Ambulance & Medical Support Services Ltd

Ambulance & Medical Support Services - Ambulance Station Sandhurst

Quality Report

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

Ratings

Overall rating for this ambulance location	Inadequate
Emergency and urgent care services	**Inadequate**

Summary of findings

Letter from the Chief Inspector of Hospitals

Ambulance & Medical Support Services – Ambulance Station Sandhurst is operated by Ambulance & Medical Support Services Ltd. The service provides an emergency and urgent care ambulance service by conveying patients from event sites to the local acute NHS trusts.

Ambulance & Medical Support Services - Ambulance Station Sandhurst is not commissioned by other organisations to deliver services on a regular basis. Work was undertaken for event organisers on an ad hoc basis and there was no formal contract issued. The service had three emergency ambulances it used to carry out the regulatory activities.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 20 March 2019. However, the service was not operating on that day. We therefore carried out an announced inspection on 01 May 2019.

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.

We rated it as **Inadequate** overall.

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

- There was not an effective incident reporting and management process in place.
- The service did not ensure all staff working for the service had the qualifications, competence, skills, experience and had completed appropriate mandatory and safeguarding training to keep people safe from avoidable harm and to provide the right care and treatment.
- The service put patients and staff at harm from the risk of cross infection.
- The service did not make sure there was safe management of medicines that complied with national guidelines and legislation.
- The service's policies and procedures were not all relevant to the service being delivered, or accurately detail current legislation and national guidance.
- There was no assurance that patients would know how to make a complaint, or the service would treat concerns and complaints seriously.
- Senior staff had gaps in their skills, knowledge and experience to effectively manage and develop the service.
- Senior staff had a lack of understanding of governance. Systems and processes were not used effectively to improve the quality of the service and keep patients safe from harm.

However, we found the following areas of good practice:

- The service had suitable premises and equipment and mostly looked after them well.
- Staff keep detailed records of patient' care and treatment.
- Staff assessed and monitored patients regularly to see if they were in pain.

Summary of findings

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

The service was rated as inadequate overall. I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.'

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South), 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	Inadequate 	The service provides medical cover at events such as boxing (in support of army medical staff), motocross and equine events for adults and children. The service conveyed patients from event sites to the local acute NHS trusts. We rated this service as requires improvement for effective and responsive. We rated this service as inadequate for safe and well-led. We did not rate caring as we did not have enough evidence to make a judgement. Senior staff lacked an understanding of governance. Systems and processes were not used effectively to improve service quality and keep patients safe from harm. The lack of staff records meant there was no assurance that staff working for the service had the relevant qualifications, skills and capabilities to deliver safe care and treatment. Policies and procedures were not relevant to the service delivered.

Ambulance & Medical Support Services - Ambulance Station Sandhurst

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to Ambulance & Medical Support Services - Ambulance Station Sandhurst

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

Ambulance & Medical Support Services- Ambulance Station Sandhurst is not commissioned by other organisations to deliver services on a regular basis. Work was undertaken for event organisers and included conveying patients from event sites to NHS hospitals on an ad hoc basis. The service had three ambulances and five rapid response vehicles. We have only reported on the ambulance vehicles used for the regulated activity.

The service for this location has had a registered manager in post since 08 September 2012. A registered manager is a person who has registered with CQC to manage a service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an inspection manager and a specialist advisor with expertise in paramedic services. The inspection team was overseen by Amanda Williams, Interim Head of Hospital Inspection.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the

Detailed findings

unannounced part of the inspection on 20 March 2019. However, the service was not operating on that day. We therefore carried out an announced inspection on 01 May 2019.

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.

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

The service is registered to provide the following regulated activities:

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

At the time of our inspection the service was in the process of deregistering two of the regulated activities, diagnostic and screening procedures and surgical procedures as the service did not carry out these registered activities.

During the inspection, we visited the ambulance station at the registered services address. The ambulances used for the regulated activity and associated equipment were kept here. The service employed two members of staff, the registered manager, who was a paramedic, and an administrator on a permanent basis. The service recruited and kept a bank of paramedics and technicians who had substantive contracts with the NHS or Ministry of Defence. These staff would be used as and when needed to deliver the service at events which included conveying patients to the local acute hospital if required. At the time of the inspection the service had access to 31 emergency medical technicians/combat medical technicians and 12 registered paramedics. We spoke to the registered manager and one of the service's self-employed staff. We were not able to observe any care being delivered to patients or speak with them as no one was receiving care during our inspection.

There were no special reviews or investigations of the service ongoing by the CQC at any time or during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in March 2017 which found that the service was meeting all standards of quality and safety it was inspected against.

Activity

- In the reporting period January 2018 to December 2018 there were 12 emergency and urgent care patient journeys undertaken.

Track record on safety

- No reported never events
- No reported clinical incidents
- No reported serious injuries
- No reported complaints

The accountable officer for controlled drugs was the registered manager.

Our ratings for this service

Our ratings for this service are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate

Emergency and urgent care services

Safe	Inadequate
Effective	Requires improvement
Caring	Not sufficient evidence to rate
Responsive	Requires improvement
Well-led	Inadequate
Overall	Inadequate

Information about the service

Ambulance & Medical Support Services – Ambulance Station Sandhurst is operated by Ambulance & Medical Support Services Ltd. It is an independent ambulance service in Sandhurst, Berkshire. The service primarily serves the communities of the Berkshire and Hampshire, but covers army boxing events in other counties.

Ambulance & Medical Support Services Ltd was first registered with the Care Quality Commission (CQC) May 2011. The service was registered with CQC, so it could convey patients from event sites to NHS hospitals. The service had three ambulances and five rapid response vehicles. We have only reported on the ambulance vehicles used for regulated activity.

The service is registered to provide the following regulated activities:

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

At the time of our inspection the service was in the process of deregistering two of the regulated activities, diagnostic and screening procedures and surgical procedures as the service did not carry out these registered activities.

The service for this location has had a registered manager in post since 8 September 2012. The service did not directly employ any staff in addition to the registered manager. They recruited self-employed staff as and when needed, to deliver the service at events which included conveying patients to the local acute hospital if required.

Emergency and urgent care services

Summary of findings

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

- There was not an effective incident reporting and management process in place.
- The service did not ensure all staff working for the service had the qualifications, competence, skills, experience and had completed appropriate mandatory and safeguarding training to keep people safe from avoidable harm and to provide the right care and treatment.
- The service put patients and staff at harm from the risk of cross infection.
- The service did not make sure there was safe management of medicines that complied with national guidelines and legislation.
- The service policies and procedures were not all relevant to the service being delivered, or accurately detail current legislation and national guidance.
- There was no assurance that patients would know how to make a complaint, or the service would treat concerns and complaints seriously.
- Senior staff had gaps in their skills, knowledge and experience to effectively manage and develop the service.
- Senior staff had a lack of governance understanding. Systems and processes were not used effectively to improve service quality and keep patients safe from harm.

However, we found the following areas of good practice:

- The service had suitable premises and equipment and mostly looked after them well.
- Staff keep detailed records of patient' care and treatment.
- Staff assessed and monitored patients regularly to see if they were in pain.

Are emergency and urgent care services safe?

Inadequate

We rated it as **inadequate**.

Incidents

The service had an ineffective incident reporting system. The service did not manage patient safety incidents well.

- The service had an adverse incident reporting and investigation policy dated May 2018. This policy included information relating to the incident reporting procedure, such as; definitions of relevant terms including, adverse incident, hazard, risk and near miss; the adverse incident reporting procedure; how to grade an incident and how to investigate an incident.
- However, it was unclear how this policy was relevant to the service as it referenced staff roles and teams that did not exist in the company. For example, regional managers, the board and the human resources team. It also referenced systems used to report incidents that the service did not have or use. For example, the electronic NORMS reporting system.
- During the inspection, the registered manager told us the service did not use an electronic system to report incidents, they were reported on a paper-based system. The adverse incident reporting and investigation policy stated all employees would receive formal training in the incident report form and the electronic NORMS reporting system during the corporate induction training and the service's training needs analysis process. The service could not show us evidence this training had taken place for staff. In addition, incident report forms were not kept on the vehicles or in the ambulance station for staff to complete if there had been an incident.
- As there had been no incidents reported between January 2018 and December 2018 we could not review any completed forms. Post inspection we requested a blank incident report form that the service used to report incidents. However, we were not supplied one. On the daily log sheets we saw there was a box for

detailing incidents but we were unsure what this was used for as on some forms the box was crossed through and on others it said to see the patient report forms. The incident reporting policy did not indicate that the service daily log sheets were a formal method of reporting incidents.

- We were not assured there was an effective incident reporting system in place as the adverse incident reporting policy did not relate to the service, there was no evidence of an incident reporting form, no evidence of staff training in incident reporting and no incidents reporting during the year.
- The service had not reported any Duty of Candour concerns between January 2018 to December 2018. 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.
- The registered manager understood and could recognise when an incident required Duty of Candour and his responsibilities in relation to Duty of Candour.
- The adverse incident reporting and investigation policy referred to the Duty of Candour. However, the policy again referred to roles and processes that did not exist in the service, for example the position of head of patient experience.

Mandatory training

The service did not provide mandatory training in key skills to all staff but expected staff to complete this with their substantive employer. The service did not make sure all staff had the required mandatory training.

- The service had not identified the mandatory training requirements for each staff group employed by the service and the frequency this must be completed to ensure staff were competent to undertake their role.
- The service stated they did not provide mandatory training and expected staff working for them to have completed mandatory training at their main place of work, either local acute NHS trusts or for the Ministry of Defence.
- The registered manager told us before employees could start working in the service they would need to show evidence of the mandatory training they had completed. This information was recorded on a central mandatory training checklist. The checklist stated mandatory training consisted of safeguarding, lifting and handling, mental capacity act and deprivation of liberty safeguards and basic life support including automated external defibrillation. The registered manager told us no information on mandatory training was keep in the staff records.
- Prior to the inspection we were provided with the mandatory training checklist for 2018. This checklist was a tick list and lacked detail. For example, only the surnames of individuals were recorded and there were no details of the role the individual held in the service. There was a single tick to say all mandatory training had been completed. Therefore, there was no detail when each element of the mandatory training had taken place or when renewal or an update was required.
- Although we were provided with some evidence that mandatory checks for staff had been completed, the service had not documented sufficient detail to be assured all staff had completed the correct mandatory training for their role or that training was up to date.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. However, there were gaps in the service's systems and processes that supported staff to understand how to protect patients from abuse.

- The service had a child protection policy and a safeguarding vulnerable adults policy both dated February 2017. The safeguarding vulnerable adults policy detailed the different types of abuse and how to recognise them and the procedures required to report safeguarding concern with a flow chart in the appendix. However, the policy was missing the local authority contact details, with question marks where the phone numbers should be and the flowchart was the safeguarding reporting about allegations regarding a member of staff not if staff had concerns about a patient. The child protection policy did not contain the same level of detail and there was no details of the

different types of abuse or the procedure to follow if there were safeguarding concerns. The policy also referenced the service's child protection officer a role that did not exist in the service. Therefore, both policies were either lacking important information or not relevant to the service.

- The registered manager was the adult and child safeguarding lead for the service and had completed level 2 adult and child safeguarding training and could demonstrate knowledge of the correct way to report an adult or child safeguarding concern.
- The registered manager reported staff were trained to level 2 adult and children safeguarding in their substantive role. Safeguarding training was reported to be part of the mandatory training. However, because of the way mandatory training was provided and documented we saw no evidence of the level of safeguarding training staff had completed. Therefore, we could not be assured staff had the appropriate level of training for the roles they carried out in the service.
- The registered manager told us that if a safeguarding concern was identified during an event the staff would contact the service's safeguarding lead who in turn would contact the event's safeguarding lead. However, there was no reference to this in either of the safeguarding policies and the registered manager could not give us an example or evidence to show this had occurred as there had been no safeguarding incidents reported.
- Staff completed a daily log sheet for each job they completed. On this form was a box to fill out if there had been any child protection issues. We reviewed three daily log sheets and all forms were filled out and indicated there had been no issues. This showed that children's safeguarding issues were being considered when staff where at events.

Cleanliness, infection control and hygiene

In general, the service controlled infection risk well. Staff kept equipment and the premises visibly clean. However, there were gaps in the service's systems and processes that supported staff to protect patients, themselves and others from infection.

- The service had a cleanliness and infection control policy dated February 2017 which we were told the staff were required to read during their induction. The policy included guidance on hand hygiene and the use of personal protective equipment.
- However, the policy referred to staff roles that did not exist in the company such as the logistics manager. There was also a section on patient transport services which the service did not operate. The policy referred to annual mandatory infection control updates. However, infection control was not documented as being part of the service's mandatory training. Therefore, there was no evidence these updates occurred or the policy was relevant to the service.
- We reviewed the three ambulances used by the service to convey patients to hospital. They were visibly clean internally and externally. Reusable equipment such as splints and monitors were visibly clean. All trolleys were clean and disposable clean linen was available.
- Many single use items had been removed from the manufacture's package, for example suction machine tubing. This meant the items were no longer sterile or packaged to reduce the risk of cross infection. Also, they no longer included the expiry date as the original packaging had been removed. The registered manager told us equipment had been repackaged for ease of access in an emergency but he did not recognise this posed a potential infection control risk.
- Personal protective equipment (PPE) such as gloves and aprons were available. However, none of the ambulances had spill kits for body fluids. The registered manager told us a disinfectant spray and paper towel was used to clean these types of spillages. However, we noted this disinfectant spray was not on all of the ambulances, including the one that had been prepared for use and was due to be dispatched to an event on the day of our inspection.
- The service had a waste policy dated March 2017. This policy included explanation of types of waste and how waste should be segregated and disposed. During the inspection we observed that waste was disposed of in accordance to the policy. Each ambulance had a container for the disposal of clinical waste and a sharps bin. Although the sharps bins were not dated with the date it was assembled.

- We saw records to confirm that each vehicle was cleaned after use, with staff signing and dating the daily log sheet to say the task had been completed. This daily log sheet did not provide detailed guidance for staff on what to check was clean in the vehicle. However, the cleanliness and infection control policy gave basic descriptions of what needed to be cleaned inside and out of the vehicle during the daily cleans. This part of the policy was relevant to the service. Post inspection the registered manager told us the guide for cleaning vehicles was in the vehicle folder for each vehicle. However, these were not present when reviewed during the inspection.
- The vehicle cleaning audit dated 2018 demonstrated some cleaning activities were recorded as taking place monthly. From the documentation we could see that deep cleans also took place. However, from the documentation it indicated deep cleans happened on an ad hoc basis as there was no regularity to the deep cleans, with them occurring sometimes every 2, 3 or 4 months. The cleanliness and infection control policy did not give any details or information regarding deep cleans or what their frequency should be.
- Dedicated mops and cleaning materials were stored in the ambulance station for cleaning the vehicles. There was no dedicated sluice to dispose of dirty water and the kitchen area was used to fill cleaning buckets and water used to clean the ambulances was disposed of down the public drain. This posed a risk of cross infection.
- There were hand-washing facilities for staff at the ambulance station and ambulances were fitted with hand sanitising gel dispensers for hand disinfection.
- The member of staff spoken with told us staff were provided with adequate numbers of uniforms which they would wash themselves. They were expected to be properly attired when on duty which he stated staff adhered to.

Environment and equipment

The service had suitable premises and equipment and mostly looked after them well.

- The service had a security policy dated December 2016. Included in this policy were details of who was responsible for security, which was the registered manager, areas certain staff had access to and how often key pad codes should be changed.
- During our unannounced inspection neither the registered manager or staff were present at the location. The ambulance station was secure. However, three ambulances were parked outside the ambulance station. We were able to gain access to two of the three ambulances as they were unlocked. This meant there was a risk that unauthorised persons would have access to the vehicles. The ambulances had medical gases and consumables stored on them, we alerted the registered manager immediately who stated they would ensure the vehicles were secured.
- The ambulance station had a forecourt where the ambulances used for regulated purposes were parked. This area was used for cleaning and restocking the vehicles. There was a garage that was used for internal deep cleaning of the vehicles and a secure room for the storage of consumable items and medicines. The garage had CCTV cameras which monitored the front door and the medicines room.
- There was a training room for the teaching of staff. At the time of our inspection we were told this room was not being used for teaching and had boxes of out of date consumables in there. There was also an office on a mezzanine floor.
- Equipment was stored relatively neatly throughout the station. All electronic equipment was tested on an annual basis. Equipment was labelled with the date of the last test which ensured it was fit for use. Equipment we checked had been tested and was in date. This including equipment used for oxygen monitoring and ECG recording.
- The service had a medical device servicing log which included a list of all equipment held by the provider and the last date it had been serviced. The majority of the equipment was last serviced in February 2019.
- On the ambulance used for the regulated activity there was equipment suitable for adults and children. This included paediatric oxygen masks and nebuliser masks.

Each ambulance had relevant emergency equipment available for both adults and children, such as defibrillators, airway management equipment and transport boards.

- During our announced inspection we found medical gases were stored securely on vehicles in a locked cupboard to prevent the risk of injury to staff and patients.Medical gases were also stored appropriately at the ambulance in a designated dry, well ventilated, on wooden shelves behind a locked gate. Full and empty cylinders were stored on separate shelves.
- We observed that there were fire extinguishers throughout the station and on the ambulances. All were in date and tagged to demonstrate they were ready and fit for use.
- Consumables were stored neatly in racking and off the floor in a locked room. Most of the equipment we checked was in date. However, we found some intubation tubes which were past their expiry date. The registered manager told us some equipment had their usage extended. However, there had been no risk assessments or manufacturer guidance to demonstrate this extension of usage did not pose a risk to patient safety.
- We noted there was a box of out of date consumables that had been removed from vehicles and kept at the station. This box was not labelled to show the items should not be used. This posed a risk that out of date items from the box could be re-introduced into the service.
- Keys to the ambulances were not stored securely outside of the driver's possession. Spare keys were stored in a safe, accessed by a combination lock. However, main keys were stored in an unlocked box, which meant the vehicles could be used without authorisation.
- Records showed all vehicles used for the regulated activity were compliant with Ministry of Transport (MOT) testing and the vehicles were regularly serviced. There were appropriate records of insurance and road tax. The service had vehicle breakdown cover for emergency assistance should the vehicle develop a fault.
- Each vehicle was fitted with a satellite navigation and tracking system. This system also sent a message to the registered manager if the blue lights were activated which indicated a patient was being conveyed to hospital on blue lights.
- We were told the daily log was used by staff to confirm the ambulance kit such as the suction unit and defibrillator and that the vehicle daily inspection checks had been completed. However, there was no standard load list (a list of consumables and equipment each ambulance should carry) or a list of vehicles checks to be carried out prior to the vehicle being used. Therefore, while staff ticked to say checks had been carried out, it was not possible to confirm or audit if all equipment and consumables were present and if the vehicles were road ready.
- The registered manager stated they and the staff member responsible for restocking the ambulances were aware what equipment and consumables should be loaded and staff knew how to check the vehicles. However, this informal system increased the risk of equipment not being available on the ambulance or vehicle problems not being spotted prior to use.
- During the inspection we found none of the three ambulances used by the service had stretchers that were fitted with a five-point harness. The provider was unaware that to minimise the risks of injury to patients and staff a five point-harness could be used. The patient care records we reviewed demonstrated that 12 patients in a 12-month period had been conveyed to hospital in stretchers without five-point harnesses. This meant they had been placed at risk of harm should the ambulance have been involved in a collision.
- The cupboards on the ambulance were labelled with the contents so staff would know where equipment was located. However, we found the labels did not correspond with the cupboard's contents. This posed a patient safety risk as staff may not find equipment and consumables in a timely manner when needed in an emergency.

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.

- The registered manager told us risk assessments were completed prior to the crew being sent to any public event. Risk assessments considered; how many people were at the event, what was the risk and the number of paramedics and vehicles required. This assessment was based on organising previous similar events. Most events had an event doctor in attendance, employed by the event and not the service, which formed part of the risk assessment.
- Staff told us whilst at events, they could contact the event's doctor for immediate advice regarding escalation if patients were deteriorating. They could also contact the registered manager for advice at any time.
- Assessment for patients were carried out and recorded on patient clinical record (PCR) forms. The documentation assisted staff in undertaking a rapid assessment and making the decision to convey to hospital or contact the NHS ambulance trust to request an ambulance to convey the patient. The forms were detailed and included, a record of the incident; assessments including vital signs and consciousness; and any medicine innervations. The PCR had a carbon copy, meaning that one copy could be left with the patient once they had arrived at the hospital. The registered manager told us he had been given compliments by the local trust on the completeness of information supplied to the trust when they handed patients over to them.
- Patients were monitored to identify early detection of deterioration whilst in the care of the service. This information was recorded on the PCR.
- We reviewed 12 PCR for patients that were conveyed to hospital. The records showed initial assessments were carried out in a timely fashion, patients were continuously monitored and forms were fully completed by the staff.

Staffing

The service had enough staff for events it was contracted to provide medical assistance for. However, there were gaps in the service's systems and processes to know if staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- The service employed two members of staff, the registered manager, who was a paramedic, and an administrator on a permanent basis. Other staff employed by the service had substantive contracts as paramedics or technicians with the NHS or Ministry of Defence and were contracted to work on a self-employed basis when required.
- The service at the time of the inspection had 31 ambulance technicians and 12 registered paramedics registered as being available to work on regulated and non-regulated work.
- All events were risk assessed for staffing needs by the registered manager and the administrator would contact staff to see who was available to work. The registered manager told us the service had access to enough staff to ensure there was the correct number of staff, at the right level, working at events.
- We saw evidence all staff had an in-date Disclosure and Barring Service (DBS) check which was reviewed during the recruitment process. This protected patients from receiving care and treatment from unsuitable staff.
- The medical director for the service was a private GP based in central London. We were told he undertook this role on a voluntary basis.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- The service had patient clinical record (PCR) forms which staff completed following their assessment and treatment of patients. The service used two versions of the form, a short form for non-regulated activities and a longer form for regulated activities. The longer form was more detailed and included conveying information such as which hospital patients were taken too.
- The PCR had a carbon copy, with the top part being retained by the service for their records and the bottom copy being left with the patient at the hospital for their

records. There was a folder on the ambulance for storage of PCRs at the event site and a secure box at the station for crews to place their completed PCRs generated after an event. The registered manager was responsible for collecting, reviewing and filing the PCRs.

- We were told if an electrocardiogram (ECG) recording had been carried out on the patient a copy of the ECG record would be printed and left with the patient at the hospital. The service was considering making a second recording and keeping that with the patients' notes at the service for completeness. However, this practice had not commenced at the time of our inspection.
- We saw that PCR forms were filed in a locked cabinet in a secure office. We reviewed the 12 PCR for patients conveyed to hospital from an event during the period January 2018 to December 2018. We found most forms to be legible and completed in full. However, we noted that two of the forms did not record the hospital the patient was conveyed to.
- The registered manager completed monthly PCR audits and spoke to staff if documentation needed to be improved. We reviewed January 2018 to December 2018 audits and action plans. These showed minor documentation errors and documented that the staff members had been spoken with.

Medicine

The service did not always follow best practice, national guidance or legislation when prescribing, administering, recording and storing medicines.

- The service had a management of medicines and controlled drugs policy dated March 2017. The policy had guidance on record keeping, security and destruction of controlled drugs used by the service. However, the policy had not been personalised for the service and included information which related to another NHS ambulance service.
- We were told that medicines were ordered from two main suppliers through electronic ordering. Post inspection we were shown the drug order forms used in the service and an invoice of medicines bought. The order form was not signed by the medical director but by another doctor who was not employed by the service. We saw no authorisation that the medical doctor had delegated this responsibility to another. This demonstrated the medical director did not have full oversight of medications being requested by the service.
- Medicines were not stored in a designated medicine room. They were stored in a locked room accessed via a key pad which was also used to store consumables. Medicines were stored in a locked metal cabinet not secured to the wall in this room. The room was monitored via CCTV.We were told by the registered manager there was restricted access to the room with only the registered manager and the member of staff responsible for restocking the medicine bags used on the ambulances being issued with the code. We were told the code was changed but were not given the frequency. We were also told, if a staff member issued with the code left the service the code would be changed.
- Medicines were stored neatly in the cabinet and the shelves labelled with the specific medicines location meaning it was easy to find the medicine needed. We completed a spot check of the medicines which showed they were all within date.
- There was a locked fridge for the storage of glucagon in the same room. However, the fridge temperature was not monitored and there were no audits of fridge temperatures. The register manager was unaware he needed to do so. This meant there was no assurance that medicines were stored at the appropriate temperature to guarantee product integrity or that the appropriate action would be taken if the fridge exceeded acceptable temperatures levels.
- Medicines taken onto the ambulances were packed into wipeable medicine pouches. There was specific pouches for the staff role. For example, paramedics had different medicines pouches to the technicians. All pouches were sealed with a green tag to identify they had been checked and were ready for use. However, there was no check list of the contents to confirm all drugs were present and no paperwork for staff to record medicine usage. Therefore, it was unclear if the correct medicines were on the ambulance and no way of auditing usage.
- At the start of each shift, paramedics and technicians collected the pouches from a central store at the

ambulance station. Staff recorded the pouch number on the daily log sheet. Daily log sheets we reviewed showed this was completed by the crews. We saw the secure storage cabinets on the three vehicles we inspected where medicines were kept on the vehicles. Any medicines administered to patients were recorded on patient clinical record (PCR). The pouches were returned to the store at the ambulance station at the end of the shift. As there was no record sheet in the medicine pouches for staff to complete when a medicine was administered, it was only recorded on the PCR, this meant medicines used could not be cross referenced with the PCR.

- The registered manager told us he carried out medicine audits to identify any discrepancies. We reviewed the drug audit tracker for 2018. The tracker did not provide full detail of how the audit was conducted or what it involved. There was a single tick to say the audit check had been completed and three columns labelled broken vials, missing lost and correct.Therefore, we were not assured there was an effective process for the recording and monitoring of medicines.
- The registered manager was the controlled drug (CD) lead and had a home office licence in place. Post inspection we reviewed these documents. We were told CDs were stored at the registered managers home address in a locked safe which was attached to an external wall. We did not inspect this during our visit. However, we were told by the registered manager the home office had completed an inspection three years ago.
- As the CD register was stored at the registered manager's home we were unable to review this at the time of our inspection. Post inspection we were sent photographs of extracts of pages from the register. From this we could see CD audits had taken place and there was a record of CDs administered including by whom and to which patient. However, the photographs only showed one page of information for two of the CDs kept. Therefore, we could not review all the evidence to say that CD documentation was complete and thorough.
- CDs were packaged by the registered manager in a pouch and brought to the ambulance station when required. They were stored in a secure safe and staff would sign them out at the start of their shift and sign back in at the end of their shift. Records we reviewed showed that staff always signed them out but did not print their name or add their staff number as required to do so by the service's paperwork. This meant from just a signature it was not always easy to see who had taken the CDs.
- There was no evidence on the patient clinical records (PCR) or other document that a record of unused CDs was recorded and that the destruction of the unused medicine was witnessed. Therefore, the service could not be assured there was no misappropriate usage of CDs.
- During the inspection we saw out of date medicine being disposed of in appropriate containers. Denature pots for medicine ampoules including CDs and yellow bins with blue tops for other medicines. There were full containers which needed collecting but from discussions with the registered manager it was unclear how often the clinical waste contractor was called to the service to make collections. In addition, the bins were not sealed and dated. This meant waste medicines could have been accessed and removed for misappropriate usage.
- We were not assured there was a formal process for the destruction of CDs. There was no trained witness who was responsible for assisting the registered manager with destroying CDs. We were told but saw no evidence that a local police officer had previous witnessed the destruction of CDs.
- At the time of the inspection paramedics working in the service were administering prescription only medicines that were not covered by schedule 17 or 19 of the Human Medicines Regulations 2012. For example, midazolam and salbutamol in both nebuliser solution and inhaler format. To administer these types of medicines a patient group direction (PGD) is legally required if the medicine is administered from the service's own stock to a patient. A PGD allows healthcare professionals to supply and administer medicines to pre-defined groups of patients, without a prescription, ensuring patients had speedy access to medicines they needed during treatment.
- The registered manager stated that PGDs were not needed as they were a small company and therefore exempt and could use a medical standard operating procedure (SOP) instead. There was no evidence

provided to us to demonstrate who had given this advice. The registered manager was unaware of national guidance relating to PGDs and the need for this service to use them.

- We reviewed the medical SOP dated January 2019 which had been signed by both the medical director and registered manager, neither signature was dated. The SOP gave authorisation to purchase the medication and a list of medication that staff working for the service could hold, store and administer.Many of the medicine's names were mis-spelt, for example, madazolame – correct spelling midazolam, benzylpenecillin – correct spelling benzylpenicillin and chlorphenamine – correct spelling chlorpheniramine. In addition, the list of medicines did not match those used in the service.
- The SOP listed the clinical grades and which medicines they were allowed to administer under the authorisation of the SOP. For example, salbutamol could be administered by emergency care assistants class 2, emergency medical technicians, IHCD ambulance technicians, combat medical technicians class 1 and HCPC registered paramedics, whereas morphine chloride could only be administered by HCPC registered paramedics.
- The SOP also listed staff working for the service and their grade. However, it was unclear if this was a current list of staff working for the service and what the process was for maintaining the correct staff list when people joined or left the service.
- The SOP directed all staff named in the document to use the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) clinical practice guidelines as to use and delivery of medicines to patients.
- We found the medical SOP was not fit for purpose. The SOP did not substitute the need for PGDs and meant the service was supporting staff to work outside their legal capacity.
- It was reported by the registered manager that medical consultants at events would at times request medicines to be administered. There was no prescription and this request was not documented on the patient clinical record (PCR). We were told by the registered manager that if the doctor prescribed a medicine they would sign the PCR but we saw no evidence of this on the PCRs we reviewed.
- Midazolam had been introduced into the service at the request of an event doctor for the use of conscious sedation at boxing events. The service was unable to evidence the medical director or registered manager were aware midazolam was available in two strengths 1mg in 1mL and 10 mg in 2mL or the risks associated with the use of this medicine. The registered manager reported the service had purchased 10 ampules of the 10mg in 2mL. He was unable to provide a reason for the purchase of the higher strength medicine.
- The British National Formulary (BNF) states there have been reports of over dosage when high strengths of midazolam have been used for conscious sedation. Therefore, use of high-strength midazolam 10mg in 2mL ampoules, should be restricted to general anaesthesia, intensive care, palliative care, or other situations where the risk has been assessed. The medicine was not being used for these interventions in the service and it's use had not been risk assessed. This posed a significant patient safety risk.
- The BNF recommends flumazenil should be available when midazolam is used to reverse the effects if necessary. During the inspection the registered manager told us the rescue medicine for midazolam, flumazenil, was not available as it had not been purchased and senior staff were unaware it was required. This meant in the event of reversal being required it was not possible to do so, placing the patient at risk of harm.

Are emergency and urgent care services effective?

Requires improvement

We rated it as **requires improvement.**

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance. However, we were not assured the service checked to make sure guidance was up-to-date and followed by all staff.

- The service had policies and procedures in place. The policies we reviewed referenced some professional and national guidance. For example, the safeguarding vulnerable adults policy referenced the Health and

Social Care Act 2014 and the waste policy referenced the controlled waste regulations 1992 which was not the most current regulation as this had been amended in 2012. Therefore, we were not assured all policies referenced the most up to date regulations and national guidance.

- Not all policies we saw had been personalised for the service provided and some included information that was not relevant to the service. This meant staff could not always follow the information and processes provided in the polices.
- The service's policies did not include a review date. Therefore, we were not assured that policies were regularly reviewed and updated as necessary. It is important that policies are reviewed regularly, to ensure any updated guidance is included.
- None of the policies we reviewed referenced relevant National Institute for Health and Care Excellence (NICE) guidance. In addition, there were no systems or processes in place to receive, review and implement NICE guidance to ensure practice and policies reflected best practice. The registered manager stated that the service was exploring asking a member of staff to undertake this task but at the time of our inspection there was no one in this role.
- The registered manager told us all staff provided care and treatment to patients in line with the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) clinical practice guidelines and this would reflect current professional and best practice guidelines. We saw copies of the JRCALC guidelines at the station and carried by the registered manager and the staff member we spoke with.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way if required.

- We were told staff followed guidance provided in the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) guidelines to support them with their assessment of patients, and the type of pain they may be experiencing.
- Patient's pain levels were recorded on the patient clinical record (PCR). Adult patients rated their current pain level between zero and 10 with zero being no pain and 10 being the worse pain a patient has ever experienced. Paediatric patients used a similar scale but from zero to four. The PCR forms we reviewed showed that patient's pain levels were being assessed regularly and medication given if required.
- Registered paramedics and technicians could administer analgesia, as analgesia was contained within the medicine packs taken to events. Nitrous oxide, an inhaled analgesic gas, was also available on the ambulances used to convey patients to hospital.

Response times

- The service did not monitor response times. They did not provide a service that had response times targets.

Patient outcomes

There was no patient outcome monitoring in place to monitor the effectiveness of care and treatment and use the findings to improve them.

- Patient outcomes and effectiveness of treatment were not audited. It was reported by the registered manager that once the patient was handed over to the hospital the service received limited feedback and did not actively see feedback. With limited feedback provided, the service had no information or data to demonstrate that the treatment the service had administered to patients had been effective.

Competent staff

The service did not always make sure staff were competent for their roles.

- Staff records were held electronically and included their application form, a copy of their driving licence and DBS number along with the date the DBS was completed. We reviewed staff files and found them to contain this information.
- We did not see copies of staff qualification certificates. Records of these were not recorded on the electronic database and we were told by the registered manager the service did not hold paper staff files as all information was held on the electronic system.

Therefore, we could not review information, as none was kept on the electronic database or in paper format, to see if staff held the necessary qualifications and were competent for their role.

- There was no job description or identified roles and responsibilities, for example, the clinical leads. Therefore, it was unclear if staff were aware of the scope of their role.
- Information regarding driving of vehicles was kept on the annual training and licence sheet. We reviewed the 2018 form and found a tick indicated if the staff member's driver and vehicle licensing agency (DVLA) licence had been seen. There was a letter by the tick which was either B or C. However, there was no reference to what this letter represented. There was also a comment box for any further information, such as if the staff member could only drive automatic vehicles. Although driving licence checks had been carried out the form lacked details making it hard to interpret.
- We reviewed the driving policy and care of vehicles policy dated March 2017. This policy included information on emergency staff driving procedures, use of audible and visual warning, vehicle security and incident reporting procedures and the forms to be used. The policy referred to roles and documentation which the service did not have, for example, control and the pre-sentence investigation report. Therefore, we were not assured that the service had driving and care of vehicles policies relevant to the service.
- When we inspected the ambulances used to convey the patients, the forms required to log driving incidents were not on the vehicle. This meant the crew could not record the information required according to the service's policy and procedures.
- We were told by the registered manager there were no records held to show drivers had completed their blue light training. We were told this training would have been completed with the staff member's substantive employer. However, without this information being recorded there was no evidence only suitably trained and experienced staff drove on blue lights.
- There was a staff induction policy dated March 2018. This policy detailed the induction process for new staff and covered site-specific health and safety information for the ambulance station. This included, information management, start and end of shift procedures, patient handling, waste disposal, infection control, manual handling and vehicle cleaning.
- For some topics there were policies to read, for example waste disposal. However, for other topics, for example patient handling, it was unclear what was included in the training as there were no written information for staff to refer to. This meant there was no assurance that all topics had been covered and there was a consistent approach to induction of staff.
- A checklist was completed for each member of staff when induction and induction training had been completed. We were told by the registered manager the checklist would be returned to the administrator to update the personnel file and for the new member of staff to be issued with a pin number. This pin number was used on the service's forms to identify members of staff completed the documentation.
- No personnel files were kept at the ambulance station therefore we could not check if there were staff records and if there were whether they were stored securely or completed in full.
- Staff were expected to record and interpret ECGs as necessary. There was no assessment to confirm staff were competent to do this task and no audits of ECGs and patient clinical records to review if staff interpretation was correct.
- We saw no evidence of staff appraisals being completed. We were told by the registered manager discussions with staff about their performance would be more of an informal chat or a debrief after events. This meant there were no record of discussions with staff or the resulting actions decided on.

Multi-disciplinary working

Due to the nature of the service there was limited opportunities for staff to work with doctors, nurses and other healthcare professionals and support each other to provide good care.

- The registered manager told us they worked well with event organisers and other services that supported

events, such as security teams and Ministry of Defence doctors. This meant there was good communication and team working between all the parties who were involved with patient care at events.

- If required, patients were taken to the emergency department for continuation of their care. The registered manager told us they received good feedback about the effectiveness of their handovers and handover paperwork. However, there had been no formal feedback between trust's and the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, there were gaps in the service's systems and processes that supported staff in these decisions.

- The service had a patient consent policy dated January 2017. The policy included information on the types of consent and guidance on gaining consent from adults, children and patients who lacked capacity. The policy also contained information on the Mental Capacity Act 2005.
- However, the policy had not been personalised to the service and included staff roles and departments which did not exist in the company, such as the operations manager, the medical directorate and the clinical support desk. This meant staff could not accurately follow all the information and directions in the policy.
- The Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) was part of the mandatory training staff needed to have completed before commencing their employment with the service. From the mandatory checklist we reviewed we could not identify where and when the MCA and DoLS training had taken place, what the training included and when staff needed to renew or update their training. Therefore, there was no assurance of the competency of staff in the area.
- The patient clinical record (PCR) form prompted staff to assess patients' mental capacity before assessment and treatment took place. The PCRs we reviewed showed this had taken place for the 12 patients the service had conveyed between January and December 2018.
- Discussion with the registered manager and the member of staff showed they was a good understanding about consent and their responsibilities.

Are emergency and urgent care services caring?

Not sufficient evidence to rate

We were not able to inspect this domain as at the time of our inspection we did not observe care being delivered.

The service had conveyed 12 patients from January 2018 to December 2018. We did not have the details to contact these individuals.

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

Requires improvement

We rated it as **requires improvement.**

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of the event they were attending.

- The service was not commissioned by any NHS or private organisations to provide an ambulance service.
- The service covered a range of events held mainly in Berkshire and Hampshire regions these included religious and sporting events. The service also covered Ministry of Defence army boxing events in these and other counties. If required the service would convey patients from events to local acute NHS hospitals.
- Work was mainly undertaken for event organisers on an ad hoc basis and there was no formal contract issued. For the army boxing events there was a memorandum of understanding(MOU). A MOU is a formal agreement between two or more parties and they are used to establish official partnerships. MOUs are not legally binding but carry a degree of seriousness and mutual respect and state what is expected of each party. Post inspection we reviewed the MOU that was used between the service and the boxing events. Terms included that the service supplied a fully equipped ambulance and a

registered paramedic and emergency technician, worked in collaboration with the ringside doctor, and could supply and administer appropriate pre-hospital emergency care drugs.

- The registered manager planned staff numbers and skill mix to meet the needs of the event. This included having capacity to convey patients to the local NHS hospital, if necessary, from the events they were providing a service for.
- The registered manager told us a post event briefing was held with the organisers and staff to review the service provision at these events. This included whether people's needs were met and areas for improvement at future events. These meetings were not minuted therefore we had no evidence they occurred or what was discussed and if any improvements had been suggested.

Meeting people's individual needs

The service took some action to take account of patient's individual needs.

- It stated in the service's patient consent policy that 'the service was committed to ensuring that patients whose first language was not English received the information they needed and are able to communicate appropriately with healthcare staff.' It stated that staff had access to interpreting services and multi-lingual phrasebooks and that other specific advice could be sought from the diversity team based at headquarters (HQ).
- Prior to the inspection we were told that all ambulances had communication aids such as translation booklets. However, during the inspection we noted these were not present and there were no multi-lingual phrasebooks. The registered manager told us they had gone missing and due to the cost of replacement they would not be replaced. In addition, we identified the service did not have a diversity team as stated in the patient consent policy and the registered manager had no examples when an interpreting service had been used.
- The policy stated that it was not appropriate to use children to interpret for family members who do not speak English or for an adult family member to interpret for a child who does not speak English, which is good practice. We were told by the registered manager that some of the events they regularly covered employed doctors who had the relevant language skills to talk to patients in their native language. Staff told us if needed they could use an online translation service through their mobile telephones.
- The service did not have equipment to support conveyance of bariatric patients. We were told the local NHS ambulance service was used if a patient was assessed as needing bariatric equipment to be conveyed safely.
- The vehicle had different points for entry, which included tailgate lift, so people who were mobile or in wheelchairs could enter the vehicle safely. This took account of people's individual needs.
- The registered manager told us if patients were violent or aggressive the support of the police or event security would be sought. The service did not convey patients experiencing a mental health crisis who were agitated or refused conveyance. The service would seek the support of the police services to ensure these patients were safely conveyed to the local NHS acute hospital or mental health services by the local NHS ambulance trust.

Access and flow

People could access the service when they needed it and receive care in a timely way.

- The service only worked at events for which they had been awarded the agreement to provide a medical or first aid service. People could access the service at any time while at an event. Patients would be assessed by the crew and the event doctor, if there was one present, and a decision made if the patient needed conveying to hospital or could be treated and discharged at the event.
- The service did not monitor how long it took for crews to treat or transfer patient care and treatment over to the local acute NHS trust.

Complaints and concerns

The service could not evidence that it treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- The service had a complaints handling policy dated March 2017. The policy set out the actions, and timescales for investigating and responding to complaints. However, it was unclear how this policy related to the service as details in the policy were not fully relevant to the service provided. It referenced roles and departments that the service did not have including the training department, the patient experience department and a complaints champion. The policy also mentioned the service's website. However, the service did not have an active website.
- The policy stated the services 'will provide a substantive response within 28 working days, those cases deemed to be of significant complexity will be afforded a target of 45 working days and the most serious will have a target of 60 days'. This conflicts with the information provided pre-inspection which stated complaints were responded to as quick as possible.
- In the information submitted prior to the inspection the provider stated patients, carers and members of the public could provide feedback via the website, by email, letter or telephone. At the time of our inspection the provider's website was not active and therefore members of the public could not obtain information about the complaints process and the expected response times to acknowledge a complaint and provide a written response.
- There were no patient feedback or complaint leaflets available on the vehicles and we were told during the inspection that patient feedback was not collected and therefore not used to make improvements to the service.
- However, we did see a sign on the ambulances that said 'comments, concerns & feedback'. The sign gave patients and their relatives access to an email address and telephone number so they could contact the service.
- During our inspection the registered manager told us the service had not received any complaints since it was registered with the CQC. Therefore, we could not review any complaints documentation or see any changes in practice.

Are emergency and urgent care services well-led?

Inadequate

We rated it as **inadequate.**

Leadership of service

Although the manager at the service had the right qualifications to run a service, they lacked the necessary skills, knowledge or experience to effectively manage and develop a service. However, the manager was visible and approachable in the service for staff.

- The registered manager, a registered paramedic was also the director of the company and had responsibility for the premises, equipment and staff.
- The service had an identified medical director who undertook the role on a voluntary basis. It was not clear what his role or responsibilities were as there was no role description for this post or signed contract. The registered manager reported the medical director had limited input into the service and all meetings between them had occurred over the telephone or via a mobile phone application. There were no formal minutes from these conversations. Therefore, we were not assured of the clinical guidance being given to the service.
- Prior to the inspection we had received the organisational chart for the company. This indicated there were three operational supervisors and two clinical leads. However, during the inspection there was no mention of these roles existing in the company and we saw no role descriptions for these posts or evidence they had been recruited to.
- The registered manager told us they were frequently part of the allocated staff at events, giving them visibility both to staff working for the service and event organisers. We were told by a member of staff that the registered manager, if not working with them, was always available via the telephone for advice and guidance.
- Often during the inspection the registered manager told us they found the governance side of the business

challenging. During the inspection the registered manager would tell us of colleagues and acquaintances they could call on for support and advice. However, this was more on an informal level and it was unclear how much input they were having into the service. From speaking with the registered manager and reviewing documentation we were not assured the registered manager understood their responsibilities or had the knowledge and skills required to effectively manage and develop a service to comply with many of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was no nominated deputy to cover for the registered manager in the event of their unavailability such as sickness and holidays. This meant there was a weakness in the service as the service did not have a documented plan should the registered manager be unavailable.

Vision and strategy for this service

The provider had developed a vision for what they wanted to achieve. However, there was no formal strategy to turn it into action.

- The provider's vision for the service was 'to deliver world class patient services through a skilled and committed workforce". The service had four strategic objectives to deliver this vision by 1) meeting NHS, industry and CQC standards in quality and performance, 2) ensure sound financial management, 3) deliver the recommendations from regulatory and professional associations and 4) work towards expansion and development of the service provided. We saw no formal plan to achieve these objectives.

Culture within the service

There were indications that the service promoted a positive culture that supported and valued staff.

- The service had a whistle blowing policy dated March 2017. This indicated that the service encouraged an environment where staff would feel comfortable and there was a framework to raise concerns. However, the policy referred to role and departments that did not exist in the company such as the director and manager of the human resources department.It also referred to a flow chart in appendix 2 to guide staff on how to raise a concern but this was not included in the policy. Post inspection we request appendix 2 of the whistle blowing policy but we did not receive it. Therefore, we had no evidence the flow chart existed. In addition, at the end of the policy it said the next review should be carried out in October 2013.
- We only spoke to one member of the team during the inspection. They indicated the registered manager promoted a caring and positive culture for staff. We were told the team were like a family with many staff having worked in the service for many years.

Governance

There were a lack of systems and processes to improve service quality and safeguard high standards of care.

- There was no process or programme to ensure policies and procedures were reviewed. All policies we looked at had no review date on them. Our review of 14 policies and procedures showed they were not written for the current needs of the service. Throughout the policies there were descriptions of the responsibilities of job roles that did not exist in the service. This included head of patient experience and the human resources team. Many of the policies described functions such as the NORMs reporting system that did not exist in the service. This did not provide assurance that policies and procedures were fit for purpose.
- The service carried out limited audits of the service. This meant areas for improvement could not be identified and changes made to the service to improve patient care and safety.
- We were told checks were made to ensure staff who worked for the service had the necessary skills and competencies to carry out their role. However, we saw no evidence of this and the service did not follow a documented process or record information in a way that could effectively demonstrate this.
- There were no recorded governance meetings between the registered manager and the medical director. Therefore, there was no assurance of the clinical guidance the medical director provided to the service.
- All meetings between the registered manager and staff were informal. Therefore, there was no record of governance, risk and performance being discussed with staff.

- There was an absence of governance relating to the introduction of new medicines. During the inspection we were told that Midazolam had been introduced into the service in October 2018.Midazolam is a medication used to cause drowsiness and decrease anxiety. It is used for anaesthesia, procedural sedation and severe agitation. It is also useful in the treatment of seizures. The registered manager told us it had been introduced into the service at the request of an army boxing doctor as a conscious sedation to assist with the removal from the boxing ring of injured boxers if necessary.
- We asked to see to see evidence of the systems and processes, including risk assessments and staff training records, that had been followed to ensure this new medicine was appropriate for the service provided and introduced in a safe way for both staff and patients.
- The registered manager was unable to provide this evidence. There had been no formal discussion with the medical director regarding the introduction of midazolam, there had been no assessment of clinical risk and there had been no documented training or assessment to ensure staff administering midazolam were competent to do so.
- Post inspection, we were told by the registered manager that midazolam had been introduced into the paramedic pouches in November 2018 after the paramedics confirmed they had read the JRCALC to familiarise themselves with its uses and contraindications of the drug. There was no evidence of these conversations or that staff were trained in the use of midazolam. In addition, the medical SOP, the way in which the service gave staff the authorisation to purchase, hold, store and administer medicines, was not updated until January 2019 to include midazolam. This meant for three months the medical director had not given authorisation for midazolam to be in the service.
- During the inspection, the registered manager told us that since midazolam had been introduced into the service it had not been administered to any patients. However, post inspection we were told midazolam had been used by a doctor at a boxing event in February 2019. The medicine had been requested by the doctor from the paramedic and the doctor had administered it to the patient. We were supplied no documentation of how this was recorded, the dose given to the patient or how unused medicine was disposed of. This meant we had no evidence of the safe use of the medication or of its management.

Management of risk, issues and performance

The service had systems in place to identify risks. However, these had not always been effective in identifying risks and where improvements were required.

- The service did not have a risk management policy but there was a risk strategy. This risk strategy which was not dated, detailed that risk to the service was covered or recorded in the company risk register, company policies and the event risk assessment.
- Types of risk to the service were covered in the adverse incident reporting and investigation policy, this included clinical, operational and financial risks and there was a Health and Safety risk management policy dated February 2017 which covered risks in the workplace.
- We reviewed the company risk register, which was referred to by different names in the policies. For example, the company risk register in the risk strategy and the corporate risk register in the adverse incident reporting and investigation policy. There were five current open and ongoing risks which included staffing levels and computer failure/data loss. Each risk was dated, had a date for review, was rated according to the risk management framework and included how the risk was mitigated. The registered manager had a good understanding of operational risks to the service.
- The service used an event risk assessment. This assessment was used to assess the potential risks of activities undertaken, the event and the workplace. The assessment reviewed hazards, those at risk were identified, what the existing control measures were, the level of risk as defined by the risk management framework and if there were any additional control measures.
- The registered manager gave us the example of driving the ambulance around the event and transporting the patient or returning to the event. The risk identified was the entry and exit of the vehicle from the event site,

which would put the patient and staff at risk. To mitigate the risk staff needed to plan where best to position the vehicle to allow easy exit from the event via arranged routes.

- Pre- and post-inspection we reviewed documentation relating to risk. We could not find details about the risk management framework which categorised risk into low (green), medium (amber) and high (red) risks by the service. Without a formal explanation it was unclear how the risk rating process was carried out and effectively monitored.

Information Management

The service did not always collect, analyse and use information to support activities.

- The registered manager did not keep detailed records to support all activities of the service delivered.
- Access to electronically held records and information was password protected. This meant only authorised members of staff had access to the information. We saw that computers were locked when left unattended.
- As many of the policies and procedures were not relevant to the service, we were not assured there were effective arrangements or processes in place to ensure data or notifications were submitted to external bodies as required. The registered manager told us he had not needed to notify any external bodies of any issues. Therefore, there was no information for us to review.

Public and staff engagement

There were limited processes in place to engage with the public and staff.

- There were no patient feedback or complaint leaflets available on the vehicles and we were told during the inspection that patient feedback was not collected and therefore not used to make improvements to the service.
- There was a box in the ambulance station where staff could leave feedback for the registered manager. The registered manager told us there had been no feedback from staff using the box. We were told staff would feedback verbally whilst working alongside the registered manager or via the telephone, there was no record of these conversations or evidence of changes made as a result of staff feedback.

Innovation, improvement and sustainability

- At the time of our inspection, the service did not have a formal approach to identify any innovation or improvement to work towards to improve the quality of care provided.
- The registered manager told us the service was committed to providing a caring and safe service to their patients and the company's success and sustainability was measured by being recommissioned by event organisers.
- We were told by the registered manager the service participated in a scheme where they donated old medical equipment and consumables to developing countries. During the inspection we saw consumables and equipment stored ready to be taken away by the charitable organisation. However, not everything was stored and labelled to indicate it was for this possible. This meant there was a risk old equipment and medical equipment could be reintroduced into the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The service must ensure there is an effective incident reporting system in place, with incident report forms accessible to staff.
- The service must ensure staff records are completed with enough detail to give assurance that staff working in the service had the relevant qualifications, competence, skills, capabilities and had completed appropriate mandatory and safeguarding training for their role and to deliver safe care and treatment.
- The service must ensure patients and staff are not put at harm from the risk of cross infection.
- The service must ensure there is safe management of medicines which complies with national guidelines and legislation.
- The service must ensure all policies and procedures are relevant to the service delivered, accurately reflect current legislation and national guidance and include a review date.
- The service must ensure there are job descriptions which identify roles and responsibility, this must include the medical director's role in the service.
- The service must ensure there is a governance process followed to support systematic improvement of service quality and safeguards high standards of care.

Action the hospital SHOULD take to improve

- Consider developing and implementing a more detailed form to record vehicle checks, load list and cleaning procedures pre- and post-use.
- Review storage and use of out of date consumables and old medical equipment to avoid out of date stock being reintroduced into use.
- Consider the including a medicine content and usage sheet in all medicine pouches.
- Improve how all ambulance keys are stored to keep them secure.
- Consider using five-point harnesses in ambulances to minimise injury to patients if the ambulance was involved in a collision.
- Standardise the location of equipment in its ambulances and making sure cupboard labels match the content so equipment can be found in a timely manner.
- Maintain records of all administration of the service's medicines by event doctors.
- Explore and implement systems and processes for monitoring patient outcomes to demonstrate the effectiveness of show how treatment provided.
- Improve how the review of staff performance is documented.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(1)(2)(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safety. Regulation 12(1)(2)(g) the proper and safe management of medicines; Regulation 12(1)(2)(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); • There was no effective incident report system in place for staff. • Not all policies and procedures were relevant to the service delivered • There was limited governance of the service.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19(1)(b) persons employed for the purposes of carrying on a regulated activity must have the qualifications, competence, skills and experience which are necessary for the work to be performed by them.** **Regulation 19(2) recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions.** • There were no job descriptions to identify roles and responsibilities and the necessary qualifications, competences, skills and experience needed for each role in the service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. Regulation 17 HSCA (RA) Regulations 2014: Good governance There was an absence of governance relating to the safe introduction of new medicines into the service.