Viking Medical Solutions Ltd

Viking Medical Solutions

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Viking Medical Solutions is operated by Viking Medical Solutions Ltd. We inspected patient transport services only. This was a very small aspect of the activities that the service provides as the main service is event first aid cover and first aid training, which are out of scope of regulation.

At the time of our inspection the service employed two permanent staff, including the registered manager for the service. Viking Medical Solutions used the support of 49 other temporary bank staff, many of whom are employed in other substantive roles within NHS organisations. The service has two vehicles which can be used for conveying patients however only one was available for use at the time of our inspection. The other being off the road at the time of inspection with engine trouble.

We inspected the safe and well led areas of the service using our responsive inspection methodology. We did this in response to concerns being raised with us relating to issues under these domains. We carried out the short announced inspection on 14 August 2019. We did not rate the service on this occasion and found;

- The service provided mandatory training in key skills including safeguarding to all staff and made sure everyone completed it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.
- Staff completed risk assessments for each patient and removed or minimised risks.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and ensured all bank staff had a full induction.
- Staff kept suitable records of patients' care and treatment. Patient record forms (PRFs) were clear, stored securely and available to staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Staff recognised incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Staff we spoke with were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service leaders had the clinical knowledge and skills to run the service. They were visible and approachable and supported staff to develop their skills.
- There was a strong focus on providing quality event care and developing the business to participate in the patient transport market.
- They had plans to cope with unexpected events and managers ensured day to day decisions avoided financial pressures compromising the quality of care.
- The service leaders were responsive following issues and concerns raised and worked swiftly to put processes in place to identify and monitor risk.

However, we found the following issues that the service provider needs to improve:

- The service leaders lacked oversight of the priorities and issues the service faced.

Summary of findings

- The design, maintenance and use of facilities, premises and equipment were not always managed to keep people safe.
- Managers investigated incidents but it was not obvious if lessons learned were shared with the staff.
- The service did not have a formal vision or business strategy in place to help deliver on strategic and operational objectives,
- The governance processes were insufficient, however on identifying weaknesses the service worked swiftly to resolve these.
- There was a lack of documented risk management and performance.

Following this inspection, we told the provider that it must make improvements, to help the service improve.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Viking Medical Solutions

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Viking Medical Solutions

Viking Medical Solutions is operated by Viking Medical Solutions Ltd. The service started in June 2018. It is an independent ambulance service in Ipswich, Suffolk and primarily serves the communities of the East Anglia area.

Viking Medical Solutions mainly provides event support and first aid training which is currently not regulated but also provides repatriation, non-emergency private patient transport and supports other local independent ambulance services for people living in the East Anglia area.

The service has had a registered manager in post since 29 June 2018.

The service is registered to provide the following regulated activities:

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

Due to the nature of the service, the only permanent members of staff are the registered manager and the operations manager. The rest of the staff are employed on a 'bank staff' basis and are comprised of; six registered paramedics, two nurses with the rest working as either technicians or ambulance healthcare assistants. The accountable officer for controlled drugs (CDs) is the registered manager.

Track record on safety

- Zero Never events
- Clinical incidents; four no harm, zero low harm, zero moderate harm, zero severe harm, zero death
- Zero serious injuries
- Three complaints

Activity August 2018 to July 2019

There were four patient transport journeys which were within regulated activity undertaken.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector with a paramedic background. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Detailed findings

How we carried out this inspection

We inspected this service using our responsive inspection methodology as a result of concerns raised in relation to staff training and competency, infection, prevention and control, incident reporting and medicines management. We carried out a short announced (24 hours' notice) inspection on 14 August 2019.

During our inspection, we visited the Ipswich base. We spoke with three staff; the registered manager and the operations manager and one other staff member. We reviewed documentation including; policies, staff records, training records, cleaning records, four patient records and inspected one ambulance.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Viking Medical Solutions is an independent ambulance service based in Ipswich, Suffolk and primarily serves thecommunities of the East Anglia area.Viking Medical Solutions mainly provides event supportand first aid training which is currently not regulated, butalso provides repatriation, non-emergency private patienttransport and supports other local independentambulance services for people living in the East Angliaarea.

Summary of findings

We inspected the service as the result of concerns raised relating to the safe transport of patients and the governance of the service.

During our inspection we found that there were enough staff with the right qualifications, skills and experience who had completed the appropriate safeguarding and mandatory training to treat and care for patients safely. The service leaders had the clinical knowledge and skills to run the service and were responsive following issues and concerns raised and worked swiftly to put processes in place to identify and monitor risk.

However, the service provider needs to improve oversight of the maintenance and use of equipment and risk management, performance and governance processes.

Patient transport services (PTS)

Are patient transport services safe?

We did not rate the service following this inspection.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The service provided a range of mandatory training both face to face and through on-line training including but not limited to; infection prevention and control, moving and handling, information governance, safeguarding of children and vulnerable adults, incident reporting, equality and diversity, capacity to consent and duty of candour.

We reviewed the staff records and saw evidence of mandatory training completion on induction included in all of the 10 staff records we looked at. However, there was no process to update or check staff mandatory training following completion of induction.

Following our inspection we saw evidence that staff had created an electronic register to monitor training compliance as well as other staff compliance for example; driving licence and safeguarding. Overall mandatory training compliance was 98%. The register used a traffic light system to denote staff who had completed training (green), staff who were due to complete training (amber) and staff who were overdue (red).

Managers confirmed that staff who had not completed mandatory training were not booked to work.

Safeguarding

The service trained staff in how to recognise and protect patients from abuse. All staff had the appropriate level 2 adult and children safeguarding training as part of their mandatory and ongoing annual training.

The service had a safeguarding policy which was accessible to staff. It outlined responsibilities, types of abuse and contact details.

New staff received an overview of safeguarding policies as part of the induction process. The registered manager was the safeguarding lead and had a level three certification.

The management staff we spoke with were able to describe how to recognise a safeguarding concern and knew what actions to take and how to refer to the local authority although the service had not had to do so prior to our inspection.

The service ensured that Disclosure and Barring Service checks were completed for all staff prior to employment and we saw evidence of this in staff personnel files.

Cleanliness, infection control and hygiene

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

The service had an in-date cleanliness and infection prevention and control (IPC) policy which staff were required to read during their induction. The policy included guidance on hand hygiene and the use of personal protective equipment. The policy also outlined standard operating procedures for cleaning of the vehicles and dealing with heavy soiling.

The vehicle and equipment we inspected was visibly clean and tidy. The service had a process for cleaning the ambulance vehicles after use and deep cleaning using a steam cleaner on a three monthly basis. We saw evidence that staff signed to confirm both cleaning and three monthly cleaning had been completed on the cleaning rotas.

Personal protective equipment was readily available and personal issue uniforms were supplied by the provider. Staff were responsible for ensuring they laundered their uniforms in line with the local policy. There were arrangements in place for ensuring uniforms were replaced when they became worn or where they had been heavily contaminated.

At the base there was a room in the process of being converted for use as a utility room although this had not yet been completed at the time of inspection. There were temporary facilities for storage of cleaning supplies in a storage cupboard in the corridor of the building.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment were not always managed to keep people safe.

Patient transport services (PTS)

The service base included office, storage and training space but did not include any enclosed garage space for the vehicles. This meant that they were parked in publicly accessible industrial unit car park whilst not in use. Staff ensured that vehicles were always locked when there was no crew member present and the keys were stored securely in the office.

The service owned two ambulances although at the time of inspection only one was in use due to the other vehicle having mechanical trouble. There was no process for ensuring compliance with the Ministry of Transport (MOT) certification for ambulances. The MOT is an annual test of vehicle safety, roadworthiness aspects and exhaust emissions required in the United Kingdom for most vehicles over three years old used on any way defined as a road in the Road Traffic Act 1988. The MOT certificate for the ambulance in use was out of date on 5 July 2019 which meant that it was not legally usable on a public road from this date. Staff said that this had been filed in the wrong vehicle folder and immediately contacted the garage and arranged to have the ambulance MOT tested on the day of the inspection. We were concerned as this meant that the vehicle may have been illegally used to when transporting a patient at the end of July 2019. Following our inspection, the service provided evidence of the MOT certificate granted on the day of inspection.

The service had an arrangement with a local nearby garage which allowed prompt repair of vehicle defects. We could see from records that vehicles were regularly maintained and serviced although due to the low annual mileage of the vehicles, servicing was not done at the same time as the MOT.

At the time of inspection clinical waste was not securely stored or routinely removed. The service had an external yellow clinical waste bin located outside the building for the disposal of clinical waste. This was not locked and was less than half full but had not been emptied for more than 12 months prior to our inspection. This meant that potentially contaminated clinical waste was left in the bin and as this was not locked it was insecure and accessible to the public. There was a contract with the local council to empty the bin when required. The staff said that the bin had been assessed as low risk due to the general lack of contaminated material, however were unable to confirm what the bin contained. Following our inspection the service purchased a lockable clinical waste bin and arranged for the bin to be emptied either quarterly or when it was half full, whichever occurred earlier.

We inspected the ambulance in use and found that all equipment inside was within service date and well organised. The consumables and life support equipment for the ambulance were neatly stored and all within use by date.

There were detailed, planned, and preventative maintenance schedules available for review during the inspection. However, there was no plan for annual MOT testing. Annual servicing of medical equipment including resuscitation and patient monitoring equipment and stretchers was undertaken.

Disposable single use equipment was kept in a dry storeroom and all consumable items we reviewed were within expiry date. There were pre-packed individual kit bags stored for use by ambulance crews and all equipment was correctly sealed and within date. There was a stock rotation system in use to ensure that disposable equipment was used in date order to avoid waste of expired items.

Medical gases were secured appropriately on the vehicle and within the ambulance storage facility. There were arrangements in place for obtaining additional medical gases on an ad-hoc or as-needed basis. This allowed the provider to only carry minimal levels of medical gases at any given time, therefore reducing the overall waste and reducing any risks associated with the storage of multiple compressed cylinders.

Firefighting extinguishers were readily available; these were serviced on an annual basis.

Assessing and responding to patient risk

Staff completed risk assessments for each patient and removed or minimised risks.

The service had a recently developed (August 2019) booking and planning policy which acted as an exclusion and inclusion criteria with one of the exclusions that they did not transport children due to having no child safety restraints in the vehicle.

Patient transport services (PTS)

The patient record forms (PRFs) we reviewed showed that staff assessed patient's suitability for transport and monitored them and their vital life signs where appropriate during transport to detect any deterioration in their condition.

All staff on the ambulance had been trained in intermediate life support, which gave them initial skills to notice if a patient was deteriorating, and when to call emergency help.

The service had an emergency and escalation policy and patient procedure if a patient deteriorated during a journey. This provided guidance on stopping the vehicle, when safe to do so, to assess the patient and call 999 for emergency support if required.

Dependent on the staff who crewed the ambulance the service was able to transport patients in an emergency as some staff were trained paramedics and had 'blue light' vehicle training but there had been no incidences of this since registration.

Staffing

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

The service employed a range of health professionals to support the provision of services. Due to the flexible nature of the service, the ambulance crews were employed via bank staff contracts.

Allocation of staff was assessed by the registered or operations manager for each booked conveyance. Staffing was planned to ensure staff had the correct skills to meet the needs of patients booked for conveyance.

There was flexibility within the staffing model to enable the provider to organise additional capacity, depending on the outcome of individual patient risk assessments.

There was an appropriate process in place for checking the professional registration of health professionals. A review of staff files confirmed appropriate checks had been carried out, in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records

Staff kept suitable records of patients' care and treatment. Patient record forms (PRFs) were clear, stored securely and available to staff providing care.

There was limited opportunity to review PRFs due to the small number of regulated activity transports carried out by the provider which fell within the scope of registration however, the four records that we did see contained all necessary information relating to patient assessments and transport.

The service retained all records which were directly attributable to the delivery of care and completed PRFs were securely stored in a locked cabinet at the registered office.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The service had a version controlled medicines management policy in place at the time of our inspection which was reviewed in August 2019 and compliant with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines 2016. The policy defined designated roles, individual responsibilities and restrictions, procurement and disposal arrangements along with recording systems.

The paramedic staff carried a range of medicines for emergency purposes when conveying patients which were safely stored in a locked cabinet at the base in line with regulatory requirements. Paramedic staff booked out medications for use and returned unused stock at the end of a shift. Medicines could be securely stored in a locked cabinet in the vehicle during transit. There was no medicines stock requiring refrigeration at the time of the inspection.

The provider had a service level agreement in place for the supply of medicines from a local pharmacy and the registered manager was the controlled drug accountable officer (CDAO). At the time of our inspection the service was in the process of arranging to appoint a medical doctor on a consulting basis. Following our inspection we saw evidence that this had taken place and that the service were in the process of setting up 42 patient group directions (PGDs) to enable non paramedic ambulance staff to administer a range of medications. PGDs provide a

legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.

Medical gases were available on the vehicle with back up supplies at the ambulance base.

Incidents

The service managed patient safety incidents appropriately. Managers were aware of what should be reported including incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. The managers investigated incidents but it was not clear if lessons learned were shared with the staff.

The service had an in date incident reporting and investigation policy. The policy included information relating to the incident reporting procedure, such as; definitions of relevant terms including, adverse incident, hazard, risk and near miss; the incident reporting procedure and how to investigate an incident.

The service recorded incidents on a paper incident form kept in an 'Incident folder'. We reviewed the four incidents in the folder. These were reported appropriately, and detailed actions taken including outcomes however, the incidents were not numbered, and there were no recorded lessons learned or evidence of shared learning. The service reported that they did have a staff bulletin and social media group where details of learning from incidents or audits was shared available on the staff notice board but at the time of inspection there was no incident information displayed.

Following our inspection, the service provided evidence of the development a new electronic incident reporting system which was available to all staff to access and view. We saw one incident report on the new system which had been graded with learning actions. The new medical consultant was contracted to review all clinical incidents. Staff were alerted when an incident occurred and there was a requirement to view the incident learning with manager oversight of those who had accessed the learning.

The registered manager described the process of how all incidents were referred back to them for investigation where applicable.

There were no incidents that required the service to offer duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw one incident where an explanation and apology had been given to a patient following an incident.

Are patient transport services effective?

Effective was not assessed at this inspection.

Are patient transport services caring?

Caring was not assessed at this inspection.

Are patient transport services responsive to people's needs?

Responsive was not assessed at this inspection.

Are patient transport services well-led?

We did not rate the service following this inspection.

Leadership

The registered manager, a registered paramedic was also a director of the company and had responsibility for the premises, equipment and staff.

The registered manager had the clinical knowledge and skills, to run the service Through maintenance of their professional qualification. However, they lacked oversight of the priorities and issues the service faced, as described below. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

We saw that all staff were encouraged to undertake training and develop skills with managers working alongside the bank staff to provide support and experience. We saw evidence of this in staff personnel files.

Vision and strategy

Patient transport services (PTS)

The service did not have a formal vision or business strategy in place to help deliver on strategic and operational objectives. However, there was a strong focus on providing quality event care and developing the business to participate in the patient transport market.

The service managers were focused on sustainability and development of services within the local and wider community. They worked with other local independent ambulance services to provide services commissioned by the local clinical commissioning group.

Culture

We were unable to speak with the core of bank staff. However, we saw comments from an anonymous staff survey which said that the managers were “friendly, approachable and always available”.

Governance

The governance processes were insufficient with a lack of effective governance structures. There were concerns regarding; oversight of vehicle MOT compliance, clinical waste disposal, mandatory training compliance and sharing of incidents. However, on being informed of weaknesses in these areas, the service worked swiftly to resolve them. The registered manager and the operations manager were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We saw evidence of a medicines record audit the service had completed and there was a process for checking and auditing the completeness of the vehicle equipment check forms.

There was a ‘regulatory board’ in the office which displayed copies of the service liability insurance, an Information Commissioner's Office (ICO) certificate to show compliance with the Data Protection Regulations 2018 and their CQC registration.

However, there was inconsistent oversight of a number of governance concerns. For example; the service had no formal reminder system to ensure that the vehicles were safe to use as evidenced by the vehicle with the out of date MOT. Following our inspection the service provided evidence that they had introduced an electronic calendar reminder for all equipment and vehicle maintenance tests, had added monitoring of reminders to the quality assurance meeting agenda, and had a board with the dates highlighted.

During our inspection we saw that there were no robust systems in place to ensure staff were supported to keep their mandatory training and competencies up to date following their initial period of training and induction. We raised this as a concern with the service and following our inspection the service developed an electronic monitoring spreadsheet for all staff mandatory training and competencies using a traffic light (red, amber green) to denote staff who were due or overdue training or competency updates.

The service held bi-monthly quality assurance meetings with a standard agenda which included; attendance, clinical matters arising, corporate matters arising, staffing matters, feedback/complaints, compliance /audits resources/equipment and health and safety. We reviewed five sets of meeting minutes and although documentation was relatively brief it did cover all agenda items and the reported incidents. The minutes were stored in a folder accessible to staff.

Management of risks, issues and performance

The service did not have a risk register or equivalent document at the time of our inspection and we were not assured that all risks to the service were identified and action taken to resolve. We discussed this with the managers who knew the risks to the service but did not have any documented actions. Following our inspection we saw that the service had developed a risk register which contained 15 risks related to the running of the service. These included some inherent risks, for example; vehicle breakdown and maintenance and financial stability. Risks had creation dates, ownership and were red, amber, green (RAG) rated. The red rated risk was related to the financial status of the organisation and planned for review on a monthly basis at the governance meeting going forward.

There was a lack of documented risk management and service performance review, however following this being raised as a concern, managers worked swiftly to put processes in place to identify and monitor risk. They had plans to cope with unexpected events and managers ensured day to day decisions avoided financial pressures compromising the quality of care.

Patient transport services (PTS)

The service did not have a formal performance review process as there were such limited episodes of care that fell within the regulated activity, however should activity increase they had the ability to monitor and audit timeliness of transfers.

Relevant insurance and indemnity certificates were available and valid at the time of the inspection.

Information management

The service had limited ability to collect reliable data and analyse it due to the small number of regulated patient transfers however, any electronic information they did collect was securely stored on password protected computers and all paperwork in locked cabinets.

Staff engagement

The service mangers actively and openly engaged with patients, and staff using e-mail and electronic social media. We saw comments posted on the social media site and on the service's own website and were shown the 'staff only' electronic social media site used for the quick relaying of messages.

Innovation, improvement and sustainability

Not inspected at this inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must continue to ensure that newly implemented governance processes are embedded and regular oversight is in place to ensure effective ongoing management of risk and performance.
- The provider must ensure that all vehicles are MOT tested and certificated.

Action the hospital SHOULD take to improve

- The provider should ensure that incident learning is shared with all staff.

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 17 HSCA (RA) Regulations 2014 Good governance **The provider must continue to ensure that newly implemented governance processes are embedded and regular oversight is in place to ensure effective ongoing management of risk and performance, specifically; oversight of vehicle MOT compliance, clinical waste disposal, mandatory training compliance and sharing of incidents.**