Intrim Medical & Rescue Services Limited

Intrim Medical and Rescue Services Regional HQ and Training Centre

Quality Report

Unit 3 Swinstead Close
Bilborough
Nottingham
Nottinghamshire
NG8 3JG
Tel: 08443100070
Website: www.intrim-medical.com

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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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Intrim Medical and Rescue Services Regional HQ and Training Centre is run by Intrim Medical & Rescue Services Limited. The service is an independent ambulance service who offers patient transport services for adults and children including mental health transfers, emergency medical cover and transport for events and repatriation.

We announced the visit to the provider with two days' notice, and visited on 13 May 2015. At the time of our visit, there were two ambulances and a rapid response vehicle in use.

We carried out this inspection was to check if suitable actions had been taken to the compliance actions we identified on our visit to the service on 21 October 2014. At this visit we found some concerns with the systems and processes in place to manage the risk of the spread of infection, we found some out of date equipment and the storage of medical gases was not suitable.

At this visit we found inadequate systems in place to ensure there was suitable and safe equipment available. To protect patients from the risk of unsafe care and treatment we considered that urgent enforcement action was required.

On Friday 15th May, we presented an application under section 30 of the Health and Social Care Act 2008 to Nottingham Magistrates Court to urgently cancel the registration of Intrim Medical and Rescue Services. This order was granted and the registration of the provider was cancelled with immediate effect.

Our key findings were as follows:

- Systems were not in place to ensure the risk of the spread of infection was being effectively managed.
- There was insufficient provision of safe and suitable equipment. This included some life preserving equipment and meant patients may not have received the care they needed. This meant there was a risk to patient's life, health, or well-being.
- Medications were not always suitably stored or obtained and we also found medicines that had past their expiry date.
- The provider did not have processes and systems in place to monitor the quality of the service provided. This meant there were no actions taken to suitably equip ambulances and ensure that equipment was safe for use.

Professor Sir Mike Richards
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)		The provider did not have processes and systems in place to monitor the quality of the service provided. This meant there were no actions taken to suitably equip ambulances and ensure that equipment was safe for use. There was insufficient provision of safe and suitable equipment. This included some life preserving equipment and meant patients may not have received the care they needed. This meant there was a risk to patient's life, health, or well-being.

Intrim Medical and Rescue Services Regional HQ and Training Centre

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Intrim Medical and Rescue Services Regional HQ and Training Centre

Intrim Medical and Rescue Services Regional HQ and Training Centre is an independent ambulance service based in Bilborough, Nottingham.

The service provides patient transport services for adults and children including mental health transfers, emergency medical cover and transport for events and repatriation. Repatriation means receiving patients who have been out of the country and required medical treatment and transporting them via an ambulance to receive on-going medical care and treatment.

Our inspection team

Our inspection team was led by: Bridgette Hill, Inspection Manager

The team included CQC managers and an inspector.

How we carried out this inspection

The purpose of this inspection was to check that the provider had taken the necessary actions to address compliance actions identified at our previous inspection on 21 October 2014.

At this visit we found some concerns with the systems and processes in place to manage the risk of the spread of infection, we found some out of date equipment and the storage of medical gases was not suitable.

Our visit was announced to the provider on 11 May 2015 and we visited on the 13 May 2015. During our visit we inspected two ambulances, one rapid response vehicle, the premises and a range of records. We spoke with the provider and one staff member.

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Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Intrim Medical and Rescue Services is an independent ambulance service based in Bilborough, Nottingham.

The service provides patient transport services for adults and children including mental health transfers, emergency medical cover and transport for events and repatriation. Repatriation means receiving patients who have been out of the country and required medical treatment and transporting them via an ambulance to receive on-going medical care and treatment.

At the time of our visit there were two ambulances in operation and one rapid response vehicle.

Summary of findings

There was insufficient provision of safe and suitable equipment. This included some life preserving equipment and meant patients may not receive the care they needed, so there would be a risk to their life, health, or well-being.

Systems were not in place to ensure the risk of the spread of infection was being effectively managed.

Medications were not suitably secure and some were out of date so were not safe for patient use.

The provider did not have processes and systems in place to monitor the quality of the service being provided. The lack of systems meant no actions were being taken to suitably equip the ambulances and ensure that equipment was safe for use.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- We reviewed incident records, these showed one incident was recorded in January 2015.
- There were no other incidents recorded.

Cleanliness, infection control and hygiene

- An area of the garage contained mops, buckets and cleaning equipment. This was tidy and well stocked. We saw one ambulance was being deep cleaned by an external company during our visit.
- The arrangements for infection, prevention and control within the service were not meeting the guidance of the Hygiene Code (The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance).
- In one ambulance the seating pad was torn, exposing foam. This had been highlighted as an infection control risk at our visit on 21 October 2014. This had not been rectified. This posed a risk of infection because the seat could not be effectively cleaned.
- There was no information for staff on how often various parts of the vehicles were to be cleaned. There were no records to inform us when the vehicles were last cleaned.
- Parts of one ambulance were dusty and an open clinical waste bag with rubbish in it was secured to an oxygen cylinder. This meant there was a risk of the spread of infection.
- We saw containers for used sharps (needles) where labels were not completed. These are important as they provide an audit trail to their origin should anyone have an injury when handling the boxes. Without a known origin it is not possible to assess the risk to the injured person.
- Gloves and hand gel were available on each vehicle for staff to use. We did not see any disposable aprons available to protect staff and patients from the risk of the spread of infection.
- Equipment for direct patient use such as cups and straws, wipes, clean urinals and vomit bowls were stored alongside cleaning materials . This did not protect patients against cross contamination risk.

Environment and equipment

- The provider had moved to its current premises in March 2015.
- Equipment storage on one ambulance and on the rapid response vehicle was untidy and disorganised. This meant there could be delays in delivering treatment to patients if staff could not easily locate the equipment they needed.
- Oxygen cylinders were stored on open racks which were not secured. These were on wheels and were unsecured so they could be removed or tampered with.
- The service dates for installed equipment in both of the operational ambulances had passed. Labels on equipment stated that servicing was due by February 2015. This included oxygen regulators. This meant staff could not be assured the regulators were delivering the correct volume of oxygen to patients.
- Three sachets of lubricant were found, these were used to aid the passage of tube insertions, such as those used to help people breath. The types of lubricant available were marketed for sexual purposes. One sachet recorded that it improved sensitivity; this was therefore not suitable to be used during a medical procedure.
- There were four endotracheal tubes available on one ambulance. Endotracheal tubes go into the lungs and are used to aid a patients breathing in an emergency situation. We found three of these tubes were out date in 2013 and 2014. This meant there was a risk that the items had perished. Endotracheal tubes have a balloon which is inflated to keep the tube in place. Using tubes that have expired meant there was a risk the tube would not inflate properly.
- On one ambulance we saw there were 13 oropharyngeal airways, out of which 11 had passed their expiry date. For staff to find and use an airway which was in date could result in severe delays when a patient may need urgent assistance to support them to breathe.
- On one ambulance there was a laryngoscope (this is an instrument used for examining airways) that contained no batteries and was not set up for use. This meant the light that is used to assist the practitioner perform the procedure of inserting a endotracheal tube would not have worked . There was a risk that delays could harm the patient. The only available blades for the laryngoscope were in packaging that had been damaged so were not sterile. This was the only laryngoscope available on the vehicle.
- In the rapid response vehicle there was a defibrillator. This did not have a battery fitted into it. We found there

was a battery which expired in two month's time in the bag. The time taken to fit the battery and the potential that it may not function to optimal performance given the short expiry date could place patients at risk. There was no backup battery available. We asked if a risk assessment had been completed on the practice of having a single battery but there wasn't one. It is recommended best practice for NHS and private ambulance providers best practice to have two batteries for a defibrillator.

- One set of defibrillation pads were out of date in 2013. This meant there was a risk that the pads could have dried out and not form a seal on the patient's chest, which could result in burns to the patient.
- There was a range of equipment available to restrain patients should this be required. This included hard handcuffs, tuff-tie handcuffs, spit hoods and limb restraints. There was a log to record when this equipment was signed out and in, however we saw some items on the rapid response vehicle which were not included on the equipment log.
- We saw a suction machine in one vehicle that did not have a service date sticker on it; the provider told us the sticker must have come off. However, we were not provided with evidence that the suction machine was serviced.
- We saw a bag containing Entonox (a pain relieving gas), and an Entonox gas giving set. Both had stickers showing the service was due in February 2015, which meant it was overdue. The bag was loose on a seat, so should the vehicle be involved in an accident this could move and injure patients or staff.
- On one ambulance, the chair used to transport patients was due to be serviced in February 2015 but this hadn't been done. This meant that safety checks had not taken place and the chair may not have been safe for patient use.

Medicines

- We saw medication stored on open shelving in the office. This medication was accessible to non-clinical staff who worked in the office.
- There were no audit records for medications so it would not be possible to establish if any had been taken.
- Staff using their paramedic registration were obtaining some medications. Medicines obtained this way should be for the use of the individual paramedic in the course of their duties and are not to be used by other service providers.
- We found some out of date intravenous medications. These included intravenous fluid (fluid which is given direct into veins), syringes of sodium chloride solution, and ampoules of water used for injection.
- One item of unsecured staff personal medication was found in the office. Personal medication was also found unsecured at our last inspection of the service in October 2014.
- Safes were available on the ambulance so that medication could be stored securely.

Records

- Patient report forms which contained personal details were stored on open shelving in the office; the provider told us that the office was a staff only area so considered there to be a low risk of unauthorised access.

Are patient transport services effective?

We did not assess this domain.

Are patient transport services caring?

We did not assess this domain.

Are patient transport services responsive?

We did not assess this domain.

Are patient transport services well-led?

Governance, risk management and quality measurement

- There was no inventory list or checks made of what equipment should be available on each vehicle to ensure it was safe and suitable to use. This meant the equipment might not always have been available when it was needed.
- We asked if there were checks made of the vehicles to make sure they were safe and suitable. We were shown

one vehicle record dated 14 August 2014; the provider confirmed no other checks had been completed. We asked what the expected frequency of checks should be and were told it should be "Daily when we are up and running." However, these checks were not completed and records showed it was nine months since the last documented check.

- Service checks of equipment on ambulances had last been completed in February 2014. At the time of our visit, no arrangements were made for equipment to be checked despite this being overdue.
- There were no standardised cleaning schedules to describe the frequency that day to day cleaning should take place and no records to indicate when vehicles were last cleaned. It could not be established that regular cleaning was completed.

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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
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There insufficient systems and processes in place to monitor the quality of the service provided. On May 15 2015 we applied for an urgent cancellation of the provider's registration under Section 30 of the Health and Social Care Act 2008 as it was considered there was be a serious risk to a person's life, health or well-being should the service continue. This was granted, and the providers registration was cancelled with immediate effect.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medications were not always suitably obtained and secure. Some were out of date so were not safe for patient use. There were not systems in place to ensure the risk of the spread of infection was being effectively managed. On May 15 2015 we applied for an urgent cancellation of the provider's registration under Section 30 of the Health and Social Care Act 2008 as it was considered there was be a serious risk to a person's life, health or well-being should the service continue. This was granted, and the providers registration was cancelled with immediate effect.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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