight. For example, within the 12 months prior to the inspection, the service conveyed 105 patients to hospital for ongoing treatment, which was approximately a third of all patients seen. The service recorded that 35 patients had required controlled drugs to be administered. The service also monitored how may conveyed patients received controlled drugs compared to those patients treated on site and not conveyed.

The service maintained a record of all events and patient transport moves from hospital which they covered and which staff had attended the events or conducted the transfers.

Staff met to discuss the feedback and look at improvements to patient care. Debriefs were held after every major trauma or medical emergency to review the effectiveness of care and treatment. Wider learning and changes to practice was communicated to all staff to ensure a consistent approach. Staff provided examples of changes made to improve patient outcomes and experience.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Good

Emergency and urgent care

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service only employed staff who were already experienced in the role they were applying for. A proportion of the staff group had additional skills and knowledge to work with patients. For example, the staff group comprised of advanced paramedics; two of whom were paramedic prescribers, and paramedics who had worked in a Hazardous Area Response Team (HART) in other roles.

Staff told us they often had the opportunity to learn from their colleagues as a result of the advanced skill mix. Staff had opportunities to work on continued professional development in specific areas of work to maintain and develop clinical competencies.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.Managers made sure staff received any specialist training for their role. The registered manager and a clinical lead provided training to all staff on immediate life support (ILS) via a local university training hospital. The registered manager was registered with the Resuscitation Council UK which meant training was in line with their requirements. Paramedics could access advanced life support (ALS) training and prehospital trauma life support (*PHTLS*) on a yearly basis which was above the basic competency requirements for paramedics in other ambulance services.

Due to the driving requirements; all staff who worked at events were required to have a C1 driving licence which enabled them to drive vehicles over 3.5 tonne.

Level 3 Certificate in Emergency Response Ambulance Driving (CERAD) training was scheduled for November 2022 for staff that required this or needed a refresher.

Staff attended scenario training as part of their annual ILS training. In addition, the larger event providers held scenario training which included the service staff.

Managers gave all new staff a full induction tailored to their role before they started work. Staff employed at the service were required to have relevant work experience in order to undertake the role they applied for. The induction comprised a paid shift under direct supervision with a senior member of the existing team. At this stage, policies and procedures were explained and the new staff member was signed up to the electronic shift rostering app. Staff were trained on the patient record forms and pathways.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of the inspection, all staff had been offered a remote appraisal. Half of staff had taken this opportunity. This was due to the majority of staff working on zero-hour contracts.

Senior staff at the service undertook conversations where training needs were identified.

The service did not have structured team meetings. This followed on from the pandemic whereby staff were not able to meet. In addition, the majority of staff had substantive positions elsewhere so found it difficult to attend a scheduled team meeting. Instead, managers shared clinical and business updates, shared learning and changes to the service via an online shift rostering app which also functioned as an electronic noticeboard. Managers identified which staff had read the information bulletins through the reporting function on the app. Staff could also liaise with their colleagues and managers, either on a one to one basis, or as a whole employee group through the app.

Staff working together met at the beginning of most shifts to discuss what events were being covered, any staffing issues and if multiple crews were working at one venue; what location each crew would be sited. Staff also discussed which local hospitals and units were available in case of any major trauma of medical emergency.

Managers identified poor staff performance promptly and supported staff to improve. At the time of our inspection, managers were reviewing their process around staff who did not undertake any shifts for a period of time. This was to ensure that staff working in the service maintained their skills and competence.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff at the service worked closely with other healthcare professionals and event staff to support patient care. At larger events which ran all year round such as race circuits; staff worked with the event medical teams which could include doctors, nurses, physiotherapist and x-ray technicians.

The registered manager had access to the local ambulance trusts pathways to support a quick and safe transfer of patients requiring conveyance to hospital.

When working at an event outside of the usual areas, managers at the service liaised with the acute emergency and trauma services in that area to familiarise themselves with pathways and contact details. Staff attended meetings prior to these shifts to receive this information.

Staff held effective multidisciplinary meetings to discuss patients and improve their care following a serious medical condition or fatality. These were in the form of debriefs held on the same day where staff from the service worked with staff from the event to discuss the incident and consider any learning.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Where patients were not conveyed to hospital, staff gave advice and signposted to appropriate services. For example, staff recommended patients went to an urgent treatment centre if their condition deteriorated.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance; however, did not always record this fully. In six out of ten records the consent to treatment box had not been ticked to indicate the patient had given their consent. However, we acknowledged that the narrative recorded by the staff onto records clearly identified if consent had been given or not to proceed with treatment.

Where patients refused all treatment or declined to be conveyed to hospital for further treatment; staff recorded this fully on patient records.

Good

Emergency and urgent care

Staff checked if patients had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) in place whilst at the event. Several of the event locations had local policies which directed staff around DNACPR and consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest. All staff we spoke with had a clear understanding of the Mental Capacity Act and knew how to assess a patient's capacity to consent to care or treatment. Staff could approach clinical leads or managers for support if needed.

Staff understood Gillick Competence and supported young people who wished to make decisions about their treatment. When working with paediatric patients, staff assessed young people's capacity to consent to care and treatment and recorded this in the notes. Staff requested parents and guardians to come to the patient where possible. Where staff had to convey a child to hospital; they waited until a parent or guardian was present if not a life-threatening case. Where emergency care was required and parents or guardians were not immediately present, staff treating the patient would convey the child to hospital whilst the parents or guardians were located; then ensure the parents or guardians followed the child.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are Emergency and urgent care caring?

Good

We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff described how they were discreet and responsive when caring for patients. Staff worked to ensure patients couldn't be overseen by other event attendees where possible. Staff carried extra blankets to cover patients to maintain dignity and privacy.

Staff told us how they treated patients kindly. Staff told us they observed colleagues to go the extra mile when supporting patients regardless of the severity of the injury. One example was provided of keeping a young patient distracted whilst receiving treatment by interacting positively and blowing up gloves like a balloon. We received patient and event feedback which highlighted a caring approach to working with patients. The feedback spoke of staff being helpful, welcoming and open to all event goers when working within an event medical centre.

Staff understood and respected the individual needs of each patient. This was evident when staff we spoke with gave examples of patient care.

Staff understood since the Covid 19 pandemic, more people were experiencing symptoms of anxiety when in large crowds and were competent to respond to patients appropriately and kindly.

Good

Emergency and urgent care

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff gave examples of working with patients who were experiencing symptoms of mental health conditions such as anxiety. Staff told us they talked to patients and supported them to do breathing exercises until the patient felt able to return to the event. Staff protected patients' dignity in these situations by taking the patient to a private place such as a medical area or the ambulance.

Staff were required to break bad news and demonstrate empathy when having difficult conversations. An example was provided whereby a staff member accompanied a doctor at an event to inform family members that their loved one had passed away. Staff understood the importance of adapting communication styles to suit difficult situations. We reviewed feedback given after events and saw a theme of professional staff who worked well together in a range of conditions.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us of an incident where an attendee of an event passed away on site. Rather than leave the deceased to wait for transport to the mortuary; a crew transported the person themselves in an ambulance so family could visit their loved one more quickly. This meant staff worked additional hours over their shift to do this.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Within patient records, staff recorded discussions had with patients about their care and treatment options.

Staff had access to communication aids where necessary to support patients who may not communicate using words.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff told us of examples of patient feedback provided to them in variety of ways, such as through posting thank you cards, providing feedback immediately after treatment, and seeking staff out at later events. We saw evidence of patient feedback; the patient shared their gratitude to the service for providing treatment and transfer to hospital; and highlighted the staff as working professionally throughout the episode of care.

Are Emergency and urgent care responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Good

Emergency and urgent care

Managers planned and organised services, so they met the needs of the local population. The service worked to both formal contract arrangements for specific event locations and to ad hoc requests throughout the country. The service was not contracted to undertake any NHS work; however, supported the local ambulance services by conveying patients to hospital when necessary.

Facilities and premises were appropriate for the services being delivered. The base unit was secure and had enough space to store all vehicles and necessary equipment and stock.

The service relieved pressure on other departments when they could treat patients without conveying them to hospital.

When working with a patient with severe injuries, staff liaised with the wider system including emergency departments and specialist units to ensure patients were seen by the right medical team in the quickest time.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

Staff made sure patients with mental health conditions received the necessary care to meet all their needs. Staff treated patients for a range of medical conditions and injuries including those relating to symptoms of mental ill health. Staff were inclusive and provided advice, guidance and care in line with best practice guidance.

Staff supported patients living with dementia and learning disabilities. Staff told us they rarely saw patients at events with advanced dementia or profound learning disabilities or other conditions which significantly impacted upon cognitive functioning or behaviour. Despite this, staff had received training in working with patients with these conditions; and were able to describe how they would care for and treat such patients.

Staff had access to communication aids to help patients who had sensory loss or did not communicate verbally.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to a telephone-based interpretation service to support communication with patients who did not speak English as a first language.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

The registered manager oversaw event bookings and scheduled these into the online staff rostering app. The registered manager ensured enough staff and vehicles were booked on to each event to support the volume of anticipated attendees. When at events, staff located themselves in strategic position to give the best possible medical coverage to the people at the events. This meant anyone requiring medical care and treatment could receive it more quickly.

Staff used back to back radios to communicate with each other to ensure events were covered fully; and to request support from other crews in the event of needing additional staff or stock.

Where the volume of work was greater than the number of staff and/ or vehicles available, the service used third party providers who were also registered with CQC to provide medical cover.

Good

Emergency and urgent care

Staff supported patients when they were transferred between services such as from the service ambulance to an emergency department. Where necessary, staff waited with the patient at hospital until a full handover had been completed to the NHS staff.

At the time of the inspection, NHS ambulance trusts and emergency departments were under immense pressure which meant ambulances often had to wait outside ED's. Staff at this service were able to speak directly to hospital staff; for example, doctors in resuscitation, to pre-alert their arrival therefore reducing waiting times. Staff could also speak with specific departments across local departments to identify where patients could be seen most quickly for serious injuries.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. Whilst there had been no complaints raised about the service, the service knew how to treat concerns and complaints seriously, including how to investigate them and share lessons learned with all staff.

Managers investigated complaints as they arose. The service had received no complaints in the 12 months prior to the inspection.

Staff understood the policy on complaints and knew how to handle them. Staff had access to leaflets explaining how patients could make a complaint; these were kept on vehicles. Staff knew how to acknowledge complaints however, as above, had not experienced any in the previous 12 months.

Patients and their families or friends knew how to provide feedback. In the past 12 months all feedback received had been positive.

Managers shared feedback from compliments with staff. Staff told us these were shared through the shift rostering app used by all staff.

Are Emergency and urgent care well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The registered manager ran the operational aspects of the service such as contracted and ad hoc work, ambulance and stock maintenance, staff allocation to shifts and clinical updates. They were supported by an administration manager who oversaw staff management for example pay, employment checks, training compliance, appraisals and any employment concerns.

Clinical leads and support staff provided additional leadership support such as overseeing stock control and providing safeguarding and clinical advice.

Staff told us managers were visible and approachable for both patients and staff. All staff we spoke with felt the managers were open and supportive. The registered manager worked regularly as a paramedic at events therefore interacting with patients, the public and event staff.

Communication with staff was, in the main, clear and outlined the priorities for the work scheduled.

Clinical oversight was provided by the medical director who was employed on a consultant basis to provide clinical guidance, updates to medical prescriptions and patient group directions, and support the service. Staff reported the medical director was approachable and worked as one of the team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The service had a clear statement of purpose reflective of the service they provided. All staff we spoke with were aware of the service and how it operated. The service identified its aim as providing medical services 365 days a year, to those needing emergency medical treatment and transport.

Managers at the service had a vision for further development of the business which was achievable and supported the needs of relevant stakeholders (event organisers). The vision was aligned to the need of medical services at local events.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture staff could raise concerns without fear.

Staff felt well supported and valued in their role. All staff we spoke with told us they were happy to raise concerns or questions with the management team or clinical leads.

Staff described a supportive and open culture; managers sought to support staff with illness or other problems.

Staff reported a strong team working approach where staff were able to communicate openly with eachother. Staff told us they enjoyed working for the company and thought it was well run and safe. Staff appreciated working with other skilled clinicians and identified this is an opportunity to learn from other team members.

Staff told us an area for improvement could be communication for example around exact shift changes; often shifts were offered with generic start and end times which could be inaccurate.

Staff told us the service had never advertised for staff; instead new staff were recruited through word of mouth and the reputation of the company.

The service had a duty of candour policy in place and staff clearly understood how and when to apply the duty of candour.

The registered manager was a liaison officer for the College of Paramedics which aimed to support staff and promote mental health awareness. We saw posters for MIND (a national mental health charity) clearly displayed. The service was able to provide peer to peer support, had a mental health champion, and the administration manager was trained by a national listening charity to listen to staff concerns and problems.

Good

Emergency and urgent care

Governance

Leaders had governance processes in place but did not always document these. Staff at all levels were clear about their roles and accountabilities.

Leaders did not have formalised operational or governance meetings. The managers, clinical leads and medical officer had regular informal meetings and conversations about the service. These were not minuted or recorded. However, based upon evidence around updates, clinical practice and learning after adverse events; we were assured that the leaders within the service had oversight of operational and clinical processes.

The service had policies in place to support operational delivery. We noted two of these had not been reviewed or updated for some time. These were the infection prevention and control (IPC) policy which was dated 2010 and the incident reporting policy which was dated 2011. Whilst the incident management policy was detailed and contained sufficient information in to support staff; the IPC policy was less specific with regards to what staff at the service were required to do. For example; when discussing laundering of uniforms; no information as to the expected temperature to do this was recorded. Similarly, we could not see any specific information regarding donning and doffing personal protective equipment (PPE), the use of masks or visors, or any guidance specific to Covid-19 or other respiratory diseases whilst working at the service. Despite this, we were assured through our regular structured conversations during the Covid-19 pandemic that staff were trained and knowledgeable about IPC practices when working at the service including Covid-19 precautions, PPE, decontamination of ambulances and hand hygiene. We also saw evidence of staff communication specific to Covid-19 government guidance which was shared with staff throughout the pandemic.

We found some areas for improvement during our inspection such as staff not always disposing of disposable mop heads immediately after cleaning vehicles, not all staff fully completed patient records and not all staff recorded the closest date of medicine expiry on drugs bags. The registered manager was aware of all of these findings and had already communicated with staff about these concerns. However, not all staff had started to work within the requested ways. The registered manager had a process for working with staff who repeatedly worked outside the provider policies and working practices.

Staff did not attend formal team meetings; however, all necessary information was shared on the shift rostering app and on notice boards at the units. Managers checked to ensure staff had read urgent updates and shared information. All staff we spoke with were aware of their roles, responsibilities and updates to clinical and non-clinical practice.

Managers completed audits of patient records, medicines and stock. These were not formally recorded however clear actions and learning points were developed following audits which were shared with all staff. A third-party provider conducted swabbing audits after deep cleans which were shared with the service.

Managers had systems to ensure all vehicles, equipment and stock were maintained, renewed and recycled as necessary. Any out of date stock was sent to the Ukraine as part of a charitable agreement. Any out of date medicines were sent to a local teaching hospital to be used in doctor training sessions.

The service had recruitment procedures in place that included pre-employment checks to ensure that all crews were suitably qualified and experienced for the role.

Good

Emergency and urgent care

Where the service required additional staffing or vehicles to meet the demands of contracted work; the service subcontracted to three independent health ambulance services which also offered urgent emergency care for events. We asked about due diligence undertaken to ensure the services work to the same standard that Inter-County Paramedics Ltd expected. We found there was no formally recorded process however the registered manager reviewed HCPC registration, CQC registration and ratings where applicable, and DBS checks.

Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service manager identified risks to the service such as business continuity in unexpected scenarios such as Covid 19, the rising cost of petrol and electricity to both the business and staff, and ensuring current contracts are renewed. Staff we asked were aware of potential risks.

During our last inspection, it was identified that the service did not have a formal risk register. There was one in place during our current inspection and managers were clearly aware of the risks and action plans in place.

Leaders at the service developed risk assessments to mitigate new or ongoing risks. We saw an up to date health and safety policy was in place, and specific risk assessments, one of which considered Covid-19 in line with providing provision for events.

Where incidents highlighted a risk in terms of clinical or non-clinical practice; managers developed learning and actions to mitigate these risks. This was shared with staff in a timely way.

Issues which impacted on the service such as a vehicle being off the road were dealt with quickly and safely to maintain service provision and performance.

Managers were aware of national issues which may affect care such as national shortages of specific medicines. Where this occurred, managers worked with the medical director to source alternative provision and informed all staff.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected information for example on patient record forms and vehicle check forms. These were reviewed and analysed by the manager who provided clear feedback and learning to staff.

Information systems were both paper based and electronic. Paper based information such as vehicle check forms were kept securely in a filing cabinet in a locked office. Electronic information included equipment maintenance records, cleaning audits, vehicle MOT and tax records, and staff details. The administration manager oversaw electronic records and updates and maintained their security and confidentiality.

Good

Emergency and urgent care

The service submitted notifications as legally required within the Care Quality Commission (Registration) Regulations 2009. Where required, the service worked with specific event venues management to submit specific work-related incidents to the Health and Safety Executive under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

Engagement

Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders openly engaged with staff on a daily basis to discuss shifts, clinical updates, shared learning and general feedback. The last staff survey had been conducted in 2019; and was put on hold over the pandemic due to significantly reduced workload. The service planned to resume the staff survey towards the end of 2022.

The service had sought to involve patients by sending out feedback forms. Plans were in place to create a feedback system for patients which enabled them to give a short overview of their care.

We saw examples of feedback from patients and event organisers which showed a consistent theme of professionalism from staff at the service.

Leaders engaged with local and partner organisations to plan medical cover requirements, to plan how to access emergency medicine if required for critically ill patients and to organise training and feedback events.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation.

The service managers and clinical leads were committed to improving the service and using research to support innovative and modern ways of working.

The service had implemented the use of antibiotics for open fractures following an evidence review. This meant patients were better protected against potential infections from these injuries.

Paramedics at the service used advanced drugs such as ketamine which is used for pain relief after severe traumatic injury and penthrox which is a non-opioid emergency analgesic. These were supported by the medical director.

The service used different colour syringes for morphine and ketamine, and labelled vials of medicine which looked similar, to reduce the risk of administering the wrong drug.

Staff had access to a Lund University Cardiopulmonary Assist System (LUCAS) mechanical chest compression-decompression system which enabled automated and continuous closed chest compression, without limiting other procedures.

Some of the improved practices had not been widely adopted by either the NHS or private sector ambulance serviced and demonstrated a proactive approach to using up to date evidence-based practice. In particular, the service focused upon improving care and treatment for trauma patients due to much of the event work being undertaken in high risk sports.

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 17 HSCA (RA) Regulations 2014 Good governance Not all patient records were fully secured at the time of our visit. The service did not document certain governance processes such as clinical governance meetings.