Event Medical Services Ltd

Event Medical Services

Quality Report

Unit 3
Sawley Street
Skipton
BD23 1SX
Tel: 01535 670648
Website: www.eventmedic.co.uk

Date of inspection visit: 29 May 2018
Date of publication: 13/08/2018

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Event Medical Services is operated by Event Medical Services Ltd. The service provides transport of patients from events.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 29 May 2018 and a follow-up phone interview on 5 June 2018.

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

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

The main service provided by this service was urgent and emergency care.

Services we do not rate

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

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

- We were concerned with the prescription, storage and monitoring of medicines.
- We had concerns about the storage and quality patient report forms. There was no system of routine audit in place to ensure documentation was appropriate.
- The ambulance station was cluttered with no clear system to ensure equipment which was not in use was cleaned and separated.There was no clearly defined sluice area with running water.
- Levels of mandatory training by staff employed directly by the service were poor.
- Complaint processes were not easily accessible and no information about complaints was displayed on emergency vehicles.
- We were concerned with the completeness of the deep cleaning of ambulances by an external company.
- The storage of oxygen, chemicals and flammable liquids was not in line with best practice guidance.
- There was no formal risk register in place, however, the management team could all describe the risks to the service

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

- New staff members underwent a comprehensive induction programme. There were additional checks in place for staff who had substantive employment within NHS services. Training was provided for staff dealing with patients with additional needs.
- There was an additional assessment to measure mental capacity, this was used alongside the patient report form.
- The provider used an additional patient record to assess for mental capacity.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. We also issued the provider with three requirement notices that affected Event Medical Services Limited. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (The North), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The provider is an independent ambulance service that provides event medical services and transportation off site for event and festival companies around England. The service has undertaken ten patient transfers off site to NHS hospitals in the 12 months prior to our inspection.

Event Medical Services

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to Event Medical Services

Event Medical Services is operated by Event Medical Services Ltd. The service opened in 2002. It is an independent ambulance and event medical service in Skipton, North Yorkshire. The service primarily serves the communities of Yorkshire, but also manages events and festival medical cover throughout England.

The service has had a registered manager in post since 2002.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in ambulance services. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Facts and data about Event Medical Services

The service was registered to provide the following regulated activities:

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

During the inspection, we visited unit three, Marton Mills. We spoke with two staff, however, due to the nature of the service we were unable to speak to more members of staff. We were unable to speak to patients and relatives as event services and transport occurred mainly at the weekend. We sent 'tell us about your care' comment cards, however, none were returned. During our inspection, we reviewed ten patient report forms. The service had two urgent and emergency vehicles which were used to transport patients from event sites, however, at the time of our inspection one of the vehicles was having its ministry of transport (MoT) test.

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 had not previously been inspected by the CQC.

Activity (March 2017 to April 2018)

- The service transported 10 patients from event sites.

Detailed findings

Ten members of staff who were contracted to work with Event Medical Services. The majority of staff used by the service were contracted sessional staff who had substantive posts with NHS ambulance providers.

Between January and December 2017 the service had no never events, no serious injuries, complaints or clinical incidents.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The ambulance service provides urgent and emergency care and transport from event sites.

The service is registered to provide the following regulated activities:

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

During the inspection, we visited unit three, Marton Mills. We spoke with two staff, however, due to the nature of the service we were unable to speak to more members of staff. We were unable to speak to patients and relatives as event services and transport occurred mainly at the weekend.

Summary of findings

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

- Medicines were not stored securely. There was no audit or monitoring of medicines which meant the provider was not aware if they were being misused.
- The completion of mandatory training for staff employed directly by the service was reported to be 50%.
- Patient report forms were not always stored appropriately. In addition there was no quality checks and audit of these forms.
- There was no clearly defined dirty utility area which had running water within the station.
- The garage was cluttered and there was no clear demarcation between equipment that was in use and equipment not in use. Excess equipment was stored in the roof space which could pose a fire risk.
- Processes to complain to the service were not easily accessible to services users and there was no information available on the emergency vehicles.
- There was no documented risk register at the time of inspection, but were advised it was being developed. All of the management team could tell us of the risks to the service.
- We were concerned with the integrity of the deep clean process. we raised concerns about the completeness of the deep clean and the provider's assurance.

However, we found the following areas of good practice:

Emergency and urgent care services

- There was a comprehensive programme of induction and mandatory training for staff. Checks were in place to monitor the qualifications and appraisal of staff who had substantive employment in NHS services. The induction included orientation to the Event Medical Service policies and procedures.
- The provider had a separate patient record form to assess for mental capacity. This was used in partnership with the patient report form.
- Staff received training for patients with additional needs.

Are emergency and urgent care services safe?

Incidents

- The service had an incident reporting policy which was updated in October 2017. The policy differentiated between adverse events, serious incidents and near misses. The policy encouraged early reporting and detailed how incidents should be reported, investigated and the learning shared with staff.
- The service had a procedure for the duty of candour. Duty of candour is a regulatory duty which 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.
- The operational manager told us there was a manager on site at every event to whom staff could escalate any concerns and seek immediate advice about an incident.
- The operational manager told us they were responsible for reviewing and assessing the information on the incident form and deciding if any further action was required.
- Staff we spoke with told us there had been no incidents to report in the previous 12 months.
- Due to the low level of incident reporting the provider was unable to identify any trends or themes relating to incidents.

Mandatory training

- The service had a training and development policy which was updated in April 2017. The policy described the process for identifying learning, education and development needs for staff. It included a list of all the courses staff were required to complete and the time intervals for refresher training.
- All staff employed directly by the provider were required to complete mandatory training. Examples of training included; basic life support, Mental Capacity Act 2005, dementia awareness, fire safety, disability awareness, moving and handling and information governance.

- There was a process to review continual professional development and training for the paramedic and medical staff that had substantive roles within NHS service providers. This meant the service had evidenced that sessional staff had the competence to carry out their role.
- Staff who had not completed mandatory training or provided assurance from substantive employers were not used until evidence of training had been provided.
- The service had a system to monitor mandatory training. We saw a spreadsheet which showed the training staff had completed. The spreadsheet highlighted when training was due and management could follow-up with staff.
- We were told 50% of staff employed directly by the event service had completed training in moving and handling, basic life support, medical gasses and oxygen therapy. Staff were send reminders to complete the training, failure to do so would stop them from being used.
- There was an effective process for checking driving licences before the commencement of employment. The management team had a record of the completion of a driving licence check. The service had an electronic system that recorded these driving licence checks.
- There was a system to check on driving competence. The office manager told us all ambulance crew had to complete an annual driving assessment. Records we reviewed showed 100% of crew completed an assessment.

Safeguarding

- The service had a policy for safeguarding children and protecting vulnerable adults from abuse. The policy gave clear guidance to staff on how to report urgent concerns and was in line with the intercollegiate guidance.
- Staff were trained to level two training in safeguarding children and vulnerable adults. Staff completed a training module on the 'PREVENT' strategy for identifying and preventing radicalisation as a part of mandatory training.
- One of the operation managers was the safeguarding lead. We noted the safeguarding lead had completed level three training in safeguarding children and adults. Staff who had substantive employment in NHS provided documented evidence of their safeguarding training.
- The safeguarding lead had a good understanding of safeguarding and when they would report an incident. The safeguarding lead we spoke and staff with could describe the signs of abuse, knew when to report a safeguarding incident, and knew how to do this.
- The operations manager told us staff would also report safeguarding concerns at the time they occurred to the service's safeguarding lead.
- There had been no reported safeguarding incidents in the last 12 months.

Cleanliness, infection control and hygiene

- There was an infection prevention and control policy. The policy stated staff should follow guidance on hand hygiene, personal protective equipment, environmental cleaning, waste management and uniforms.
- The service had a uniform and laundry policy which was updated in January 2018. The policy detailed the process of wearing personal protective equipment and laundering uniforms to reduce the risk of infection.
- Staff we spoke with were aware of their responsibilities related to infection prevention and control.
- There was a waste management policy which defined clinical waste and described how it should be segregated and stored for collection. We saw evidence which showed clinical waste was collected by an approved contractor.
- Data provided by the service showed 68% staff had completed infection prevention and control training. Management told us the staff who had not completed the training had recently joined the service and were in the process of completing the modules.
- We inspected one ambulance and were told this had been last used two weeks prior to our inspection. Staff we spoke with told us the ambulance vehicles were subject to deep cleaning every eight weeks by an independent company. The vehicle we inspected was last deep cleaned in March 2018 and was due to be cleaned again on 5 May 2018.This vehicle was dusty and

some of the medical equipment such as leads from the electrocardiography machine were dirty. We shared our concerns with the provider regarding the completeness of the deep clean, due to the level of cleanliness in some of the ambulance drawers.

- There was no clear segregated sluice area within the ambulance station. In the area put aside as a dirty utility there was no running water which could be used to clean equipment if it had been contaminated during a patient journey. However, there were single use mop heads and mop buckets which were colour coded. The clinical waste bin was locked and separated from domestic waste.

Environment and equipment

- We saw evidence that information in relation to the two ambulances was recorded on a spreadsheet. The information included the date purchased, date of vehicle excise licence expiry, date of ministry of transport test (MoT) expiry, date of deep clean, date equipment was replenished, date of reporting of defect, date of repair and date of safety check. All the information for both vehicles was in date.
- There was evidence of an electronic diary system which would inform the management team in advance of the date when a vehicle required to be serviced, or needed a ministry of transport test or when the vehicle excise duty was due.
- There were car seats available for the transportation of children. The service informed us they rarely transported children.
- The ambulance station was cluttered and there was no clear segregation of equipment which was in use and out of use. Equipment was not cleaned and covered ready for the next use.
- There was an excess of equipment stored in a mezzanine level and this posed a fire risk. We raised this with the provider during the inspection.
- Chemicals which were subject to control of substances hazardous to health regulations were not stored in a locked cupboard.Following our inspection, we received assurance a lockable metal cupboard had arrived and was in use.
- The service subcontracted a mechanic to work with the vehicles. The workshop area of the garage we found two full cans of petrol which were not stored securely.

Medicines

- We found six prescription only medicines were stored on the emergency ambulance. These included some controlled (which did not require a home office licence) medicines which were not included in the Schedule 17 exemption medicines. Schedule 17 exemption medicines are those which can be administered by a paramedic for the immediate, necessary treatment of sick or injured persons. We informed the provider of this at the time of inspection and these were immediately placed in the secure storage within the ambulance station.
- At the time of inspection the provider did not employ a medical director who could prescribe and monitor medicines. We were concerned with the process to acquire prescription only medicines without a medical director in post. The registered manager reported that these medicines were prescribed and provided by an acute NHS hospital pharmacy department.However, pharmacy departments are unable to prescribe medicines. We raised our concerns with both the provider and the NHS trust following the inspection. We received assurance from the NHS trust that they no longer provide medicines to the service.
- The provider could not account for the medicines which had been used. Following our inspection, we were provided with evidence which showed the service was beginning to implement an audit of medicines.
- The service employed paramedics on a sessional basis who were able to bring their own supply of medicines during their employment.
- The service had previously carried controlled drugs and held a Home Office licence to be able to do so. At the time of inspection the service did not carry or use controlled drugs and no longer held a Home Office licence.
- The service had a medicines management policy in place at the time of our inspection. This did not include how medicines would be audited, and managed.
- Medical gases such as oxygen were stored in a lockable facility, however, these were not stored off the floor in

line with best practice guidelines. Additionally, there was no separation of empty and full gas cylinders. The service had a contract with an external provider to replenish gasses when required. There were medical gasses signs on the door of the ambulance station. Gases were stored at the back of the garage, but there was no evidence of a standard operating procedure to prevent an ambulance reversing into them.

Records

- There was a data protection and information governance policy which was in date and had a review date. The service used paper patient report forms which write in triplicate. Staff we spoke with told us documentation was stored in a secure room in locked filing cabinets. However, during our announced inspection we found four patient report forms were left in the locked ambulance in a draw. These were dated August 2017 and contained patient identifiable information.
- There was no audit of records. This meant the service did not monitor documentation and identify processes to improve it.
- The service had a do not attempt cardio pulmonary resuscitation policy which described the procedure for staff to follow. All staff were aware of the need to enquire about the existence of do not attempt cardio pulmonary resuscitation orders.

Assessing and responding to patient risk

- Each event and transportation booking had a risk assessment completed. Throughout the event dynamic risk assessment took place and any additional concerns were escalated to.
- The service did not have protocols and pathways for the transportation of patients with common conditions for example chest pain. However, the management team demonstrated, knowledge of trust specialities and where to take critically ill patients. Additionally, there were clear lines of communication with NHS ambulance providers to identify which hospitals could take patients.

Staffing

- The service was contracted on an as required basis; this meant that there was no rota required. Staff provided their availability to cover the demand. If more staff were required, the registered manager would approach additional staff from neighbouring independent ambulance providers. There was a process in place to review the staff member's training and competence records.
- The service subcontracted other independent ambulance providers to provide support for larger events. Processes were in place to ensure all staff who worked for the service had the appropriate qualifications and skills required to undertake their role.
- There was no process in place to ensure that staff with substantive employment outside of the service had had enough rest between shifts.
- The length of shift was dependant on the length of the event with the potential to transport patients. There were appropriate numbers of staff on-site to allow members of the team to have a break.

Anticipated resource and capacity risks

- The service assessed risk for events using the industry recognised best practice standard.
- Escalations plans were in place for each event the service covered. For example, where the contract required two emergency transport vehicles and both were required to transport patients the event would be halted and NHS ambulance services would be called.
- Staff communicated with each other during events using handheld radios, however, these were used for priority communications.Staff also used a secure social media group to provide update information to the event coordinator for example, crowd movement.

Response to major incidents

- The service was not part of local resilience plans and response to major incidents. This meant there were no major incident plans in place.
- The service did not have a formal business continuity plan; however, the service would contact NHS ambulance services to identify if the local hospital was on divert.
- Due to the nature of the contracted work if there was adverse weather expected, the event and possible need for transport was cancelled by the organisers.

Emergency and urgent care services

Are emergency and urgent care services effective?

Evidence-based care and treatment

- A range of pathways were used which complied with the National Institute for Health and Care Excellence guidelines and the Joint Royal Colleges Ambulance Liaison Committee guidelines. These pathways were in line with the NHS trust from which the service sub-contracted.
- Guidelines and pathways were accessible to staff through the staff portal. Policy updates were communicated through a staff mobile alert network.
- Policies and procedures were regularly reviewed and updated where required.

Assessment and planning of care

- There were no documented pathways in place regarding the conveying of patients to the most appropriate hospital. The registered manager told us this was the closest hospital to the location of the event/transfer of patients. However, in large city events the service ensured patients were transported to the most appropriate specialist centre.
- The service did not provide transport for mental health patients as part of a contract.
- There were protocols in place for the treatment and transportation of children when they presented to the service without a parent or guardian.

Response times and patient outcomes

- The service was contracted to provide medical support and transport patients from event sites and was not required to audit response times.

Competent staff

- Staff we spoke with told us the induction course for new staff was carried out over three days. The first day included information about the company and the operating procedures. The next two days were used for staff to complete a first aid at work course and commence working on 14 on line modules covering a wide range of work related subjects. Staff had eight weeks to complete the courses. Staff were given an induction period. The length of time was dependent on experience. The induction included an awareness of policies and procedures.
- There was an electronic staff training record and diary system which informed managers when staff refresher courses were required. There was an induction checklist to ensure all staff had completed relevant training prior to becoming operational on the ambulance. Data we checked showed 100% of staff completed induction.
- All staff that had been employed for longer than 12 months had an appraisal. The service had a system to check when staff appraisals were due and this was recorded on a spreadsheet.
- Continuous professional development was ongoing. We saw a list of available training courses for ambulance crew. Staff were sent an email reminder when training was due.

Coordination with other providers

- Event Medical Service worked with commissioning providers to ensure the service provision met the needs of the event.
- Due to the low number of transfers undertaken by this service there was no information available at the time of inspection regarding working with other agencies.

Multi-disciplinary working

- Event Medical Service worked with NHS ambulance providers in case patients required transport from event sites.

Access to information

- Staff could access policies and procedures through the electronic staff portal whilst on event sites.
- Staff could communicate with colleagues using handheld radios for priority communications.
- Staff we spoke with could explain that a do not attempt cardiopulmonary resuscitation form was a patient held document which had to be correctly signed and went with the patient to be handed over to the receiving service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was no formal process to establish consent for care, treatment and transfer for children when patients or guardians not present. However, the registered manager described to us there was a standard verbal procedure in place; for example, referring to the event welfare and security team to locate the child's guardians.
- The service used a separate patient assessment record to assess for mental capacity. These were used in addition to the generic patient report forms if the staff felt the patient was unable to make choices for themselves. Training was offered to staff and included awareness in dementia training.
- Staff we spoke with understood the importance of obtaining consent appropriately and assessing mental capacity.

Are emergency and urgent care services caring?

Compassionate care

- Staff we spoke with showed an awareness of the importance of maintaining patients' privacy and dignity at all times.
- Staff we spoke with described how they would take steps to try and minimise distress in patients and families. This included speaking to patients in a reassuring, polite, and friendly way, and explaining what was happening.Relatives were encouraged to stay with patients.
- We saw evidence of feedback from one client dated July 2017 which identified the crew were helpful and thorough.

Understanding and involvement of patients and those close to them

- Staff we spoke with demonstrated an awareness of involving patients and their carers in the decision to transport from an event site.

Are emergency and urgent care services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The service was contracted to cover events and transport people off site; part of the delivery was to work with the organisers on where to place staff depending on the size of the site and the type of the event.

Meeting people's individual needs

- The service had a policy for the care of bariatric patients which was updated in February 2018 and provided guidance on the safe transport of bariatric patients. It detailed the list of equipment required and the manual handling procedure. The registered manager told us this equipment would be used when the service was contracted to cover wrestling events.
- Staff received training in caring for patients with dementia, learning disability and patients with complex needs.
- During the inspection we saw evidence of a pack of information held in the vehicles which contained an emergency phrase book in multiple languages.

Access and flow

- The service used the recognised industry standard guidance to ensure resources were allocated appropriately. Where two emergency transport vehicles were required for an event, contingencies were put in place to ensure people could be transported off-site in an emergency, if both vehicles were transporting patients.

Learning from complaints and concerns

- Service users could provide feedback to the service through the provider's website, however when we reviewed the website it was difficult to locate the feedback link.
- At the time of our inspection the service had not received any complaints between June 2017 and May 2018.

- There was no information displayed on vehicles informing patient and relatives how to make a complaint; however, the office manager told us during our inspection this would be addressed.

Are emergency and urgent care services well-led?

Leadership of service

- The senior leadership team consisted of two directors, one of which was the CQC registered manager and office and training manager. The managers we spoke with were aware of their roles and responsibilities, and staff we spoke with knew who the different leads were and what they were responsible for.
- The senior leadership team supported service delivery by working clinically at events when required and undertaking an on-call rota for out of hours work.
- We were provided with evidence which indicated the senior leadership had the appropriate skills and knowledge to undertake that role. This this included training records and employment history.
- There was an open-door policy, and staff we spoke with reported they had open access to the senior leadership team.
- Staff we spoke with told us when they encountered difficult or upsetting situations at work they could speak in confidence with the managers and had support from colleagues.
- Staff we spoke with told us the senior leadership team were supportive and approachable.

Vision and strategy

- The service did not have a formal documented vision and strategy. However, the registered manager could clearly articulate their key priorities for the service.
- Staff we spoke with were able to articulate the same priorities for the service.

Governance, risk management and quality measurement

- There were management team meetings. The managers meeting took place every month to discuss governance, audit monitoring and risk within the service.
- The service had undertaken a range of risk assessments for example, injuries from assaults, electric shocks, sharps, bariatric patients and spillages.
- The registered manager told us information and learning was cascaded to staff.
- All staff members had access to an online portal. Service information was shared with staff through a secure social media group.
- The service had a recruitment policy which set out the standards it followed when recruiting staff. The registered manager told us, as part of the staff recruitment process, they carried out appropriate background checks. This included a full disclosure and barring service check, proof of identification, references, as well as driving licence checks. We reviewed the staff files and found these checks had been completed.
- There was no risk register in place at the time of inspection. The service was in the process of developing a risk register. The senior management team could inform us of risks they had identified including the number of independent ambulance and event providers bidding for event services.

Culture within the service

- The leadership team and staff were committed to the service. Staff were encouraged to undertake accredited training courses.
- The service had an open and honest culture. Staff we spoke with told us the culture of the service was friendly and approachable.
- Staff we spoke to were proud of the work they carried out.
- Staff we spoke with told us the management team was supportive and approachable. They told us they usually met individually with the operations manager if needed.

Public and staff engagement

- The service's publicly accessible website contained information for the public in relation to what the service could offer.

Emergency and urgent care services

- Staff we spoke with were positive about their engagement with the managers of the service. They told us they felt involved in decision making around the service and their roles. In addition, they told us they were kept informed of any planned changes and always felt listened to.
- Staff could access information such as policies and procedures electronically through the online staff portal.
- The registered manager told us the service had plans to develop patient feedback using the website.

Innovation, improvement and sustainability

- The service was researching the use of handheld radios which included global positioning system. This would mean the event lead would be able to identify where all the team members were in real time.
- The service has begun to work with local colleges to begin an apprenticeship programme, but there had been no suitable candidates by the time of our inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must take action to audit medicines used within the service.
- The provider must take action to ensure that prescription only medicines are prescribed by a medical practitioner.
- The provider must take action to ensure all medicines are stored appropriately.
- The provider must ensure patient report forms are promptly stored in the correct place and securely once they are completed.
- The provider must audit patient report forms to ensure information is accurate, learning identified and improvements made.
- The provider must take action to improve mandatory training compliance.
- The provider must ensure there is an appropriate dirty utility area with running water, the garage is free from clutter and equipment is segregated to reduce the fire risk and confusion and storage of chemicals, flammable liquids and oxygen are in line with best practice guidance.
- The provider must assure themselves that the external cleaning company is undertaking the deep clean of emergency vehicles in line with the contract.

Action the hospital SHOULD take to improve

- The provider should investigate ways in which to gain patient feedback.
- The provider should make available information on how to complain about the service is visible on the emergency vehicles.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have systems in place for the safe prescribing, monitoring and audit of medicines. The service had stocks of medicines which were prescription only and fell outside of the section 17 and 19 exemptions. Regulation 12 (1)(2)(f)(g)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have robust systems in place to, audit, monitor and maintain records and share learning. Regulation 17(1)(2)(a)(c)(f)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The service did not have a dedicated sluice with running water, the garage was cluttered and posed a fire risk. The storage pf flammable liquids and oxygen needs to follow best practice guidance.

This section is primarily information for the provider

Requirement notices

The deep clean of the emergency vehicles did not meet the expectation of the contract. Equipment was dirty and the draws did not appear to have been emptied and cleaned.

Regulation 15 (1)(a)(e)(2)