Transsecure NW Ltd

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Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

TransSecure NW Ltd opened in August 2019. It is an independent ambulance service based in Blackburn. The service provides patient transport services for local, regional and national acute NHS hospital trusts, local authorities and independent hospitals, 24 hours a day, 365 days a year.

The service provides patient transport services for adults; the service does not transport children. The service transports patients with mental health needs and those detained under the Mental Health Act 1983. The majority of work undertaken by the service is inter hospital transfers; however, the service also transports patients with mental health needs to and from home addresses when required.

We carried out a short notice announced focused inspection of the service on 19 October 2020. We inspected the providers services to check on the progress towards addressing the concerns and action we took following our previous inspection in July 2020. We did not rate the service.

We found the found the following areas that still required improvement:

- We were not assured that there were systems or processes in place to safeguard service users from abuse and neglect. The safeguarding policy did not guide staff in relation to safeguarding children and it was unclear when a concern would be reported to the local authority. The provider was unable to evidence the skills and competencies of its safeguarding lead.
- We were not assured there were robust systems and processes in place to ensure the safe management, prevention and control the spread of infection. The provider's infection prevention and control policy did not include information about how to manage risks related to the COVID pandemic. The policy included information about preparing food which would not be expected in the service delivered by the provider.
- We were not assured that effective systems were in place to ensure the safety of the care and support provided was regularly assessed and monitored to ensure it was being delivered safely. There were no completed risk assessments of the ambulance vehicle. The ambulance risk assessment policy did not define how the levels of risk used were derived, nor did it set out the need for a formal risk assessment and how these should be reviewed. Adaptations of the spare ambulance vehicle had not been completed and there were exposed metal parts that could pose a risk to patient safety.
- We were not assured that care was provided in a way to reduce the risk of avoidable harm to service users. The deteriorating patient procedure did not outline clear processes to manage service users in the event their condition deteriorated and they needed additional support. The provider did not have equipment to monitor oxygen saturations or blood pressure required to undertake vital observations.
- There was no clear policy or process to determine how many staff were needed to safely care for service users during transportation.
- Although staff had undertaken training in the management of epilepsy, it was unclear if staff understood the emergency management of other conditions. Further, although staff had completed first aid modules as part of their food and hygiene training and the management of seizures and epilepsy training, without the additional training there was an increased risk that early signs of a deteriorating patient would not be recognised. The provider informed us that plans had been made for staff to complete additional first aid training.
- We were not assured there were systems and process in place to support service users to safely manage their medicines, and to safely manage the risks to patients being transported while sedated. Contrary to the provider's

Summary of findings

overarching medication policy which indicated staff could support a patient to administer non-prescribed medicines, the nominated individual told us staff would not administer medicines in any circumstances and there was no risk assessment form on how to safely store patients' own medicines during transport. The policy included information that was not reflective of the service provided.

- The provider had a recruitment policy and had reviewed staff driving licences. However, the policy was not robust, included information not reflective of the service provided, and there was no evidence that driving assessments had been undertaken. The policy did not include information on how the provider would assess against the fit and proper persons requirements for all staff and there was no other policy outlining these.
- We were not assured the provider had robust processes to ensure that directors who had responsibility for the quality and safety of care and for meeting the fundamental standards of care were fit and proper to carry out the role. The provider had not undertaken important checks such as an enhanced disclosure barring service check, bankruptcy and insolvency checks on the appointment of its new director. The fit and proper person requirements for directors had not been included in the provider's recruitment policy and there was no other policy outlining these requirements.
- We were not assured that restraint would only be used as the least restrictive option or that there were sufficient policies and procedures to support staff in the application of the Mental Capacity Act. The provider did not always recognise when restraint had been used and could potentially use restraint when not needed. The provider did not have a clear policy and procedure to support staff in seeking patients' consent, to act in their best interests, or when undertaking a mental capacity assessment.
- We were not assured there were effective systems for governance and risk management to ensure service users received safe care and treatment. There were no audit programmes in place to undertake and record any patient quality monitoring or audits in relation to key processes. There was no policy and procedure to support staff in correctly applying and completing the new risk assessment process. The provider's training policy was still being developed and it was not clear which elements of staff training were mandatory. A number of the provider's policies and procedures contained information that was not reflective of the service provided. The provider did not have policies for some key areas such as mental capacity and health and safety.

However, the provider had made the following improvements since our last inspection:

- Although we were not assured the provider always recognised when restraint was used, most staff had completed additional accredited training which included, prevention and management of violence and aggression by patients; use of mechanical restraint; and, training and handling.
- Further online training completed by staff included but was not limited to safeguarding level two adults and children; first aid; fire safety; infection prevention and control; medicines management; and, information governance. All of these modules were completed in October 2020 and were valid for a period of 12 months.
- The provider had begun the implementation of a staff induction guide, which outlined training that was to be delivered at the start of employment of all staff. This was to be delivered by the operations manager and covered several important topics such as incident management, safeguarding, mental capacity and mental health. However, it was unclear if this had been fully completed at the time of the inspection.
- The provider had improved patient documentation to support staff in capturing all parts of patient journeys.
- The provider had implemented registers that provided evidence that staff had read all appropriate policies and procedures.
- All policies now have version controls and owners (role titles).

We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inspected but not rated	TransSecure NW Ltd is an independent ambulance service based in Blackburn which provides patient transport services for adult patients to local, regional and national acute NHS hospital trusts, local authorities and independent hospitals. The service transports patients with mental health needs and those detained under the Mental Health Act 1983. We carried out a short notice announced focused inspection of the service on 19 October 2020. We do not rate focused inspections. However, we found the following areas that still required improvement: • We were not assured that there were systems or processes in place to safeguard service users from abuse and neglect, to ensure the safe management, prevention and control of the spread of infection, that care was provided in a way to reduce the risk of avoidable harm to service users, or that the safety of the care and support provided was regularly assessed and monitored to ensure it was being delivered safely. • We were not assured there were systems and process in place to support service users to safely manage their medicines, and to safely manage the risks to patients being transported while sedated. We were not assured that restraint would only be used as the least restrictive option or that there were sufficient policies and procedures to support staff in the application of the Mental Capacity Act. • We were not assured the provider had robust processes to ensure that directors who had responsibility for the quality and safety of care and for meeting the fundamental standards of care were fit and proper to carry out the role. We were not assured there were effective systems for governance and risk management to ensure service users received safe care and treatment.

Summary of findings

However, the provider had made the following improvements since our last inspection:

- Most staff had completed additional accredited training which included, prevention and management of violence and aggression; use of mechanical restraint; and, training and handling. Further online training completed by staff included but was not limited to safeguarding level two adults and children; first aid; fire safety; infection prevention and control; medicines management; and, information governance. The provider had begun the implementation of a staff induction guide, which outlined training that was to be delivered at the start of employment of all staff.
- The provider had improved patient documentation to support staff in capturing all parts of patient journeys.
- The provider had implemented registers that provided evidence that staff had read all appropriate policies and procedures, and all policies now have version controls and owners (role titles).

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Background to Transsecure NW Ltd

TransSecure NW Ltd opened in August 2019. It is an independent ambulance service based in Blackburn. The service provides patient transport services for local, regional and national acute NHS hospital trusts, local authorities and independent hospitals, 24 hours a day, 365 days a year. The service provides patient transport services for adults; the service does not transport children.

The service transports patients with mental health needs and those detained under the Mental Health Act 1983. The majority of work undertaken by the service is inter hospital transfers; however, the service also transports patients with mental health needs to and from home addresses when required.

TransSecure NW Ltd is registered to deliver the following regulated activity:

- Transport services, triage and medical advice provided remotely

At the time of the inspection, TransSecure was in the process of identifying an individual to undertake the role of registered manager.

This location has been inspected once previously since it was registered in August 2019. The previous inspection was carried out in July 2020. We took urgent enforcement action to suspend delivery of regulated activities by the provider following that inspection.

The current focused inspection was undertaken to assess if the provider had made sufficient improvements. Although we saw some improvements, we identified that there were still areas that posed a potential risk to patients.

How we carried out this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We did not identify any areas of outstanding practice.

Areas for improvement

Action the provider must take to improve

Action the provider MUST take is necessary to comply with its legal obligations.

- The provider must ensure that it meets the requirements set out in Schedule 3 and Schedule 4, part 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 6(1)(3)(4))
- The provider must ensure that the use of the secure cell is included in the risk assessment form and only used when appropriate and deemed the least restrictive option. (Regulation 11)

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- The provider must ensure there is clear policy or procedure which supports staff in seeking consent, acting in a service user's best interests or undertaking a mental capacity assessment. (Regulation 11)
- The provider must ensure there is an effective process to manage deteriorating patients in terms of physical or mental health conditions in the event their behaviour deteriorated and became uncontrolled. (Regulation 12(1)(2))
- The provider must ensure there is a clear policy to support staff in managing service users who had received sedative medication. (Regulation 12(1)(2))
- The provider must ensure it has appropriate equipment required to monitor and undertake observations of oxygen saturations or blood pressure whilst transporting a service user who had been sedated or who had deteriorated. (Regulation 12(1)(2))
- The provider must ensure it reviews its restraint policy to include appropriate information, best practice and guidance to keep service users safe, and to remove inappropriate references. (Regulation 12(1)(2))
- The provider must ensure it reviews its patient booking exclusion criteria in relation to patients who are immobile. (Regulation 12(1)(2))
- The provider must ensure it reviews its overarching medication policy to ensure there is clear information for staff relating to the administration or support with administration of non-prescribed/prescribed medicine. (Regulation 17)
- The provider must ensure it reviews its risk assessment, policy and processes to ensure staff are supported to understand how to ensure medicines are safely stored during transport. (Regulation 12(1)(2))
- The provider must ensure it has a clear policy or process to support staff to determine how many staff members were needed to safely care for service users during transportation. (Regulation 12(1)(2))
- The provider must ensure it reviews its infection prevention control policy to include relevant information about infection control precautions in line with current guidance around the transmission of COVID-19. (Regulation 12(1)(2))
- The provider must ensure it completes adaptions to is spare vehicle to ensure there are no exposed metal parts in the middle saloon that could pose a safety risk to patients. (Regulation 15(1))
- The provider must ensure it reviews its safeguarding adults' policy to supporting staff in recognising safeguarding concerns for children and young people who may be related to or in contact with patients, and to clarify when a safeguarding concern would be reported to the local authority. (Regulation 13(1)(2)(3)(4))
- The provider must ensure it obtains and records evidence that its external healthcare professional safeguarding lead has the required skills and competence to undertake this role, and that is has a formal agreement in place to support the role. (Regulation 13)
- The provider must ensure it reviews its ambulance risk assessments for the spare vehicle to demonstrate how any associated risks have been assessed and planned for by the service. (Regulation 17(1)(2))
- The provider must ensure its ambulance risk assessment policy defines how the three risk assessment levels of risk are derived and clarifies when a formal risk assessment is required and should be reviewed. (Regulation 17(1)(2))
- The provider must ensure it develops and implements an audit programme to undertake and record any patient quality monitoring or audits in relation to key processes. (Regulation 17(1)(2))
- The provider must ensure it reviews its patient risk assessment process to ensure it has a policy and process to support staff in the correct application and completion of the risk assessments. (Regulation 12(1)(2))
- The provider must ensure it has a policy or process that clearly defines which elements of training are determined as mandatory. (Regulation 17(1)(2))
- The provider must ensure it reviews its policies and procedures to remove elements that are not reflective of the service it provides. (Regulation 17(1)(2))
- The provider must ensure it develops policies and procedure for covering important topics such as mental capacity or health and safety. (Regulation 17(1)(2))
- The provider must ensure it puts in place an overarching governance policy or system to ensure that important policies, procedures and risks are managed effectively, and that the quality safety of services provided are monitored and improved based on the most up to date legislation and best practice guidance. (Regulation 17(1)(2))
- The provider must ensure it has a clear process to determine how the restraint register and incident forms would be reviewed to identify potential failures in care or whether improvements were needed. (Regulation 17(1)(2))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Patient transport services

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Are Patient transport services safe?

Inspected but not rated

We do not rate focused inspections.

Safeguarding

We were not assured that there were systems or processes in place to safeguard service users from abuse and neglect.

During our previous inspection, we were not assured there were systems or processes in place to deal with safeguarding concerns. This was because information we were told about safeguarding referrals conflicted with the provider's policy, not all staff had received safeguarding training to an appropriate level as outlined in the intercollegiate document *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Fourth edition: January 2019*, and there was a lack of clarity over the level of training undertaken by the provider's safeguarding lead.

Prior to the current inspection, the provider told us it was no longer transporting children under the age of 18 years and that a safeguarding adults policy had been drafted. The provider also told us that online safeguarding adults training levels one to three were being taken by staff with expected completion by 25 September 2020. At the time of the current inspection the provider employed eight staff. The provider submitted seven training certificates for staff in QA Level Two Award in Safeguarding and Protecting Children, Young People and Adults at Risk. In addition, training records submitted by the provider showed that nine staff had completed online safeguarding adults levels one to three and safeguarding children levels one to three online training. The provider explained any additional certificates supplied were for temporary staff that were no longer employed. This was an improvement since the last inspection.

However, during the inspection, we continued to have concerns that the provider did not have effective systems and processes to safeguard patients. Although staff had completed training for safeguarding adults and children level three, this had not been done in line with the intercollegiate document as face to face training had not been provided. During the inspection the provider informed us that level two training had been delivered face to face and that similar was planned for level three once this could be facilitated.

Prior to the inspection, the provider sent us two newly released electronic documents in relation to safeguarding; "TS-POL-17 B1 Safeguarding Adults Policy" and "TS-OMP-02 B1 Safeguarding Adults Procedure". The documents were prepared by the Operation Manager, checked by the Quality Manager and approved by the Managing Director. However, there were some inconsistencies in the page titles which, within the document, changed from safeguarding to restraint. Further, the documents made references to unrelated activities or organisations; i.e. sport and sport organisations. This meant we were not assured that the policy was reflective of the service being provided to support staff.

The policy document included definitions of an adult at risk and listed types of abuse and safeguarding risks and provided examples of signs and indicators of abuse. Although it listed female genital mutilation as a potential form of abuse, it did not provide any definition or understanding of this within the body of the document. The procedure document, in section 6.1, appeared to conflate employee concerns, that would normally form part of a HR, whistleblowing or lone-working policy with safeguarding concerns.

The document clarified that staff should complete and submit a safeguarding report form to the safeguarding lead or welfare officer and it also includes the contact details for the Blackburn local authority safeguarding adults lead. However, the individual roles and responsibilities of who undertook which element of the process were not always clear and there was no guidance on how to manage safeguarding concerns out of hours. As with the previous document, this document also made inappropriate references to sport or sports organisations.

Although the provider did not transport children, neither the safeguarding adults policy or procedure included any reference in the body of the documents to support staff to understand and recognise when they may come across situations where they may need to safeguard a child. The safeguarding adults procedure included a report form in the appendix, which included a prompt to consider if there were any children at risk. This further prompted staff to complete a safeguarding children referral form and attach it to the safeguarding report form. However, there was no safeguarding children referral form included in the document.

During the current inspection the provider told us the current safeguarding lead was an external healthcare professional, who was commissioned by the service and had received training to level three. However, the provider was unable to provide evidence that the identified person had the required skills and competence to undertake this role. In addition, there was no formal agreement to support this arrangement. This meant that there was an increased risk that the safeguarding lead would not always be available to support the provider when needed.

In our last inspection, CQC identified that the provider did not have clear documentation for staff to complete if a safeguarding incident had been identified. During this inspection, the provider had attached an appendix to the safeguarding policy for staff to use. However, we were informed by the provider that all safeguarding referrals would be made to the commissioner or the safeguarding authority. This was also written in the safeguarding policy, meaning that there was an increased risk that safeguarding referrals would not always be made appropriately when needed. This was a continued breach since the last inspection.

In response to our concerns regarding safeguarding, we wrote to the provider and asked that it take urgent action to address these.

Infection prevention and control

We were not assured there were robust systems and processes in place to ensure the safe management, prevention and control the spread of infection.

During our previous inspection we only found evidence that one staff member had completed online training in infection, prevention and control. Prior to the current inspection, the provider told us it would update its infection control policy and procedure and create a personal development plan policy to be added to the recruitment policy. The provider told us an infection control log book had been created and was available in the vehicle.

The provider told us that all patient escort staff would complete online infection prevention and control training before the re-inspection. In the 13 training certificates submitted to us prior to the inspection, nine showed that staff had

completed infection prevention and control, including COVID, level one and two online training. This was an improvement since the last inspection. This was one more than the eight staff employed by the provider; however, the provider explained they had included certificates for temporary staff that were no longer employed at the time of the inspection.

The provider's infection control and prevention policy and procedure (TS-OMP-05) was issued on 10 October 2020 as a new release and included a version control section. The policy was prepared by a named staff member, checked by the Quality Manager, and approved by the Managing Director.

The policy referenced a range of legislation documents from a range of national bodies including, although not limited to the *Public Health (Control of Disease) Act 1984 (as amended)*; the *Health and Social Care Act 2008 code of practice on the prevention and control of infections*; and the *Health and Safety at Work etc. Act 1974*.

The policy required staff to clean the ambulance daily, including before and after each transport with a deep clean weekly and additionally if contamination occurred between transfers. It cross referenced to the ambulance risk assessments. This was an improvement since the last inspection.

However, there were also a number of inconsistencies in the policy. For example, details outlining the cleaning of equipment had not been included. In addition, the policy did not include the minimum training requirements for staff to complete. Further, the policy included a section on sepsis and referred to a sepsis tool to assist in the recognition of sepsis; however, there was no sepsis tool included in the policy so it was unclear where staff could access this. The policy also referred to management of clinical sharps (implements that break the skin such as needles or catheters), which would not be expected in the type of service offered by the provider, and which would be excluded by the requirements of the overarching medication policy and procedure for staff not to administer medicines.

During the current inspection, we continued to have concerns about the robustness of the provider's infection prevention and control measures. Although the provider had implemented personal protective equipment such as face masks and visors in response to the COVID pandemic, the provider's infection prevention control policy did not outline any information about this, meaning that it was unclear if the provider had considered and had kept up to date with the most recent national guidance regarding the pandemic. The provider told us it would not transport any patients who were COVID positive. Although the provider told us that patients were screened at the booking stage and that all patients had their temperature checked, there was an increased risk that staff would not be aware of the precautions which were needed to be followed in light of Covid-19, thereby increasing the risk of transmission to patients and exposing them to the risk of harm due to the lack of information in the policy to support staff.

Further, the policy referred to preparing, cooking and storing food in a service user's home, which again would not be expected in the type of service offered by this provider.

In response to our concerns regarding infection prevention and control, we wrote to the provider and asked that it take urgent action to address these.

Environment and equipment

We were not assured that effective systems were in place to ensure the safety of the care and support provided was regularly assessed and monitored to ensure it was being delivered safely.

Inspected but not rated

Patient transport services

During our previous inspection we were not assured that the provider had effective systems in place regularly assess and monitored the safety of care and support delivered. This is because we found no evidence of risk assessments for the ambulance vehicle, which included ligature points in the middle compartment.

Prior to the current inspection the provider told us it had created an ambulance risk assessment policy, which would include a daily check form. The provider also told us it would create a document and process library. The provider submitted a two-page ambulance risk assessment policy and procedure (TS-POL-12, issue B1), which was issued as a new release on 7 October 2020. It included a version control section. The document was prepared by the Quality Manager, checked by the Operation Manager and approved by the Managing Director.

There was an ambulance risk assessment policy and procedure. This outlined some key operational and patient safety risks including self-harm. The purpose of this document was to identify and evaluate potential hazards; it stated that there were three levels of risk and identified some of the potential hazards including risk level and mitigating controls. However, there was no indication on how the level of risk was derived. It did not set out the need for a formal risk assessment outlining any actions required to mitigate risks and for these risk assessments to be regularly reviewed. Risk assessments should be reviewed regularly to ensure that the risks to staff and service users being harmed has not changed and that no further control measures are needed.

Also, the mitigations within the document were not always robust and neither the document nor the checklist provided advice to staff on how to report any hazards identified. For example, the mitigations for a number of hazards include “daily vehicle check” and “pre transfer check” but did not specify the items/areas to be checked. There was no indication that the daily checklist would be recorded or stored for audit purposes and there were no areas of the checklist for staff to add comments or to sign and date to confirm the checks had been carried out.

Further, during the current inspection, we continued to have concerns that one of the ambulances was not safe for use. Although the provider indicated that the vehicle was a spare in case the primary vehicle was unavailable, the adaption of the vehicle had not been completed and posed a potential risk to patient safety. Metal parts of the vehicle were exposed in the middle saloon which patients had access to. The provider indicated this would be rectified but there was no indication of when this would be completed.

The provider was unable to provide evidence that important equipment such as the automated external defibrillator or fire extinguishers had been serviced or had been assessed as being fit for use. This meant there was an increased risk that equipment would fail during use. In addition, the provider did not have a health and safety policy which outlined the requirements for servicing of equipment and how this was to be monitored. However, following the inspection the provider indicated that they had planned to undertake an annual service of the automated external defibrillator.

Although the provider had amended the vehicle inventory list to reflect what equipment was needed on the main vehicle that was used, the inventory had not been updated and implemented on the spare vehicle. This meant there was an increased risk that all equipment would not always be available when needed.

In response to our concerns regarding equipment, we wrote to the provider and asked that it take urgent action to address these.

Assessing and responding to patient risk

We were not assured that care was provided in a way to reduce the risk of avoidable harm to service users.

Inspected but not rated

Patient transport services

During our previous inspection, we were not assured that staff were suitable or had the qualifications, competence, skills and experience to care for patients safely. This was because we found that, although some patient transfer records showed the use of mechanical restraint, not all staff had completed mechanical restraint training or prevention and management of violence and aggression (PMVA) training. We were given conflicting information in interview about the use of handcuffs and restraint straps, both of which were available on the vehicle.

Prior to the current inspection, the provider told us that restraint straps were no longer used, that staff had received mechanical restraints training and that all but one member of staff had completed PMVA training. The provider told us its policy would be updated to include details of techniques used in the prevention and management of violence and aggression training. The provider submitted training certificates for 13 staff prior to our inspection; these included staff who were no longer employed by the time of the current inspection. The certificates submitted included all eight currently employed staff.

The provider told us that all but one eligible staff had completed the face to face training. The course content included awareness of relevant legislation, the psychology of anger, recognizing triggers and alarm signs of anger, disengagement and physical intervention, demonstration and training the use of physical restraint techniques and mechanical restraints (handcuffs).

The training certificates showed that eleven staff had completed a two-day PMVA face to face training course. The certificates showed that nine staff had completed the PSTS/Conflict Management and PMVA Theory (prevention and management of violence and aggression) online training. This meant that some staff had completed both courses. This was an improvement since our last inspection.

The submitted certificates showed that nine staff members had completed handcuffs and emergency response cuffs training; this included all eight currently employed staff members. The submitted certificates showed all eight currently employed staff members had completed manual handling face to face training.

The provider told us all its handcuffs had been serviced and were checked daily. The provider told us that restraint straps were not used, and that staff would be given training in their appropriate use if a decision was made in the future to use them. Further, the provider told us that the operations manager would be part of the escort staff on all journeys where restraint was being used. We confirmed during inspection that all soft cuffs and straps had been removed from the vehicles. This was an improvement since our last inspection.

The provider's restraint policy and procedure (TS-OMP-07, issue B1) was issued on 10 October 2020 as a new release and included a version control section. The policy was prepared by a named member of staff, checked by the Quality Manager and approved by the Managing Director. The Quality Manager and the Managing Director.

The policy referenced a range of guidance documents from a range of national bodies including, though not limited to, the National Institute of Health and Care Excellence: NG10 Violence and aggression: short-term management in mental health, health and community settings (2015); *NG108 Decision-making and mental capacity (2018)*; the Department of Health *Positive and Proactive Care: reducing the need for restrictive intervention (2014)*; and the Care Quality Commission *Brief guide: Restraint (physical and mechanical) (2015)*.

Although the provider's review of the restraint policy was an improvement since the last inspection, we continued to have concerns that it did not include appropriate elements to keep patients safe. For example, it did not include;

- references to the Mental Capacity Act code of practice which has extensive guidance regarding restrictive interventions, restraint and mechanical restraint.
- references to National Patient Safety Authority safety alerts regarding restraint which outlines the need for monitoring of vital signs post restraint.
- reference to medical emergencies such as positional asphyxia.
- Reference, in the body of the document to, *National institute for Health and Care Excellence NG10 and Department of Health: Positive and Proactive Care (2014)* (sections 1.423) regarding the avoidance of certain positions in restraint, higher risk patients and maximum timescales for restraint as well as post restraint debrief.

Further, on reviewing the restraint policy we also identified that;

- there was no specific guidance to support the use of handcuffs.
- it contained examples which were related to different services such as the use of bed rails and locked bedroom doors.
- it stated that the threat of restraint could be used to force service users to do something that they are resisting.
- the policy referenced out of date legislation, the Mental Health Act 2008, despite this being updated in 2015.

The deteriorating patient procedure identified the role of staff which was to monitor patient vitals and record observations should their physical health deteriorate. However, the procedure did not outline clear processes to manage service users in the event their behavior deteriorated and became uncontrolled. For example, procedure indicates that medical attention must be sought if a patient's vital signs such as blood pressure alters. However, the provider did not carry equipment to monitor this such a blood pressure machine or oxygen saturation monitors. Further, there was no criteria to support staff in calling for emergency assistance such as the police when needed.

The procedure did not outline clear processes to manage service users in the event their behavior deteriorated and became uncontrolled. For example, there was no criteria to support staff in recognising in seeking assistance when service users behaviour deteriorated beyond the point in which it could be safely managed in line with their competencies. In addition, it was unclear what action should be taken as the policy stated that the emergency services should be called, or the commissioner must be informed.

As the policy does not reflect best practice and guidance, there was a risk that staff could use restraint inappropriately and fail to adhere to the necessary safety precautions, thereby meaning service users could or would be exposed to the risk of harm.

In response to our concerns regarding restraint, we wrote to the provider and asked that it take urgent action to address these.

During our previous inspection, we only found evidence that only one staff member had completed first aid training. Prior to the current inspection, the provider told us that first aid training had been completed by 25 September 2020, and that patient escort staff would complete basic life support training in house and then undertake formal face to face training in the next available slot (once COVID restrictions allowed). Eight certificates submitted to us after the inspection showed that staff had completed cardiopulmonary resuscitation and basic life support online training, and that first aid modules were included in the food and hygiene training and seizure and epilepsy training.

The provider informed us at the time of inspection that staff had not completed additional first aid training in addition to basic life support training. Additional first aid training was important as part of staff roles and responsibilities to monitor patients for signs of deterioration and without the training there was an increased risk that a deteriorating patient would not be recognised.

In addition, it was unclear if staff understood the emergency management of other conditions such as diabetes. However, we did note that staff had undertaken training on how to manage epilepsy. Following the inspection, the provider informed us that plans had been made for staff to complete additional first aid training.

Although there was evidence that staff had completed additional training since the last inspection, the provider told us that the training policy was in development. It was unclear what elements of training were determined as mandatory meaning there was an increased risk that staff would not always keep up to date with changes to best practice guidance and legislation in order for them to undertake their roles safely.

During our previous inspection we were not assured that staff had access to the information needed to provide safe care and treatment to people being transported. This was because there was no patient risk assessment process in place or policy to support risk assessments, and we found very limited evidence of staff undertaking additional risk assessments to mitigate any known or identified patient risks.

Prior to the current inspection, the provider told us that primary and dynamic risk assessment forms would be created which would score risks (high, medium or low), and would include risks such as allergies, infection status, medical conditions, and last administered medicine. The provider subsequently submitted a primary risk assessment form (TS-OMF-08 B1) and a dynamic risk assessment form (TS-OMF-09 B1). Neither document had a date of issue or owner recorded.

The primary risk assessment form included checks on whether the patient had impaired mental capacity or if they were subject to a deprivation of liberty safeguard order. A free text field enabled staff to record any current risks such as patient current presentation, medical conditions, physical limitations, infection status, allergies and medication. A further free text field enabled staff to record any mitigating actions for the identified risks. Subsequent fields enabled staff to assess whether or not to continue with the booking, and whether any mental health act documentation (H4) was ready prior to the acceptance of the booking.

The dynamic risk assessment form included free text fields for any identified risks (including relating to original or destination environments and convenience stops) and mitigations for the risks identified.

However, although staff had undertaken generic online risk assessment training, there was no policy or procedure to assist with the implementation of this new process to support staff and to ensure that the correct application and completion of the risk assessments. This meant that there was an increased risk that the patient risk assessment process would not always be followed, completed properly or documented as required. The operations manager outlined that they would be on every journey so they would be responsible for completing this. However, there were no contingency plans to ensure that staff would be able to complete this process fully if the operations manager was unavailable. Accordingly, service users may or will be exposed to the risk of harm if staff did not know how to complete the risk assessment process and the operations manager was not available to complete this, as it would mean that all risks may not be identified.

During our previous inspection, we found there was no evidence of monitoring or recording patients' vital signs during or after restraint as outlined in best practice guidance. *National institute for Health and Care Excellence NG10 and Department of Health: Positive and Proactive Care (2014).* Further, we found no evidence that staff involved in four transfers where restraint was used had received training or were assessed as competent in interpreting vital signs.

Prior to the current inspection, the provider told us that restrained patients were under constant supervision by a minimum of two members of staff to detect any concerns or changes in the patient's vital signs. These staff members

would use verbal and visual checks. The provider did not carry any monitoring equipment on the vehicle which meant there was a risk that they would not be able to fulfil the requirements of national guidance in relation to monitoring vital signs. Also, as there limited evidence of what first aid training staff had undertaken to ensure they were competent in interpreting vital signs.

During our previous inspection we found that, although a restraint register was in place, there were no associated incident reports or investigations of the mechanical restraint used in four patient journeys in line with national guidance. We also found evidence that one restrained patient had allegedly been harmed and that the use of restraint may have been disproportionate; however, there was no evidence that an incident had been recorded or investigated.

Prior to the current inspection, the provider told us that a new restraint register was to be created to capture the relevant patient, journey, restraint and vital signs details. The provider subsequently submitted a restraint register form (TS-OMF-23 Issue B1), although this did not identify a document owner. The form included columns for each of the mechanical / physical, start time, end time of restraint, total duration, vital signs check, verbal comm check, planned or unplanned, date, location to and from, distance travelled in restraints, and signatures.

Although the service had implemented a restraint register and an incident form for all staff to complete, there was no clear process which determined how these would be reviewed to identify potential failures in care or whether improvements were needed. The provider did not have a policy or process to support this.

During our previous inspection, we were not assured there were effective systems for governance and risk management to ensure patients received safe care and treatment. This was because there were no inclusion or exclusion criteria to ensure that staff transported patients who they could competently and safely manage.

Prior to the current inspection the provider told us it had created a new booking policy that required risks to be recorded on the booking form. The provider expected to exclude wheelchair users and bariatric patients from its transfer criteria and told us it would incorporate inclusion and exclusion criteria in its patient transfer policy.

Prior to the inspection, the provider submitted its booking policy (TS-POL-16, issue B1). The policy was issued in October 2020 and authorised by the managing director.

There were exclusion criteria for patient transfers which excluded the following service users: those under the age of 18 years; those classified as blind; those classified as deaf and require sign language to communicate; and those with a bariatric history. The director and nominated individual informed us during the inspection that people who were immobile were excluded from being transported during patient transfer, but this had not been included in the documented exclusion criteria. This meant that there was an increased risk that exposed service users to the risk of harm, as staff may not have the experience, skills and competencies to transport service users who should be included within the exclusion criteria.

During our previous inspection, we found no clear patient deterioration procedure to determine how many staff were required to safely transfer a patient. Prior to the current inspection, the provider told us that it had created a new booking policy which stated the process for determining how many escort staff were needed.

The provider had created a new booking policy which stated the process for determining how may staff were needed. However, during inspection we found that the provider still did not have a clear policy or process that supported staff to

determine how many staff members were needed to safely care for patients during a patient transport journey. Although the provider had set a minimum number of staff as three, this could be potentially increased to five, but the criteria for increasing the number of staff were not clear. This meant that there was an increased risk that there would not always be enough numbers of staff to meet the needs of the patient.

At the last inspection we were told that patients detained under the Mental Health Act 1983 would be transported in the celled part of the vehicle whether or not they posed a risk to self or staff. However, we found no evidence of any recorded risk assessments to support this decision or that this was the least restrictive method of restraint for the purpose of the transport.

During the current inspection the use of the secure cell was not included on the risk assessment form for staff to ensure that this type of restraint was only used when appropriate and as the least restrictive option. Restraint must be proportionate to the risk of harm and the seriousness of that harm.

In response to our concerns, we wrote to the provider and asked that it take urgent action to address these.

Medicines

We were not assured there were systems and process in place to support service users to safely manage their medicines, and to safely manage the risks to patients being transported while sedated.

During our previous inspection, we found there were no policies, processes or procedures to determine and manage the risk during transfer for patients who had received sedation medicine.

We continued to have concerns about the transport of patients who had been sedated. The provider told us that it would transfer patients who had been sedated. However, the provider did not carry the required monitoring equipment to ensure that such patients were kept safe. For example, there was no equipment to monitor oxygen saturations or blood pressure. In addition, there was no requirement for a patient escort staff member to travel in the same compartment with patients so that any such risk was mitigated. This meant that there was a potential that patients would be placed at risk of avoidable harm. On reviewing the provider's policies, how to monitor and safely transport patients who had been sedated was not outlined to support staff.

Further, at the last inspection, CQC were informed that patients who had received rapid tranquilisation would not be transported. However, during this inspection CQC were informed that this group of patients would be transported. The medication policy and procedure had not been updated to reflect this.

During our previous inspection, we found that the provider's overarching medication policy indicated that staff could support patients with medicine administration; however, apart from one staff member, there was no evidence that remaining staff had received training in the safe handling and administration of medicines.

During the current inspection, we saw the provider had updated the medication policy and procedure since our last inspection. We saw that all eight currently employed staff had received online training on the safe handling and administration of medications. This was an improvement since our last inspection.

However, we had continued concerns that medicines would not be managed safely and that there was a risk that staff would administer prescribed or non-prescribed medicines inappropriately. We were not assured that the provider's overarching medication policy was specific to the service and adequately supported staff around the management of medication to keep patients safe from avoidable harm.

The provider submitted a copy of its overarching medication policy and procedure (TS-OMP-06, issue B1) prior to the current inspection. The policy was issued as a new release on 06 October 2020 and included a version control section. The policy was prepared by the Quality Manager, checked by the Operation Manager, and approved by the Managing Director.

The policy referenced a range of legislation documents from a range of national bodies including, although not limited to the *Medicines Act 1968,* the *Medical Act 1983,* the *Misuse of Drugs Act 1971, the Misuse of Drugs (Safe Custody) Regulations 1973,* and the *Mental Capacity Act 2005.* However, it included elements that would not be required by the service, such as the Nursing and Midwifery Council's *six rights to medication administration and drug rounds*. It also referenced medication charts, and these must be kept up to date but later in the policy is stated that these did not need to be completed.

We were told by the provider that staff would not administer medicines under any circumstances. However, this was in contradiction to the information included in the overarching medicines policy. For example, the policy continued to outline the levels of support for medicine administration. Level one stated that staff could provide general support or some assistance with medication administration. Level two stated staff would take responsibility for administering non-prescribed medication. The policy indicated that level three administration would not be undertaken by the service, which used a specialised technique. Further, the policy went on to require all staff, who provide assistance to patients with non-prescribed medicines due to impaired cognitive awareness or sensory or physical disability, to be trained and assessed as competent.

The procedure within the medication policy stated that staff were responsible for agreeing the level of support required and ensuring that the appropriate record keeping was met. However, the medication assessment form which was attached at the end of the document to be completed by staff was not referenced within the procedure or how they were to complete and keep the information. Therefore, it was still unclear how staff would know to complete this form in the event of needing to assist a patient with their medication. The medication assessment form was still more reflective of an assessment tool used in an inpatient setting and did not appear relevant to a transport service.

The policy states staff must only administer medication when they have been trained and assessed as competent. It also states training will be in line with the remit of their role and in line with the Training and Competency on Medications Policy and Procedure. However, there was no such policy or procedure available.

The overarching medications policy clarified that medicines remained the property of the service user being transported, and that the provider would only transport them with the patient. It stated that the risk assessment would detail how the patient's own medicines would be safely stored during transport. However, on reviewing the risk assessments, there was not a section to complete this. If staff are not aware of the processes to ensure medications are safely stored, medicines may not be stored securely meaning that service users would potentially be placed at a risk of avoidable harm.

In response to our concerns regarding medicines, we wrote to the provider and asked that it take urgent action to address these.

Inspected but not rated

Patient transport services

Are Patient transport services effective?

Inspected but not rated

We do not rate focused inspections.

Consent, mental capacity

We were not assured that restraint would only be used as the least restrictive option or that there were sufficient policies and procedures to support staff in the application of the *Mental Capacity Act*.

We were not assured that the provider would always recognise occasions when restraint had been used and would potentially use restraint on occasions when not needed. The provider was not aware that the use of the cell in the ambulance was a form of restraint, including when the cell door was not closed, nor was this recognised in the newly implemented risk assessment forms that we observed during the inspection. The provider stated during the inspection that the cell door was not always locked and therefore restraint was not always used. However, the provider's policies, processes and risk assessments did not support this.

The provider did not have a clear policy and procedure which supported staff in seeking consent, acting in a patient's best interest or undertaking a mental capacity assessment. Although limited aspects of mental capacity were documented in the safeguarding policy, the staff induction guide and elements of online training, there was insufficient information which detailed how this would be applied in practice in relation to the service that would be provided on occasions when this was needed. This meant there was a risk that staff would not know what processes and procedures should be followed if service users were not able to make some decisions for themselves.

In response to our concerns regarding the application of the *Mental Capacity Act*, we wrote to the provider and asked that it take urgent action to address these.

Are Patient transport services well-led?

Inspected but not rated

We do not rate focused inspections.

Leadership of service

We were not assured the provider had robust processes to ensure that directors who had responsibility for the quality and safety of care and for meeting the fundamental standards of care were fit and proper to carry out the role.

Inspected but not rated

Patient transport services

Prior to our current inspection, the provider submitted a copy of its recruitment policy. The policy included requirements for pre-employment checks that were in line with the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The policy included reference to criminal records checks, and for positive DBS checks the policy indicated that the employee would be subject to the DBS risk assessment process to determine the outcome.

However, since our last inspection a new director had been appointed, and at the time of the current inspection, steps had not been taken to make sure that the requirements as set out in Schedule 3 and Schedule 4, part 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

An enhanced disclosure baring check had not been completed as is required. In addition, other checks had not been completed such as bankruptcy and insolvency checks. This meant there was a risk that the person appointed may not be suitable for the role, thereby exposing service users to the risk of harm and demonstrated there was a general lack of oversight and appropriate systems in place.

The provider had not included the fit and proper person requirements in the recruitment policy and there was no other policy outlining these requirements. This meant there was an increased risk that such checks would not be undertaken in the future when needed, thereby exposing service users to the risk of harm as people who are unsuitable for roles may be employed by the provider.

In response to our concerns regarding regarding the fit and proper person requirements, we wrote to the provider and asked that it take urgent action to address these.

Governance

We were not assured there were effective systems for governance and risk management to ensure service users received safe care and treatment.

During our previous inspection we were not assured that the provider had robust governance procedures to support staff and monitor the safety of the services being provider. This was because the provider's policies and procedures were not always reflective of the service provided; there were gaps in policy version controls; policies did not always reference appropriate national guidance; and, polices referenced documents that were not in use at the time.

Prior to the current inspection, the provider told us it was updating its policies, including its overarching medication policy and procedure, its restraint policy and its challenging behaviour, violence and aggression policy.

However, during the current inspection we remained concerned that there was no overarching governance policy or system. This meant there was an increased risk that important policies, procedures and risks were not being managed effectively to ensure that that the provider monitored and improved the quality and safety of the services being provided based on the most up to date legislation and best practice guidance.

During the current inspection, we saw that the provider had implemented a new risk assessment process. The provider told us that any patient assessed, at primary risk assessment stage, as presenting with risks of violence or aggression would be transported in the celled section of the vehicle. Any informal or voluntary patients, or those assessed as low risk, would be transported in the middle section of the vehicle.

Patient transport services

An overview of the risk assessment processes was outlined in the recently developed staff induction guide. However, it was unclear whether this document was still in draft format and how this would be applied in practice to support staff as there was no supporting policy or procedure. This meant that there was an increased risk that the risk assessment process would not always be followed or documented as required. The operations manager outlined that they would be on every journey so they would be responsible for completing this. However, if the operations manager was unavailable, there was an increased risk that staff would not complete this process fully.

We continued to find that there were several policies which were not reflective of the service that was being provided. For example;

- The medicines management policy made references to nurses and medicines administration charts. It referenced not administering medicines but then referenced different levels of administration which was confusing. In addition, the medicines policy referred to other policies which were not available to the provider such as a controlled drugs policy and procedure as well as covert medicines policy and procedure.
- The infection prevention and control policy referenced procedures for sharps boxes and information about preparing food in service users' homes. For example, the policy states that all staff should adhere to TransSecure NW Ltd hygiene policy and ensure that all food prepared in the service users' home for the service user is prepared, cooked, stored and presented in accordance with the high standards required by the *Food Safety Act 1990 and the Food Hygiene (England) Regulations 2005*.
- There were elements of the recruitment policy which were not applicable to the service provided, including but not limited to an electronic staff record (ESR) system, workforce planning group, personnel development plans (which the provider did not have), secondment opportunities, agency staff and agenda for change.
- The safeguarding policy did not mention safeguarding children even though staff may come into contact with them and their parents. This is not in line with guidance. It did not fully outline female genital mutilation (FGM), the intercollegiate document, or the training requirements.

Further, the provider did not have policies and procedures covering important topics such as mental capacity or health and safety. This meant that there was a risk that staff would not have the necessary guidance to support them to undertake their roles.

Although the provider had set out what all staff were required to complete as part of induction training, the provider did not have a process for mandatory training. This meant the most important aspects of this training had not been identified and there was no process to make sure that all staff kept up to date with important topics such as safeguarding. The provider told that a training policy was being developed, but there was no indication of when this would be completed.

The provider told us that several policies and processes were still in development. This included important policies such as the governance policy, risk management policy as well as the induction and training policy. We were told that policies that were still in development would include how oversight of the service would be facilitated, including any audit programmes.

This was important as the provider did not currently have a system in place to do this. For example, although the provider had amended the infection prevention control policy, it stated that this would be monitored through audits; however, in the absence of the overarching governance policy, there was an increased risk that this would not be completed.

In addition, although the provider informed us that an individual had been identified to update policies and procedures, there was no evidence of how this would be achieved in a timely manner, reflecting the most up to date legislation and best practice guidance. For example, the provider had not considered implementing the recently introduced Restraint Reduction Network Training Standards – January 2020. This was important as its purpose was set out for providers to be assured that any training commissioned had been certified by the network.

Although the provider had implemented a restraint register and an incident form for all staff to complete, the provider did not have a clear process which determined how these would be reviewed to identify potential failures in care or if improvements were needed. The provider did not have a policy or process to support this.

During the previous inspection we found no evidence, confirmed by the registered manager, that the provider undertook quality monitoring or audits for key processes. Prior to the current inspection, the provider told us it would develop a quality management system document which would include infection prevention and control as part of the operational checks. The provider expected to demonstrate this to staff on a training day on 11 September 2020.

However, during this inspection, we continued to find there were no audit program in place to undertake and record any patient quality monitoring or audits in relation to key processes such as infection control processes or patient records. This meant there was a risk that improvements needed in the delivery of care to the service users would not be recognised and acted upon.

The provider had commissioned an external audit process which reviewed the providers recruitment procedures as well as other policies. However, considering the evidence found in the inspection, we were not assured that these quality audits had identified all areas for improvement.

The provider had implemented a safeguarding action plan to make improvements. However, it was unclear how these improvements would be implemented, who by and in what time period.

The providers recruitment policy stated that driving assessments under test conditions would be required for all staff who drive vehicles. However, we found no evidence that these had been completed. This meant there was a risk that staff did not have the skills and competencies to undertake this safely.

In response to our concerns regarding the provider's governance systems and processes and lack of overarching governance policy or system, we wrote to the provider and asked that it take urgent action to address these.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 6 HSCA (RA) Regulations 2014 Requirements where the service provider is a body other than a partnership

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Transport services, triage and medical advice provided remotely

Regulation 11 HSCA (RA) Regulations 2014 Need for consent