Lifestar Medical Limited

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Quality Report

Lifestar Medical Limited
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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 know to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Lifestar Medical Limited is a small, family run, independent ambulance service, based in Cornwall but providing some services out of the county. Lifestar Medical Services has one depot in Truro, Cornwall.

The service provided includes patient transport for admissions/discharges and hospital appointments, long distance repatriation, organ and surgical team support, holiday transport for clients with mobility issues, neonatal transfers, high dependency/ITU transfers, specialist bariatric transfers and event cover.

In England, the law makes event organisers responsible for ensuring safety at the event is maintained, which means that event medical cover comes under the remit of the Health & Safety Executive.

Lifestar Medical Limited is registered with CQC to provide the regulated activities of:

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

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 25 July 2017.

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?

Services we do not rate

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

We saw that:

- Incidents and complaints were well managed, staff were aware of the duty of candour and the need to be 'open and honest' regarding incidents.
- There were reliable systems to keep patients and staff safe and safeguard them from abuse and avoidable harm. All records were stored securely to ensure patient confidentiality.
- Staff training was provided to enable staff to be competent in their roles and staff were provided with timely appraisals and learning opportunities. There was a sufficient skill mix and level of staff to meet the needs of patients. Bookings were reviewed to ensure the appropriate assessment and planning of care took place to meet patients' needs.
- Staff records showed a high level of attendance at training; however, no overview was available to ensure any gaps in training were identified. This was planned to be put in place. Appraisals had been completed for all staff. Supervision of staff was ongoing, but as an informal process.
- Cleanliness and infection control prevention for the environment, vehicles and equipment was in place and monitored by the infection control lead.
- During the inspection we were not able to observe any patient journeys or direct care but noted staff spoke in a caring and insightful way of patients in their care. Consideration of the patient and staff needs was undertaken when planning patient journeys, both locally and nationally. Feedback from people who use the service, those who are close to them and stakeholders were consistently positive about the way staff treated people.
- Through staff interviews and observations we saw there was good leadership of the service from the managing director and the registered manager. The provider had introduced a system to obtain patient experience feedback of their journey. This development was in its infancy but was being supported with staff involvement.

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 that included several areas of medicine practice. Details are at the end of the report.

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

- Some aspects of medicines practice required further attention to ensure patients were not at risk. These areas included the provider not having the correct licence in place for the storage of controlled drugs. Further areas for improvement included storage of oxygen and medical gases and the lack of patient group directions (PGDs) for patient medicine administration. The recording of controlled drugs was in place but two full signatures for each controlled drug administration were not being recorded. Some first aid items such as dressings were noted to be out of date and thus no longer suitable for use.
- Following the inspection the managing director has confirmed that an application to obtain a licence from the Secretary of State for the storage of controlled drugs is underway. He has also updated CQC with his continued efforts to arrange Patient Group Directions (PGDs).
- A management overview of aspects of safety was not undertaken to ensure that all of the processes in place were being completed. These areas included cleaning of vehicles, equipment checks in vehicles, management of clinical waste and used linen and overviews of staff training.
- Not all paramedic staff dealing clinically with patients had level 3 safeguarding training. The provider confirmed this will be addressed.
- Policies were not referenced to National Institute for Health and Care Excellence (NICE) or The UK Ambulance Services Clinical Practice Guidelines 2016 to ensure they followed national guidelines.
- There were no audit outcomes of key performance indicators such as times of collection of patients and the monitoring of delays and aborted journeys. Data about the services provided was available, but the provider did not work towards any key performance indicators.
- Data and information was gathered but the provider was not using this to measure the quality of the service. Audit of aspects of service were not undertaken to identify the service's strengths and areas for further development.
- Risk management was not recorded to identify how risks were measured and monitored. No risk registers were in place.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We saw that: • Incidents and complaints were well managed, staff were aware of the duty of candour and the need to be 'open and honest' regarding incidents. • There were reliable systems to keep patients and staff safe and safeguard them from abuse and avoidable harm. All records were stored securely to ensure patient confidentiality. • Staff training was provided to enable staff to be competent in their roles and staff were provided with timely appraisals and learning opportunities. There was a sufficient skill mix and level of staff to meet the needs of patients. Bookings were reviewed to ensure the appropriate assessment and planning of care took place to meet patients' needs. • Staff records showed a high level of attendance at training; however, no overview was available to ensure any gaps in training were identified. This was planned to be put in place. Appraisals had been completed for all staff. Supervision of staff was ongoing, but as an informal process. • Cleanliness and infection control prevention for the environment, vehicles and equipment was in place and monitored by the infection control lead. • During the inspection we were not able to observe any patient journeys or direct care but noted staff spoke in a caring and insightful way of patients in their care. Consideration of the patient and staff needs was undertaken when planning patient journeys, both locally and nationally. Feedback from people who use the service, those who are close to them and stakeholders were consistently positive about the way staff treated people.

Summary of findings

• Through staff interviews and observations we saw there was good leadership of the service from the managing director and the registered manager. The provider had introduced a system to obtain patient experience feedback of their journey. This development was in its infancy but was being supported with staff involvement.

However :

• Some aspects of medicines practice required further attention to ensure patients were not at risk. These areas included the provider not having the correct licence in place for the storage of controlled drugs.

Further areas for improvement included storage of oxygen and medical gases and the lack of patient group directions (PGDs) for patient medicine administration.

The recording of controlled drugs was in place but two full signatures for each controlled drug administration were not being recorded. Some first aid items such as dressings were noted to be out of date and thus no longer suitable for use.

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• A management overview of aspects of safety was not undertaken to ensure that all of the processes in place were being completed. These areas included cleaning of vehicles, equipment checks in vehicles, management of clinical waste and used linen and overviews of staff training.

• Not all paramedic staff dealing clinically with patients had level 3 safeguarding training. The provider confirmed this will be addressed.

• Policies were not referenced to National Institute for Health and Care Excellence (NICE) or The UK Ambulance Services Clinical Practice Guidelines 2016 to ensure they followed national guidelines.

Summary of findings

• There were no audit outcomes of key performance indicators such as times of collection of patients and the monitoring of delays and aborted journeys. Data about the services provided was available, but the provider did not work towards any key performance indicators.

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Lifestar Medical Limited

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Lifestar Medical Limited

Lifestar Medical Ltd was established in 2004 and is a family run independent ambulance service, located in Truro, Cornwall. The service provides patient transport services and medical transportation primarily across Cornwall and Devon, and also across the UK.

The managing director of the company works as a paramedic and the registered manager works in the office and also as an ambulance care assistant. The registered manager has been registered with CQC since 2011.

The service was last inspected in 2014. No previous regulatory action has been taken.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,and two other CQC inspectors. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

Facts and data about Lifestar Medical Limited

The service is registered to provide the following regulated activities:

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

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

The majority of work undertaken was patient transfer journeys. Some higher dependency provision was available in the form of patient transfers which required a registered paramedic in attendance.

In the last year, July 2016 to July 2017, the service had provided 1,742 patient transfers and 217 paramedic transfers. The service provided is mostly Cornwall county based, with some work in Devon, but some journeys were patient transfers to other parts of the country.

The service undertakes sub-contracted work and work undertaken at short notice. It does not currently hold any contracts for regular patient transfers. Contracts were in place with Devon and Cornwall Clinical Commissioning Groups for trained crew transfers. Private work undertaken includes patient transport services where sometimes medicines need to be administered. The service will then put on a qualified team.

Detailed findings

The service employs 21 staff in total – 14 ambulance care assistants, one ambulance technician and six paramedics. There were two managers, three full time staff and four seasonal staff. The remaining staff also worked in other services as a primary employer and undertook work for Lifestar Medical in addition to that.

The accountable officer for controlled drugs (CDs) was the Managing Director.

The service is contactable 24 hours a day, with office hours Monday to Friday and weekend and out of hours work undertaken. These services were staff skill specific and the work would only be accepted if the provider were confident of the skills and availability of the staff.

There was one office and ambulance base located in Truro. This consisted of an office and toilet and shower facilities. Ambulances were stored on a local recreational site with a container storage facility. There were six ambulances available; with two of those about to be taken out of service.

Lifestar Medical Limited's track record on safety included no never events, clinical incidents or serious injuries. Eight incident forms had been completed in the timescale July 2016 to July 2017. One complaint had been received.

During the inspection, we visited the ambulance station. We spoke with five staff in person and two by telephone. Staff included administration staff, patient transport drivers, paramedic staff and managers of the service. We were unable to observe any patient journeys or meet with patients. However, we were able to speak by telephone with a person who uses the service.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Patient transport services (PTS)

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We saw that:

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Patient transport services (PTS)

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Are patient transport services safe?

Incidents

- The provider had a system and policy in place to report and respond to incidents. Staff told us they were encouraged and supported to report incidents and near misses. The reporting was in a paper format and was completed by staff and then given to the registered manager. The registered manager took the appropriate action to investigate and record any actions and any issues. Outcomes were shared with the management team on a daily basis. Staff confirmed they always received feedback at handover from incidents reported and were aware of any learning or system changes made as a result.
- Eight incidents had been reported between July 2016 and July 2017. We reviewed all the incident forms. There were a range of issues reported, which included poor discharge arrangements, infection control risks and issues encountered when patients reached their destination.
- Any incidents which resulted in serious harm or death to patients or staff were reported to the relevant bodies, for example the Health and Safety Executive and CQC. Incidents arising during sub-contracted work from another ambulance service were jointly investigated. Evidence was available of an incident which was jointly investigated and learning actions taken.
- As a single service company there were no means to measure incident performance internally, and no external measurements were in place.
- 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.
- A duty of candour policy was available to staff on line. This document outlined Lifestar Medical's policy on openness and how they met their obligations to patients, relatives and the public by being open and honest about any harm events. This policy was to be implemented following all patient safety incidents where moderate, severe harm or death had occurred. Incident records recorded any contact with patients and any discussions as part of duty of candour.

- Staff told us they were aware of the duty of candour through the mental capacity e-learning provided and the company policy. Staff told us they had not been involved directly in any part of the duty of candour process.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- There were no clinical dashboards available to establish an overview of the safety and quality of the service provided. Data about the service was recorded but not used to monitor or demonstrate the quality of the service. Most work was sub-contracted from other ambulance providers and in those instances data had not been requested. Private work was also undertaken and the same data was recorded but not used to demonstrate the service provided.
- The provider explained that as they are such a small service they had not found the need to gather the data in a separate document to demonstrate clinical quality. This was now being reviewed to enable easy access to data and to develop the service.

Cleanliness, infection control and hygiene

- Infection control practices were in place and understood by staff. The provider had an infection prevention, control and decontamination policy available for staff online. This provided staff with guidance to ensure infection control systems would be met. The policy covered health care waste, sharp objects, spillage of body fluids, equipment, and vehicle cleaning. There was a copy of the code of practice for health and adult social care and the prevention and control of infection, and related guidance, available to staff for reference in the office.
- The provider's infection control lead had undertaken e-learning in infection control. The lead undertook the deep cleaning of all ambulances and monitored cleaning schedules and records for all vehicles. Should any vehicles be found to fall below the standards specified within the policy an incident report was completed.
- We saw the cleaning schedules detailed the frequency and the method required to ensure effective prevention and control of infection. We viewed four vehicles which were all maintained to a clean standard. Each ambulance had a fluid spill kit on board to enable staff to manage any spillage. Cleaning equipment was in place for immediate response to any infection control issue until the vehicle could be taken to be deep cleaned. Cleaning solutions and access to an external tap for ambulance cleaning were at the parking area at the local recreation area, and also at the office.
- We saw a sample of staff records which confirmed staff had received training in infection control. Staff we spoke with demonstrated their knowledge of infection control practices and the management of clinical waste.
- Infection control information for each patient was gathered at the booking stage. This was recorded on the patient journey record to enable all crews to be aware of any risks. Staff confirmed that at the ward handover of each patient Lifestar Medical staff would re-check any infection control risks and manage the patient appropriately. Multiple ambulance occupancy would not be booked if infection control risks were identified.
- The procedure for the disposal of linen was not formalised and so not monitored to ensure risks were safely managed. The management of linen was detailed in the infection control policy. Staff explained all used linen was returned to a local hospital for washing and the trust allowed the service to collect replacement clean linen. This was existing practice and not covered by a service level agreement. Staff explained how infection control risks of this practice were managed. All used linen was secured in a red bag (alerting trust staff to its used and contaminated status). The crews wrote on the bags where the linen was from and the level of contamination. If the linen was used but not fouled it was exchanged on the wards. If fouled, the red bags would be taken directly to the trust laundry. The disposal arrangements were not monitored by the service to ensure safe practice was maintained.
- The provider had contractual arrangements with an external provider for clinical waste bins and disposal of sharp instruments. Due to returning late the night before the inspection, the clinical waste bag in one ambulance had not been taken to the hospital. The clinical waste bag was attached to the oxygen cylinder strap and was not tied up and therefore had been open overnight. This was an infection control risk.
- Auditing of other areas of infection control did not take place. Hand hygiene audits were not completed. As we were not able to undertake ambulance journeys we were not able to observe if staff followed good hand

hygiene practice. Personal protective equipment (PPE) such as gloves and aprons were available to enable crews to protect themselves and patients from transfer of infection.
- The office space appeared very clean and there was a clean and well equipped toilet and shower facility for staff.

Environment and equipment

- Equipment was serviced to ensure it was safe for use. Records showed that equipment in six vehicles had been serviced for use annually. The equipment included defibrillators, oxygen equipment, wheelchairs and weight checks. Two vehicles were blue light vehicles, and were only used by trained crew.
- An equipment policy was available to staff online. The policy identified vehicle checks, servicing, replacement and cleaning. Some servicing was completed by an external service. Records identified that fire extinguishers were checked annually by an external service contractor.
- Staff had specific training on the use of equipment to ensure patient safety. When new equipment was purchased, staff completed training to ensure their competence. For example, the provider had purchased a stair riser to enable the assisted movement of patients up and down stairs. The registered manager was instructed in its safe use and cascaded the learning to all staff.
- We spoke with staff who told us about their responsibilities regarding vehicle safety. There were daily and weekly checks carried out on vehicles for safety; these were recorded on a checklist. We observed the checks taking place and saw staff recorded any concerns they had regarding vehicles. Concerns were noted and actions were taken.
- There was no audit or spot check of the completion of these checklists by the management team to be assured this was being completed.
- We saw MOT records and insurance and service dates for eight vehicles which were completed and up to date. The provider had a vehicle recovery contract in place. The staff handbook provided staff with information in the event a vehicle broke down. Contractual arrangements were in place for routine servicing and emergency repairs.
- Equipment was stored securely and office space was secure. The office space ensured safe storage of keys and equipment. However, the container used for storage required further organisation to ensure safety. The storage of clean equipment amongst used equipment did not ensure all equipment remained clean. For example, used sharps boxes were stored among clean equipment; latex gloves were stored among non-latex gloves.
- The storage container was found unsecured on one occasion. We informed the provider who immediately secured the unit. We were informed by the management team there were no medicines or sharps in the container; however, the container did store sharp instruments, cleaning solutions, counter medicines and pain relieving medical gases. This lack of security posed a risk as the storage container was in an area which was accessible to members of the public.

Medicines

- Medicine systems were in place to ensure medicines security. Some aspects of medicine management required further development to ensure they were in line with national policy and guidance.
- Lifestar Medical held a stock of controlled drugs. As such, a licence from the Secretary of State should be held. This licence was not in place which meant the service was not compliant with legislation as set out in the Misuse of Drugs Regulations 2001.
- Following the inspection the managing director confirmed his application to obtain a licence from the Secretary of State for the storage of controlled drugs was underway.
- The provider had a controlled drugs policy. This policy had been written to provide all staff at Lifestar Medical with guidance about medicines management. The policy was available on the staff intranet. Staff understood their responsibilities for transporting medicines and confirmed that only paramedic staff could administer medicines.
- The ordering of any controlled drugs was the responsibility of the accountable officer, in this case the managing director of Lifestar Medical. Stock ordering, collection and disposal of surplus or out of date stock were the responsibility of the accountable officer. An agreement was in place with the local trust for the provision of medicines used by paramedics. The law allows registered paramedics to obtain stocks of the parenteral (injection) medicines for administration in Schedule 17, Part 3 of The Human Medicines

Regulations, as well as pharmacy medicines, both under exemptions in regulation 230 of The Human Medicines Regulations. We checked the controlled drugs register, which correctly tallied with the stock held in the safe and paramedic bags.

- Lifestar Medical had an appointed person who was responsible for the keys to all controlled drugs. The managing director was the primary key holder but was able to delegate the responsibility when needed to the business manager. Only trained crews could administer medicines and they were aware of the safe storage arrangements. Out of hours access to the paramedic bags containing the medicines could be arranged. The paramedic bags were kept secure between uses by plastic ties which needed to be cut to be removed to ensure they were kept updated and secured between uses.
- The medicines bags used by the paramedic staff contained controlled drugs. These were signed in and out of the secure cupboard by the paramedic using the medicines bag for any work which required it. The use of controlled drugs was also recorded in a record book. This provided an audit trail.
- The controlled drugs record included the date, time and patient's name. The paramedic dispensing the medicines recorded their initials, but they did not sign the record. A witness signature, for example the second crew member, was also not recorded. There is no legal requirement that sets out that administration must be witnessed. However it is regarded as good practice. It can be difficult for solo responders however, it is seen as good practice that they obtain a witness signature as soon as they can.
- On every ambulance vehicle within the fleet, with the exception of the wheelchair vehicle, a cupboard was in place with a lock and key. This was to ensure that when staff carried any medicines, they could be stored safely and securely. Guidance for staff was available in the staff handbook for the storage and management of take home medicines.
- Oxygen storage in the storage container was not safe. There was no risk assessment carried out to ensure the chosen location for storage was safe. We saw three cylinders of oxygen were stored upright but unsecured; this posed a risk if they fell over. We also noted that another medical gas was stored in the same manner, posing a risk. The storage container was very hot and not well ventilated, both of which are not suitable storage conditions. There was no signage on the container to indicate medical gases were being held. Warning notices should prohibit smoking and naked lights within the vicinity of the storage. The provider was directed to the Health and Safety Executive, website and guidance 'HTMO2' on design and construction of a medical gas cylinder store.
- Oxygen storage on board the ambulances varied. Some cylinders were secured upright; some were stored horizontally and unsecured. This meant there was a risk they could roll around and injure someone, or get damaged. If a patient was identified as needing oxygen during a transfer, the patient's oxygen cylinder was secured and the provider's supply used for the duration of the journey. This enabled the provider to ensure the safe transport of the oxygen being used.
- A list of medicines was available, which detailed the medicines which could be administered by paramedic staff. The service did not have Patient Group Directions (PGDs). PGDs are written instructions for the administration of authorised medicines to patients and are needed to ensure that medicines are only administered to patients by staff with the legal authority to do so. The managing director has provided verbal reassurance that this issue is currently being addressed. Following the inspection the managing director updated CQC with his continued efforts to arrange Patient Group Directions.
- First aid kits were carried in all ambulances but were not all in a condition suitable for use. We checked four ambulances and the storage container and noted several items used for first aid were out of date.

Records

- Transfers of personal and sensitive information were conducted in a secure and confidential manner. Information technology systems within the office were operated confidentially. Records were stored securely in a locked office. There was one key available for staff access, which was locked in a key safe outside. Secure disposal of records was by shredder and disposed of by an external service.
- We saw the provider had a system in place to obtain the initial assessment of people's health and support needs prior to transporting them. This information was recorded on journey sheets and provided to staff. This meant staff had information so they were able to meet a

person's needs and could ensure that necessary equipment was available. Staff we spoke with told us about their understanding and responsibilities regarding patient confidentiality.

- Patient records were kept secure. Relevant notes from the hospital were handed to the ambulance crew at the ward transfer handover. Any special requirements or risks were discussed at this time. The notes were then stored in a locked cupboard in the ambulance. On arrival at the patient's destination they were then provided to the patient or the appropriate person.
- As part of the induction process, people who worked for Lifestar Medical Limited were informed of their responsibilities regarding data protection and confidentiality. Further training was being implemented about information governance. Staff confirmed their understanding of patient confidentiality and the processes in place.

Safeguarding

- There were reliable processes and practices in place to keep patients and staff safe and safeguard them from abuse and avoidable harm. The Lifestar Medical safeguarding policy provided definitions of types of abuse and included reference to the Mental Capacity Act (2005). The policy provided a flow chart to advise staff of immediate actions to take should they have a safeguarding concern. Advice about safeguarding procedures was included in the staff handbook; this included the procedure to follow when reporting any concerns.
- We saw a record of when a crew had concerns and had raised an alert with the local authority safeguarding service. Staff we spoke with were clear about their safeguarding responsibilities and the actions they would take to raise concerns.
- Safeguarding training for staff was included in induction. The training for adults and children was to the level two standard and also covered escorts and driver escorts, moving and handling for escorts, and equality and safeguarding for transport coordination. A further policy identified that should a patient be less than 16 years an escort must be in place. Devon e-learning included induction for escorts and drivers/escorts, manual handling training for escorts, equality and safeguarding for transport co-ordination.
- The registered manager took the lead on any safeguarding issues. 'Safeguarding children and young people: roles and competences for health care staff Intercollegiate document 2014', states all clinical staff working with children, young people and their parents and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person must be trained to safeguarding children level three. This included the paramedic trained staff working for Lifestar Medical. The provider confirmed that not all paramedic staff had level three training and confirmed this would be addressed. The ambulance care assistants were non-clinical staff and so trained to level two. We saw this recommendation had been met for non-clinical staff.

Mandatory training

- An induction training programme was in place for all new staff at the start of their employment. The length of induction varied until all areas of the programme were completed. The content of induction included all the aspects included in mandatory training. The provider had introduced a staff competency check list as part of induction.
- On commencement of employment all new staff undertook a driving review and remained escorted until both the new staff member and the managing director was confident driving the vehicles. No blue light training was needed as this was not part of the service provided.
- A programme of mandatory training was in place for all staff. This included face to face training and e-learning which was accessed via the staff portal and was supplied by the local county council. Staff had access to the portal which could be used on computers in the office or from home. Face to face training included moving and handling, health and safety and infection control. Staff confirmed they were supported to complete training and develop their practice.
- Mandatory e-learning included safeguarding adults and children, the Mental Capacity Act 2005 sections one to nine, information governance, dementia, disability confident, equality essentials, person centred thinking, carer aware, infection control, food safety, infection control, nutrition and hydration, and handling difficult conversations.
- We asked for evidence of the compliance rates for staff undertaking the e-learning but the provider was unable to report this electronically. Training compliance was

therefore recorded on paper with the date of completion and copy of certification on file. These were mostly complete, however gaps for one paramedic showed they did not have all training certificates.

- It was not clear how the organisation ensured that all staff remained up to date with their mandatory online training. The registered manager has since contacted the training provider to access the overview and establish all staff had completed the required training. A training record was provided after the inspection which provided an overview of all training completed by all staff. This showed that with the exception of two new staff most areas of training were complete. The new staff were undertaking the training. All staff had completed some level of first aid training, health and safety, moving and handling , infection control and equality essentials. With the exception of four staff, all staff had completed training in the Mental Capacity Act and dementia care. Most staff had training in handling difficult conversations and conflict resolution. Not all staff had completed training to manage substances hazardous to health.
- For those staff who worked in other ambulance services, evidence of training was requested and further training supplied as required.
- E-learning was completed through Cornwall Council. There was also some training completed via Devon County Council. Identity cards for Devon County Council were not provided unless training was completed and evidence of a disclosure and barring service (DBS) check was in place.
- There were four staff members in the process of completing their e-learning. They had been allowed to work as assurance had been received of completed training with their previous employers, so they were given extra time to complete the Lifestar Medical training.
- Last year the provider started using an external company. They were a first aid company. They provided the First Person on Scene (FPOS) training and health and safety at work training, which included manual handling and infection prevention and control. Staff attended the training centre for this. Every six months paramedics also completed mandatory paramedic update training. This training included patient assessment, basic life support, catastrophic haemorrhage control, advanced life support, trauma and medical scenarios, and suctioning. The non-paramedic staff also attended for basic life support training.

Assessing and responding to patient risk

- Risk assessments were undertaken for patients who may have been at risk or had specific needs. The criteria for risk assessments were two fold. If staff were aware of risks a pre-planned risk assessment took place. In all cases when staff arrived at the point of pick up a risk assessment was undertaken of the area and patient. We saw evidence of risk assessments being completed to ensure a successful service delivery and to avoid delays.
- Guidance was available for staff for the management of a deteriorating patient. In the event of a patient's condition deteriorating, the ambulance would be stopped at the nearest opportunity and in a safe place. The staff would assess the situation and in the event of sudden death or serious illness they would call '999' to request an emergency ambulance to attend. If required, they would commence resuscitation (unless a documented Do Not Attempt Resuscitation form was held by the patient). The guidance stressed for staff it was very important to make sure they were aware when leaving the wards if there was a Treatment Escalation Plan or Do Not Attempt Resuscitation order in place and if it was signed and in date.
- Staff we spoke with understood the action they would need to take if a patient deteriorated during a journey. All crews were trained to resuscitate patients and automatic external defibrillators were carried to aid resuscitation.
- Staff told us that if more than one patient was being transferred an assessment was made of any patient with risks and a decision made about who would be transferred first. This was in place to safeguard vulnerable adults and children. For example, if there were two patients in the ambulance and one patient had some cognitive impairment, that patient would be transferred first.
- Staff had access to some training to support patients with mental health needs. Should those patients being transferred have deterioration in their mental wellbeing, crews would stop the journey and request support and advice from the registered manager or managing director.

Patient transport services (PTS)

Staffing

- Recruitment procedures were in place to ensure all staff met the legal requirements, including Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A recruitment policy was in place to assist managers in the recruitment, selection and retention of staff, and to ensure they met employment legislation and best practice. There were 21 staff in total: 14 ambulance care assistants, one ambulance technician and six part-time paramedics. There were also two managers: the registered manager and the managing director. Two of the paramedics also worked for another service and the remaining four worked for Lifestar Medical when requested. Most of the staff were part-time or worked when requested.
- The registered manager ensured that qualified paramedics were registered with the Health and Care Professions Council (HCPC). The HCPC is the professional body that is responsible for the registration and competence of qualified paramedics.
- Staff worked in pairs unless it was identified that only one staff member was needed. A lone working policy was in place to ensure staff were aware of how to maintain their own safety and the company's responsibility to their safety.
- Staff wore a uniform and had an identity card; this enabled people to be aware that the person worked for the organisation. All staff signed a working time directive opt-out to exceed 48 hours each week. The provider depended on the staff member's professionalism to declare if they had exceeded safe working hours.
- Staff breaks were managed by the staff themselves and the provider relied on their professionalism to ensure their own welfare was met. The staff handbook and statement of terms and conditions of employment stated the hours in which staff should take a break dependent on their working hours. Staff should have a 30 minute meal break and were responsible for organising this, this required flexibility between staff, control office and patient needs. The management team did not monitor staff breaks and so were not assured staff had appropriate breaks as required. During long journeys the management team told us staff would swap drivers and ensure they stop at service stations for breaks for themselves and a comfort stop for the patient. There was no evidence or audit in place to establish that this took place.
- The rota was planned based on a nine hour day with three to four shifts a week; staff had an option to take more if they wanted to. There was rota shift work Monday to Friday for sub-contracted work.

Response to major incidents

- The provider had in place a Major Incident Policy to inform staff of their responsibilities in a major incident. This outlined the operational arrangements to be undertaken by Lifestar Medical at the time of a critical incident, major incident or civil emergency. It was prepared in the light of advice from the Department of Health: NHS Planning Guidance 2005, Civil Contingencies Act 2004.
- The managing director explained that whilst they had no formal links to the local ambulance or hospital trust to support in any major incident, they would respond as needed. Staff training had not been provided to enable them to be knowledgeable on how to deal with any major incidents but they had the knowledge and experience of their other employment roles.
- The Lifestar Medical Business Continuity policy also considered other aspects of business continuity, including internal major incidents including the loss of a headquarters building, extensive sickness among personnel, and failures in information technology. The registered manager explained the contingency plans were in place for poor weather and the need to consider increased local population during holiday seasons.

Are patient transport services effective?

Evidence-based care and treatment

- Policies for staff were available electronically at the office and were accessible by connection to an external network facility. Staff we spoke with said they knew there were policies and procedures and were able to access them. Documents and procedures which may be needed on the ambulance were stored in a file in the vehicle. Policies were not referenced to National Institute for Health and Care Excellence (NICE) or The UK Ambulance Services Clinical Practice Guidelines 2016 to ensure they followed national guidelines.
- Senior management staff regularly accessed the electronic system to update the policies. When any new policies or changes had taken place the registered manager emailed all staff to prompt them to review.

- The managing director was also a paramedic who worked alongside staff on a daily basis. This role enabled an ongoing informal review of practice to provide assurance of standards of care.

Assessment and planning of care

- Assessment of the patient's needs and care required during transportation was gathered prior to the journey. As this was a very small service providing sub-contracted work and ad-hoc services, the provider had not found the need to have an electronic system of working.
- Should a patient provide any level of risk, a risk assessment was undertaken by the management and a decision made about which staff would be most appropriately skilled to provide the work. The registered manager was very clear that bookings taken were skills specific to meet patients' needs and minimise risk.
- The numbers of crew required was assessed prior to the journey to establish if staff went out in one or two person crews. Should a one person crew attend a journey which was not safe to undertake alone, the job would be re-allocated. Occasionally staff worked alone, for example when using the wheel chair vehicle. This was agreed with hospital staff beforehand to ensure a lone worker was appropriate for the patient.
- The office staff confirmed the majority of bookings (up to approximately 80%) were booked the day before the journey was needed, while some were booked on the day. The remaining 20% were booked in advance.
- Longer nationwide journeys were planned in advance. Staff told us the service did not provide food for patients. Water was carried on the ambulance for long journeys. If a patient required food and drinks during long transfers then the trust or departing hospital would arrange food for them.
- The management of patients' pain was planned by the hospital prior to discharge and medicines were only administered if the transfer was staffed by trained paramedic staff. The staff carried pain identification charts on each ambulance to identify the level of pain for those patients with communication difficulties.

Response times and patient outcomes

- We asked the provider how they monitored response times and patient outcomes. They confirmed they did not undertake this monitoring as the service they provided was so small. Information was gathered about some outcomes for patients. However, there was no audit to identify outcomes and provide key performance indicators such as times of collection of patients and the monitoring of delays and aborted journeys. Most work was sub-contracted to Lifestar Medical from other ambulance providers. The provider did not supply detailed information back to the services supplying the sub-contract work, other than staff daily times for each patient. This meant there was no evidence for response times and clinical quality measures available for review.
- From the data made available to us a brief review showed that arrival and departure times were mostly completed within an acceptable timeframe for the bookings taken by the service. This did not include the sub-contracted work, which the provider had no control over. In this instance the crews were booked by the contactor and the details of service provided was managed by that service. The only detail Lifestar Medical had was the staff hours worked.
- A satellite navigation system was available for staff but this did not enable the office staff to know where the ambulance crews were located. There was no other system in place which would alert the office based staff if the ambulance was not at the correct location or had been stopped for any length of time. The provider stated this was not necessary, they would rely on staff contacting them to alert them of any changes or problems.

Competent staff

- Individual staff training records showed a high level of attendance. However, no overview was available to ensure any gaps in training were identified.
- An induction was provided for all staff and further training was also provided. Training was face to face for some subjects, and online for other subjects. An induction policy was available to all staff through the office or online. This provided an outline of the base-line induction for all new Lifestar Medical employees, including any agency or voluntary workers. Managers were responsible for completion of the local induction and the relevant checklist. The local induction process started on the first day the employee attended their place of work, and would be completed within the first week. A staff competency checklist was in place for all staff. Checks were made every 12 or 24 months, or in

between if needed. This included revisiting equipment checks and the staff handbook. Staff we spoke with confirmed they had completed the induction and found it to be sufficient to introduce them to the service.

- Mandatory training was provided to all staff. Training was either e-learning or face to face in-house training. Staff who had completed training with other employers provided evidence in the form of certificates and training subject content to Lifestar Medical. All staff had completed basic life support or advanced life support training, dependant on their role. This included using semi-automatic defibrillation.
- Qualified paramedics were required to complete continuing professional development (CPD) as part of their registration with the HCPC; the registered manager provided certificates to demonstrate that paramedic update training had been undertaken by those paramedics working at the service. Of the six paramedics working at the service, two worked elsewhere and updated their practice there. Despite this, the update training had also been completed by them. The remaining paramedics had undertaken the update training and we heard one example where a paramedic had updated their intubation practice.
- There is no formal recognised training for ambulance care assistants (ACAs), but the provider had implemented an ongoing programme of training. The responsibilities of ACAs included: driving, moving and handling of patients, patient care and comfort during journeys.
- There was no training overview to indicate what staff training was required for each staff role. The management team decided the training which was required by staff and all staff completed these e-learning modules.
- Appraisals were completed annually by the managing director and were up to date. Records showed 12 appraisals were completed in the last year. The remaining staff either were not required to have an appraisal because they had started within the last year, or because they were absent from work. Five examples of completed appraisals were viewed and showed staff assessments and any comments were included.
- There was an informal process of supervision, with no records completed. If the managing director as part of a crew observed practice he would provide feedback, or if staff requested observation this supervision and support would be provided.
- A policy was in place to ensure all staff had the appropriate driving licence checks and were aware of their responsibilities to report any licence changes. The policy also included instruction for staff about driving restrictions and the use of audible and visual warnings (blue light use). The ambulances used did not meet the weight criteria which would require staff to take extra driving instruction.
- We saw that all driving licenses were checked annually to ensure staff were licensed to drive the correct class of vehicle and did not have any driving convictions that would affect the organisation. Staff understood their responsibility to inform the provider of any new driving convictions.

Coordination with other providers and multi-disciplinary working

- Lifestar Medical management met with providers and communicated with other services when needed. The management told us about the good relationships they had with hospital staff and the reliance they had on reputation as a good service.
- A commissioning agreement was in place to enable Lifestar Medical to be used by the local clinical commissioning groups to provide trained staff transfers. Coordinated working took place with local independent ambulance services. A service had recently sub-contracted work to Lifestar Medical. As part of working together, these services undertook due diligence checks of how Lifestar Medical ran its business and the information it held. The reports we saw completed did not raise any concerns.
- Information about the running of the service was provided to staff through email and bulletins placed on a notice board in the office. The management told us that they did not hold team meetings. This was because the service they provided varied and it was very difficult to get the staff together. However, we were told of breakfast events where staff could get together and information was shared. We were also told of a training BBQ event being planned to include both training and staff meeting socially.

Access to information

- General service information for staff was accessed on the intranet, which all staff had log in details for. Staff told us the system worked for them and that paper

documents for immediate use were held in the ambulances. All staff we spoke with confirmed the availability of senior staff to discuss any issues they had or to access further information.

- Lifestar Medical Limited provided a staff handbook with information to support staff with their role. The handbook was kept in vehicles so staff had immediate access to information. Staff also had telephone access to the registered manager both in office hours and out of hours.
- Staff told us that patient diagnoses and any issues they needed to know were confirmed with them prior to transportation by the registered manager, noted on the journey log and confirmed again by ward staff when collecting the patient.
- Do not attempt resuscitation and treatment escalation plans were available in most instances to ambulance crews before the journey. These were confirmed by crews with ward staff on each handover. When patient information was gathered by the administrative staff any advanced patient directives were included to ensure crews were aware of any decision made about resuscitation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had in place a policy for capacity to consent, which included adults with mental health needs. The policy aimed to promote staff awareness around the importance of ensuring that patients were able to give informed consent to any procedure, treatment or intervention undertaken by Lifestar Medical staff.
- Training had been provided for staff in aspects of the Mental capacity Act, including dementia care and physical interventions. Data provided showed that out of the 21 staff listed on the training record, three staff were new starters who were undertaking the training and four had not at this time completed the training. The remaining staff had completed the training.
- The provider had in place a policy to inform staff of actions to take if the patients had a do not resuscitate policy in place. Lifestar Medical received calls to transport patients in possession of a Do Not Attempt Cardio Pulmonary Resuscitation Order or Treatment Escalation Plan, which indicated what treatment was to be given. Lifestar Medical staff, during the transportation of patients, had a responsibility for the continuation of patient care. This included do not attempt resuscitation decisions if they had been put in place by a hospital prior to discharge or transfer of the patient, or by a General Practitioner prior to the admission of a patient. Staff understood the policy and the expectations on them to comply with the directive.
- Staff confirmed they had transported patients who had a Deprivation of Liberty Safeguard in place and they were aware of the need to ensure they understood what this meant in each case.
- The organisation provided a service when required to children. The Gillick competence test refers to the ability of the child to consent to or refuse treatment, in this case transport, without the permission of their parent or guardian. Staff required this training to judge when the child's decision could or could not be overruled by the adult. This training was part of the e- learning for staff.

Are patient transport services caring?

Compassionate care

- During the inspection we were not able to observe any patient journeys or direct care but noted that the staff spoke in a caring and insightful way of patients in their care.
- The provider told us the focus of their service delivery was patient care. Patient safety and comfort was their priority and as a service, they were confident they offered comfortable and versatile vehicles with trained uniformed ambulance personnel. They strived to ensure that every service user was treated with care and dignity.
- We spoke with a relative of a regular patient who told us that both the patient and relative were treated with dignity and respect. They saw a variety of staff and all had been helpful and cooperative. They told us staff took the time to interact with people who use the service and those close to them in a respectful and considerate manner. They also told us "I would give them all five out of five" for the service provided. They described equipment provided to support the patient's needs and that staff were confident in using the equipment.
- Confidentiality was maintained by the secure management of records and the safe handling of verbal information, both on the collection of patients and the handover to the destination staff.

Patient transport services (PTS)

Understanding and involvement of patients and those close to them

- Lifestar Medical staff who received bookings considered both the patient and those people close to them. Staff told us they tried to be as helpful as possible to support the patient. For example, we saw booking and journey record notes which included "call granddaughter once dropped off and let her know". We also spoke with a family member of a patient who told us that staff explained what was happening and that any questions they had would be answered.
- We received feedback from a stakeholder. They told us Lifestar Medical "are absolutely excellent" and "nothing is too much trouble, they deal with complex patients who require you to wait at the hospital. They will always wait and bring the patient back to ensure they are not hanging around. They demonstrate professionalism to both patients and staff and relatives. They explain what's happening and put everybody at ease".

Emotional support

- The registered manager explained that when bookings were taken they were more than happy to ring the patient and talk through what the transfer would involve. If the patient was on a ward, the registered manager would ring the ward to establish if the patient had any specific needs, including any emotional support needed. This information would then be passed on to staff.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The service planned and delivered services in a coordinated and efficient way that responded to the needs of the local population. The commissioning arrangements only covered the transfer of patients who needed trained staff. Remaining patient transfer work was undertaken either as a sub-contract or when needed.
- Due to the nature of the distance transfer work undertaken, significant planning went into the journey to be taken. Staff attended the office and any planned work was communicated to staff when they agreed to undertake a journey. We observed plans being made to transport patient's long distances out of the county. The journeys were sometimes return trips, and so staff stayed with the patients to ensure a continuity of care.
- A stakeholder told us that patients at the end of their lives and with complex needs needed specific extra care and support. They told us that Lifestar Medical staff always delivered a standard of service which enabled the patient and relative to voice any issues and included them in any discussion about the transfer.
- Mental health work was not regularly provided. However, staff undertook restrictive practice training in preparation. Lifestar Medical sometimes were requested to provide the vehicles, but the staff were provided by the mental health service.

Meeting people's individual needs

- People's individual needs and preferences were central to the planning and delivery of the service. We were told by the provider about how the staff team worked across all areas to support people with complex needs. This included participation in a pilot scheme to transport patients with autism and learning difficulties to hospital whilst under sedation.
- The provider's website identified that the service could be provided to the whole population. This included adults, children, and people living with learning disabilities or an autistic disorder, and those with mental health issues, dementia or a sensory impairment. Staff received the training needed to undertake each role. Should the staff not have the skills needed to meet the patient's individual needs, the work was not undertaken and the management looked into training to develop that aspect of their service for the future.
- Systems were in place to support patients with limited communication to indicate to staff their needs. We saw communication sheets kept in each ambulance which were in picture format and would enable patients to indicate their needs. The subjects included 'Things I may need', personal hygiene and pain levels.
- Equipment was in place to support the transportation of bariatric patients. The staff understood the adaptations available to support this group of patients.

- The organisation had access to translation and interpretation services through the office staff. Leaflets and information, for example on how to make a complaint or leave a compliment, were also available in larger print for patients who had a visual impairment.

Access and flow

- The service was operational 24 hours a day, seven days a week, to receive calls, manage bookings and respond to queries. The office was only open Monday to Friday. Out of hours and at weekends the registered manager or managing director was available by telephone. Staff confirmed that the on call staff member was always contactable.
- The registered manager confirmed work at short notice could be undertaken if there were staff available with the specific skills needed. Should staff be delayed the registered manager would ring the ward or patient to explain the delay and reassure them that a crew would be there.

Learning from complaints and concerns

- Complaints were managed responsively and used to develop the service provided. The provider had a complaints policy in place and staff could access this policy online. The policy included actions staff should take and the format of any investigation. The policy stated "Lifestar Medical expects learning from the customer experience expressed as complaints to be used to systematically improve the quality and performance of services".
- Complaints were managed by the registered manager. Staff members were not involved unless called upon for information. We were advised by staff that any outcome from complaints was fed back to them for learning and outcomes included in future training.
- Complaint/compliment leaflets were visible and available on each ambulance. They were available in larger print. There were stamp addressed envelopes available to enable patients to take a leaflet and respond in their own time. We saw four responses, all were positive in content.
- There had been one complaint between July 2016 and July 2017. This related to incorrect information as part of the booking. The work had been sub-contracted from another independent ambulance provider. The investigation had been undertaken by the other provider with information provided by Lifestar Medical management. Learning had been taken from this complaint and changes in practice developed.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The service vision for leadership development aimed to develop staff to lead improvements. The provider told us they had a strong commitment to education, with an increasing focus on the professional development of the workforce. For example, a staff member had expressed a wish to develop specific roles, so the management had appointed them as the infection control lead.
- Staff spoke positively about management and their leadership. They spoke about the management's availability and accessibility and were confident in asking for advice and support. The managing director was a registered paramedic and so was a source of advice and support for other staff, both qualified and unqualified.

Vision and strategy for this this core service

- The provider had redefined their strategic aims to ensure they were meeting and improving on the delivery of the service. A business plan was in place which identified the need to respond to the challenges of the current economic climate, ensuring they were supporting the rest of the health community in delivering significant change. They noted that the organisation needed to take stock, get back to basics and ensure they were providing high quality patient care through highly skilled, professional staff.
- To support the delivery of Lifestar Medical's vision, the provider had developed Lifestar Medical's Customer Charter. Staff understood the service's vision. The charter included :
- Learn - Monitor, reflect and learn from every patient and every journey.
- Improve - Always look for ways to improve our patient experience and relationships with commissioners.
- Focus -
- Efficiency/Effectiveness - Provide an efficient and effective service at all times.
- Safety uppermost towards our patients and staff.

- Treatment - Ensure that only highly trained and skilled individuals, qualified to the appropriate level provide first class service.
- Accountability towards our contractors and patients.
- Respect - Particularly our patients but treat everyone we come into contact with, with dignity and respect.

Governance, risk management and quality measurement

- Data and information was gathered but the provider was not using this to measure the quality of the service. Audit of aspects of the service was not undertaken to identify the service's strengths and areas for further development.
- No monitoring was undertaken of how long staff drove for. If staff were on a long journey, no record was maintained of who was driving at any given time. This meant there was no indication of whether staff had driven for too long. The provider told us they would review this. There was no record kept of who was driving, which had an implication for any accidents, investigations or convictions.
- Risk management was not recorded to identify how risks were measured and monitored. No risk registers were in place and there were no processes to assess, monitor and mitigate the risks relating to the health and safety and welfare of patients and others. The provider told us that because the service was so small risks were managed immediately and monitored on a day to day basis. The provider used reflective practice to review events to take learning and implement immediate changes in practice. There was no means to review these changes to measure effectiveness.
- Lifestar Medical policies were kept in the office and online through a secure server system. They were there for staff to read and to adhere to. Staff signed to say they had read each policy. As and when there was a new policy, or an update added to a current policy, the registered manager notified all staff.
- A whistle blowing policy was in place to enable staff to raise concerns. It was the company's policy to ensure any employee with a grievance had access to a procedure that could lead to the prompt resolution of the grievance in a fair manner. Staff told us that any issues they had could be raised and discussed.
- The provider told us that due to the size of the company they did not hold meetings. The two directors worked in the office daily, and all matters were dealt with on a daily basis, rather than the need for meetings to bring management together.

Public and staff engagement

- The provider had introduced a system to obtain patient experience feedback of their journey. We saw on the journey sheets that staff recorded how the patient had responded to the transfer journey, for example a sad or smiley face. This demonstrated that staff were aware of the patient's perspective and used the tool to try and improve the service.
- The provider had recently started to request feedback from patients. Staff would supply the form and pre-paid envelope to one in four patients. We reviewed the four responses received. This quality monitoring was currently under development.
- Staff told us they felt engaged and included in the development of the service. They felt able to raise issues and ideas and felt listened to and appreciated.

Innovation, improvement and sustainability

- Lifestar Medical had over the past two years been involved in a new innovation with a consultant anaesthetist from the local hospital trust. The consultant anaesthetist had a special interest in working with people with learning disabilities and autism and asked if Lifestar Medical would be interested in doing a pilot exercise in dealing with this patient group out in the community. The pilot was to reduce anxiety in this group of patients who may not be comfortable in a hospital setting.The project involved suitably trained Lifestar Medical staff accompanying the consultant and a theatre technician in attending a patient's home, and sedating and anaesthetising the patient. Following this, transporting the patient to the local hospital trust so that various procedures could take place. When treatment/ procedures were completed Lifestar Medical staff then returned the patient back home where the necessary procedures were implemented to allow the patient to wake up and stabilize before leaving the patient.

Patient transport services (PTS)

- The management of the service explained the difficulties of developing a small ambulance service. They had been exploring a number of diversifications to ensure the sustainability of their service, for example a responsive falls service was being considered.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Improve medicines management to ensure patient safety and to meet legislative requirements.

Action the hospital SHOULD take to improve

- Review data and information gathered to measure the quality of the service. Audit of aspects of the service were not undertaken to identify the service's strengths and areas for further development.
- To ensure two full signatures were being recorded for the administration of controlled drugs. This should be considered as good practice.
- Undertake a management overview of aspects of safety to ensure that all of the processes in place were being completed. These areas included cleaning of vehicles, equipment checks in vehicles, management of clinical waste and used linen and overviews of staff training. Some first aid items such as dressings were noted to be out of date and so no longer suitable for use.
- To ensure that all paramedic staff dealing clinically with patients have level 3 safeguarding training.
- Undertake risk management to identify how risks were measured and monitored. No risk registers were in place.
- Ensure policies reference National Institute for Health and Care Excellence (NICE) or The UK Ambulance Services Clinical Practice Guidelines 2016 to underpin good practice.
- Undertake audits of key performance indicators, such as times of collection of patients and the monitoring of delays and aborted journeys. Data about the services provided was available, but the provider did not have any key performance indicators to work towards.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. 12(2) without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (g) the proper and safe management of medicines How the regulation was not being met: The provider did not have a home office license for the storage of controlled drugs. The storage of oxygen and medical gases did not comply with national guidance. Patient group directions (PGDs) for patient medicine administration were not in place to ensure staff had the correct guidance for administration.