Broughton Park Ambulance Services Ltd

Quality Report

33 Broom Lane
Salford
Lancashire
M7 4EQ
Tel: 01617089999
Website:

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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

Broughton Park Ambulance Services Ltd is operated by Broughton Park Ambulance Services Ltd. The service provides emergency and urgent care and a patient transport service.

We inspected this service using our focused inspection methodology. We carried out the short announced inspection on 29 July 2020.

We did not rate this inspection as it was a focused follow-up.

- Since the last inspection, volunteer responders had received safeguarding training for children and adults to level three. We found that they reported concerns to one of two managers, available 24 hours a day, who had received level four safeguarding training. However, from the records we saw, safeguarding decisions made were not clearly documented as consistent with the information recorded by the volunteer responder and statutory notifications were not always routinely submitted to CQC.
- Call handlers received calls, via the dedicated phone number. Patients identified as not breathing or unconscious were immediately referred to the local NHS ambulance trust. Since the last inspection, for other calls identified as less serious, they did not triage or give advice except to call 111 or signpost to other services.
- Volunteer responders completed records of care given on patient report forms. Since the last inspection, an electronic application had been piloted where information was recorded with each responder being provided with an electronic tablet. The paper records we reviewed were not always legible or completed fully. Neither the paper record or the application included early warning scores for children and antenatal women, although; there were plans to include in the electronic version.
- Since the last inspection medicines had been removed from ambulances, except for oxygen, burns gel and skin adhesive (not for head injury use now). These were only used for first aid. Volunteer responders had received training for administration of these and there was a guideline for oxygen use.
- Since the last inspection, the incident process had been reviewed. There was an increase in reporting from 17 in 12 months, to 119 in four months. Staff were encouraged to report incidents and received feedback. Although no serious incidents had been identified there was no standardised procedure setting out how they would be investigated. Managers understood their responsibilities for duty of candour.
- In 2020 The service had reviewed policies and processes with the support of other similar organisations as well as external stakeholders in order to provide care in line with national guidance. An audit programme had been established including for volunteer responders records of care and infection prevention and control.
- Volunteer responders undertook first response in emergency care (FREC) courses either to level three or four. They received an induction and were expected to observe care with senior staff until deemed competent.
- Protocols included at least two members attended a call, however; we found six incidences were one member had attended.
- Since the last inspection, the service had sought support from other organisations and re-structured the service with a clear management structure. They had built a new building,the locationincluded a room that could be utilised for meetings and training purposes, as well as a locked store cupboard and offices where records were securely stored. Personal protective equipment (PPE) was accessible to volunteer responders. The service had

Summary of findings

been engaging with other health professionals as well as the local community to enhance and improve the service. Volunteer members were updated of changes, at meetings, however; minutes did not include regular agenda items and did not always include a list of attendees. There were plans for further improvements, although these were not fully implemented or embedded.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and some actions 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 three requirement notices. Details are at the end of the report.

Ann Ford
Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care		We carried out a focused follow-up inspection of elements of safe, effective and well-led domains.

Summary of findings

Contents

Broughton Park Ambulance Services Ltd.

Services we looked at
Emergency and urgent care

Summary of this inspection

Background to Broughton Park Ambulance Services Ltd

Broughton Park Ambulance Services Ltd, also known as Hatzola Manchester, is operated by Broughton Park Ambulance Services Ltd. The service registered in 2017. It is an independent ambulance service in North Manchester and Salford. The service is wholly funded by a Manchester based beneficiary. It is run by locally trained volunteer responders from the Jewish community with a population of about 4,500 people.

At the time of the inspection, a new nominated individual had recently been appointed and the new manager was in the process of applying to be the CQC registered manager.

Patients served by the service may be suffering with minor to major illness or injury.

Our inspection team

The team that inspected the service comprised two CQC inspectors. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Broughton Park Ambulance Services Ltd

The service is currently registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the base location and spoke to staff via teleconference calls. We spoke with 10 staff including volunteer members, call handlers and management. During our inspection, we reviewed 55 sets of patient records.

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 November 2019.

Activity (April 2020 to July 2020)

- In the reporting period April 2020 to July 2020 there were approximately 1000 emergency and urgent care patient calls undertaken.

There were 30 first response emergency care (FREC) volunteers who worked at the service, 16 of which were trained to level three and 11 to level four.

Detailed findings from this inspection

Emergency and urgent care

Safe	
Effective	
Well-led	

Are emergency and urgent care services safe?

We did not rate safe as it was a focused follow-up inspection.

Safeguarding

Volunteer responders understood how to protect patients from abuse and the service worked with other agencies to do so. Volunteer responders had training on how to recognise and report abuse and they knew how to apply it.

There was a safeguarding policy and process to follow in the event of a safeguarding concern. Staff were required to report any concern to a safeguarding lead, trained to level four who was contactable 24 hours a day.

The volunteer responders received level three safeguarding training for adults and children, the compliance rate for training was 100%.

The safeguarding leads reviewed the information in order to make a decision about any need to send a referral to the local authority as well as submitting a statutory notification to CQC. Since April 2020, the service had made 17 safeguarding referrals to the local authorities; six for children and 11 for adults, however; only three notifications for abuse, had been received by CQC.

The reviews included monitoring for any frequent call addresses. Senior managers ensured that any suspected concerns were reviewed to ensure they met the threshold of abuse or neglect. We were told that they had been encouraged to work with the community in early intervention programmes. Plans to implement these had been on hold due to the COVID-19 pandemic.

The organisation piloted an electronic application where staff could record what first aid and any transport had been carried out rather than using a paper-based system of patient report forms. The application included a safeguarding section. If the patient was under 16 years old, the form could not be submitted without completing the section to consider if a safeguarding concern had been identified. A free text box was available to include any narrative about the decision. The application also identified any concerns that the staff member needed to be aware off from any previous call.

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.

To access the service, the local community called a dedicated phone number that connected to a call handler who operated from their own homes. The call handlers covered the service 24 hours a day. There were four at the time of inspection, we were told that the service was recruiting more volunteer members to support this service. The call handlers followed a script set out in the dispatch policy. The call handlers we spoke with, over the phone, explained the changes in how calls have been handled since the review of the service. The policy included that call handlers did not triage patients. If the patient was not conscious or breathing, after confirming the address, callers were instructed to dial 999 in order to request a response from the local NHS ambulance service for trained paramedic staff. If callers requested advice, they were signposted to call 111. The call handler confirmed, with callers, if there was any COVID-19 symptoms and also any environmental hazards to be aware of at the address. On the electronic application, the expectation was that this would be highlighted for any future calls.

The volunteer members took observations of vital signs, dependent on the nature of the call. Patient pathways had been reviewed although there were plans to re-visit them for completeness. There were no pathways recorded on the patient report forms. For patients who complained of chest pain, volunteer members had a chest pain pathway to follow. If members were trained as

first response in emergency care (FREC) level four, they could carry out an electrocardiogram, however; senior managers told us that this was not interpreted by the volunteers. For paper patient report forms, the ECG was attached and handed over to the local NHS accident and emergency department staff for their review. For electronic patient report forms, a photograph of the ECG could be taken, printed and shared with the clinicians.

The paper patient report form included a section to record a patients national early warning score (NEWS) with the electronic application able to calculate the updated NEWS tool for adults. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. However, the system did not currently include early warning score systems for children or antenatal women. There were plans to add this to the system.

Of the 55 patient report forms reviewed, 47 were either transported to the local accident and emergency (by the provider or local NHS ambulance trust) or advised to attend. The patient report form where volunteer members recorded their care and actions included a care plan agreement section where patients or guardians signed to indicate agreement with the advice of the volunteer member. We found that this section was completed for all of the electronic records reviewed, however; none of the paper records had been signed. This meant they were not always assured that patients or guardians followed advice.

There were plans to forward a copy of each patient report forms to the patients GP but the service was awaiting approval regarding any data protection concerns.

There was a dedicated ambulance to transport patients with symptoms of suspected COVID-19. Personal protective equipment (PPE) was accessible and available to members including hazardous material suits if needed. The service was considering use of positive pressure hoods.

There was a use of blue lights driving policy accessible for volunteer responders to follow. Ambulances were fitted with dashcams to monitor driving, however; no audits had been completed at time of inspection.

Records

Volunteer responders kept records of patients' care and treatment. Paper records were not always clear or consistently completed.

Volunteer responders completed patient report forms each time they attended a call. These included the incident date, call time, arrival time, time left scene, patient demographics, any past medical history, allergies, presenting details, capacity assessment, observations and care plan agreement. The paper forms were in line with the local NHS ambulance trust records. The forms also included details about advice to be given dependent on the pathway.

An electronic application had been developed to replace the paper patient report form, although at the time of the inspection a pilot had been completed and the service was in the process of implementing the application for all volunteer members.

Following the pilot of the application, each staff member was being provided with a secure electronic tablet for recording patient care. Both paper and electronic systems were in place, at the time of inspection, although the plan was to be paperless. All patient report forms were scanned into the organisations systems and stored securely.

We reviewed 55 patient report forms that were used to record patient care. These were a combination of paper (39 records) and electronic records (16 records). The paper records were not always completely legible and details of incidents were not always clear with context open to interpretation. The paper records were not always completed including the care plan agreement. None had been completed in paper versions, whereas all electronic care plan agreements were signed. Of the 17patient report forms for adults completed, only two had the capacity assessment section completed. There was no reference to parent / guardian on the electronic patient report form and Gillick competence for patients under the age of 16 years was not included on the forms. Gillick competence is a term used to decide whether a child is able to consent to their own medical treatment, without the need for parental permission or knowledge.

Since April 2020, all patient report forms records were being audited for completeness. An audit in May showed significant improvement of April records. The service audited 100% of the patient report forms in April and

identified a number of gaps in the consistency of the reports, although; the numbers had fallen in May. For example, it was identified that 51% of the patient report forms had missing observations, in April, compared to 11% in May. For April 32% of patient report forms had a second set of observations missing, compared to 2% in May. These audits were planned to be monthly. A new member of the management team had been identified to undertake these audits as part of their role. Senior managers told us that any non-compliance with completion was addressed with the individual volunteer members to understand the gaps.

Medicines

The service used systems and processes to administer, record and store oxygen, burns gel and skin adhesive for minor wounds for use in first aid.

The service had developed a medicines management policy in early 2020 during the review of all policies. A guideline for the administration of oxygen was provided following the inspection. The training curriculum for first response in emergency care (FREC) level three included safe administration of emergency oxygen.

At the last inspection we found that a range of medicines were stored in the ambulances that were not stored securely and not monitored. For this inspection, there were no medicines seen in ambulances with the exception of oxygen, burns gel, skin adhesive for wounds (other than head injuries) and saline for cleaning. Managers told us these were used for emergency first aid only. Oxygen cylinders were stored securely in ambulances. This was given to patients where oxygen saturation levels were lower than normal level, including for patients with suspected COVID-19. There was an ambulance dedicated to transporting these patients.

Since the last inspection, eight FREC four volunteer members had undertaken training in safe administration of emergency medication (SALM), although they were not currently registered to treat patients and no evidence was seen in patient report forms of medicine use other than oxygen, burns gel and skin adhesive.

The volunteer member kit bags were in the process of being standardised for a consistent approach. We were told a dedicated team member ensured sufficient stocks were available and carried out daily checks that were monitored.

Incidents

The service managed patient safety incidents. Volunteer responders recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and partner organisations.

The service reported a total of 119 incidents between April and July 2020, none of which had been classified as serious. At the previous inspection, 17 incidents had been reported in a twelve month period.

The incident form had been reviewed and simplified for staff to complete electronically although the office manager also supported staff to complete the reports as staff could initially email incidents to be submitted formally.

Volunteer members accessed a social media platform for reporting of maintenance or refuelling needs for the ambulances.

Senior managers investigated incidents, however; there was no evidence of a recognised investigation methodology such as root cause analysis or that staff had received any training to support incident investigations.

Senior managers were aware of their responsibilities regarding duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

We saw evidence that if a concern was identified, the service contacted external stakeholders, as relevant, about the issue to help make improvements across the system.

We were shared examples of when learning had been identified and shared from incidents with volunteer members, the local community and other healthcare professionals.

Emergency and urgent care

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

We did not rate effective as it was a focused follow-up inspection.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure volunteer responders followed guidance.

All policies had been reviewed in 2020 to ensure that they reflected the registered regulated activity. Staff we spoke with told us they could access policies and guidelines they needed and were clear to follow.

The reviews included pathways that included guidance for burns, cardiac chest pain and major trauma as well as signposting to other services. We were told that one of the roles for a new member joining the organisation will be to review the pathways for completeness.

Senior managers told us that volunteer members followed guidance in line with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) as well as being supported by partner organisations.

Audit plans were in development. Infection, prevention and control had been monitored through the pandemic with ambulance audits completed in May 2020 and June 2020. Compliance rates were between 95% and 100%. Patient report form audits took place in April 2020 and May 2020 with improvements noted.

There were plans to implement call handler audits. Currently, senior managers listened to live calls, on an adhoc basis, but plans include the recording of all calls.

Competent staff

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

Staff received an induction booklet to help explain the service provided including the provider's expectations from volunteers regarding first aid and transportation.

There was a policy and process for assessing the competency of staff. The volunteers' personal development plan was a tool for monitoring, managing and improving performance. Targets were established at time of induction. Appraisals were completed quarterly and annually as well as ad-hoc observations. The meetings were also used to check the well-being of the volunteers to support them in their role. A volunteer member, with a clinical qualification had been identified to oversee the performance of other member.

New starters shadowed and then worked with experienced staff initially. Protocols included that at least two members should attend calls together. Of the 55 patient report forms reviewed, there were six incidences were staff attended on their own; all were trained to FREC level three. Following the first aid care, all of these patients were advised to go to accident and emergency at the local NHS hospital. There were 11 incidences where the two or three members who attended were trained to FREC level three; 10 were advised to go to accident and emergency.

The service had identified four levels for volunteer responders. Level one was an observer, level two a second responder, level three was a first responder and level four were the most experienced. Levels one, two and three all received first aid emergency response (FREC) training to level three including first aid at work, paediatric first aid and safeguarding level three. Level four volunteer responders had received FREC training to level four. Volunteer members also completed annual immediate life support (ILS) training. Mandatory training included moving and handling, use of blue lights and application of skin adhesive for minor wounds. Some training modules had been delivered virtually during the Governments restrictions due to the Corona Virus Pandemic.

Are emergency and urgent care services well-led?

We did not rate well-led as it was a focused follow-up inspection.

Emergency and urgent care

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Volunteer responders were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

An advert was published to inform the local people that the service was operating again. This stated that they were an addition to the local NHS ambulance service and not a replacement. The provider could signpost the public to other organisations depending on their needs.

Senior leaders had met with volunteer members to inform them of changes made prior to April 2020 including changes in policies, pathways and safeguarding.

The service was in the process of setting a requirement of a minimum number of call-outs for the volunteer members to ensure they had the appropriate skills and competence to undertake their role.

Members personal folders were stored securely in a locked cupboard in an office. Personnel checks included annual renewal of enhanced disclosure and barring checks.

There were processes in place to recruit volunteers including behavioural standards expected. Checks had been completed to ensure senior leaders were fit and proper to undertake their roles. Volunteer members were required to complete annual disclosure and barring checks.

Monthly oversight meetings took place where senior leaders reviewed results of record audits, safeguarding referrals. Dash cam footage was reviewed to ensure appropriate use of blue lights.

General meetings took place with staff. Monthly meetings were held where operational items were discussed. Video conferencing was used during the Governments restrictions due to the Corona Virus Pandemic.

A list of attendees was not included in all the minutes we reviewed although we were told that they are now added as standard. Information was in note form with no set agenda items. There were actions identified, with updates from previous meeting, however; there was no clear action plan to indicate progress.

The service had not received any complaints since April 2020, however; we found that although the complaints policy signposted to an external organisation; this was for the adult social care sector rather than for an independent ambulance provider.

A patient feedback form had been developed with plans to give to a minimum of 50 patients a month. The form was currently a paper record although there were plans to introduce an electronic system. The service was working with local community groups and hoping to develop this following easing of Government restrictions.

The service shared examples of when it had approached external stakeholders to alert them to concerns they had seen as well as engaging with the community about certain issues.

The service was engaging with local trusts and encouraging an ‘open door’ policy for other professionals and stakeholders to see their service in operation.

A new office building had been constructed which included a room for meetings or training purposes as well as a locked storage room and office. Staff were encouraged to use the space to meet between calls. The ambulance storage area had been moved and lighting installed for security. There were plans to build a shelter over the ambulances and a secure shed to store any waste such as sharps. They were expecting delivery of a new ambulance to add to the fleet.

Staff we spoke with, including responders and call handlers, told us they had seen improvements in the organisation since April 2020. There was a clear management structure with clear guidelines and policies available to follow. There had been opportunities to complete training both mandatory and other learning. They received notifications when training was due. There was good communication, including through the pandemic with adequate supplies of personal protective equipment. Incident reporting was encouraged either electronically or via the administration team and feedback was received. Safeguarding reporting has been encouraged and leads were also available to discuss or refer to.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all safeguarding concerns are assessed and referred appropriately. (Regulation 13)
- The provider must ensure that CQC are notified of all safeguarding referrals. (Regulation 18)
- The provider must ensure that all records are completed fully and consistently. (Regulation 17)

Action the provider SHOULD take to improve

- The provider should ensure that any improvements in processes are embedded and sustained.
- The provider should ensure that children and antenatal women are assessed and recorded appropriately on the patient report records.
- The provider should consider the skill mix of members attending calls.
- The provider should consider reviewing the incident investigation process.
- The provider should consider reviewing the external signposting in the complaints policy.
- The provider should consider reviewing how meetings are minuted and actioned.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (1)(2)** **Recording of concerns were not always consistent with senior reviews.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1)(2)(c)** **Patient records were not completed fully and assessments not completed for all patient groups.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Regulation 18 (1)(2)(a)(e)** **The service did not always submit safeguarding notifications.**