Kernow Ambulance Service

Kernow Ambulance Service

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Kernow Ambulance Service is operated by Kernow Ambulance Service to provide a non-urgent patient transport service for patients with mental health conditions and learning disabilities. The service is operated from a base in Bodmin, Cornwall and provides transport across the UK for people aged between 14 and 65.

We first inspected Kernow Ambulance Service on the 24 October 2017. During that inspection we raised concerns about safety of service users. Following the inspection, we took enforcement action and issued a warning notice regarding the governance arrangements to monitor the service provision. We also issued two requirement notices. One was regarding the assessment and response to patient's needs, with regard to the use of mechanical restraint in accordance with the Mental Health Act 2015, and the second related to pre-employment recruitment checks.

In January 2018, the registered manager sent us an action plan outlining the actions they had taken, and planned to take, to improve the areas of concern. We carried out a focused inspection on 13 June 2018 to ascertain if actions had been completed, and the concerns addressed. We announced the inspection at short notice to ensure the availability of key staff.

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 found the following areas of good practice:

- Incidents were fully investigated and the findings used to improve services.
- The named person for safeguarding was identified within policies for children and adults.
- Infection control procedures were safely managed including the risk from clinical waste, contaminated linen and the safe handling of sharps.
- Pre-employment processes were used to ensure only suitable staff were employed.
- All staff received mandatory and service specific training, records were kept up to date and compliance monitored to identify when update training was required.
- The risks associated with transporting patients with mental health needs were identified, assessed and used to inform care plans; including the potential need for restraint.
- Consent and mental capacity was assessed for each patient to ensure their rights were respected.
- The systems and processes introduced as part of governance arrangements provided an oversight of the quality and safety of the service provided to patients.
- The provider used audits and other assurance methods to improve the quality of services provided and maintain patient safety.

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

- Planning and recording for longer journeys where risks were increased due to comfort breaks and stops for ambulance driver rotations to occur.

Amanda Stanford
Deputy Chief Inspector of Hospitals (South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Kernow Ambulance Service provides non-emergency ambulance transport, predominantly for people with mental health conditions. The provider also conducts transfers for patients detained under the Mental Health Act 1983. During the inspection, we saw the provider had made significant improvements in response to the breaches identified within the warning notice and the two requirement notices. The senior management team could demonstrate a number of systems and processes which had been implemented to change practice and comply with the Health and Social Care Act 2008 (Regulated activities) 2014. This ensured a safer service to patients and effectively monitored the quality of services provided.

Kernow Ambulance Service

Detailed findings

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Detailed findings

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Background to Kernow Ambulance Service

Kernow Ambulance Service is operated by Kernow Ambulance Service. The service opened in 2014 as an independent provider transporting vulnerable adolescents and adults. The service is based in Bodmin, Cornwall and predominantly operates across the UK.

The registered manager, Lee Clarke, had been in post since 2014. He was the registered manager at the time of our inspection in October 2017.

The service is registered to provide the following regulated activities:

- Patient transport services, triage, and medical advice remotely.

During the short notice inspection on 13 June 2018, we visited the ambulance station and administrative office in Bodmin. We spoke with five staff including two Ambulance Healthcare Crew and three members of the management team. During our inspection, we reviewed 20 sets of patient records.

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 service had previously been inspected once in October 2017. At that time, we found services did not achieve all the required standards of quality and safety it was inspected against.

Activity November 2017 to May 2018

- There were 532 patient transport journeys undertaken.

25 Ambulance Healthcare Crew worked at the service.

Track record on safety:

- No never events
- 87 clinical incidents
- No serious injuries

The provider has not received any complaints.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Mary Cridge, Head of Hospitals Inspections.

Patient transport services (PTS)

Safe	
Effective	
Responsive	
Well-led	
Overall	

Information about the service

The main service provided by this ambulance service was patient transport.

Summary of findings

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- Incidents were fully investigated and the findings used to improve services.
- The named person for safeguarding was identified within policies for children and adults.
- Infection control procedures safely managed the risk from clinical waste, contaminated linen and the safe handling of sharps.
- Pre-employment processes were used to ensure only suitable staff were employed.
- All staff received mandatory and service specific training, records were kept up to date and compliance monitored to identify when update training was required.
- The risks associated with transporting patients with mental health needs were identified, assessed and used to inform care plans.
- Consent and mental capacity was assessed for each patient to ensure their rights were respected.
- The systems and processes introduced as part of governance arrangements provided an oversight of the quality and safety of the service provided to patients.
- The provider used audits and other assurance methods to improve the quality of services provided and maintain patient safety.

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

- Planning for longer journeys where risks were increased due to comfort breaks and stops for the ambulance driver rotation to occur.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- Kernow Ambulance Service had improved process for the investigation and management of clinical incidents since the last inspection. The processes included occasions where restraint had been used in response to aggressive behaviour. In contrast to our previous inspection, we found the provider undertook a thorough review of incidents and completed improvement actions. The provider also took a consistent approach to learning from those events, for example staff had been reminded about the proper use of the buckle and harness which had resulted in a reduction in use of this restraint.
- The provider demonstrated a clear understanding of their responsibilities for the safe management of incidents. The policy for incident management (14 January 2018) had been reviewed and updated to include a new incident management process. The new policy had been implemented to inform all staff of the correct actions to take. On receipt of an incident report, a member of the management team completed a new incident investigation form to capture immediate findings and required actions. At this point, the incident harm level was assessed and categorised as part of the review.
- Since our previous inspection, an incident database had been implemented to record the incident management process. This included discussion at a governance committee where factors such as compliance with local policy and the Mental Health Act Code of Practice 2015 were considered. The committee agreed any further steps and incidents were also considered closed on completion of these actions. For example, the referral process had been re-evaluated and refined following incidents, the governance committee felt key information had not been obtained at initial conversations and the template was updated with additional prompts for staff.
- Systems were available to record incidents and to review for learning to improve practice. During our inspection we reviewed five incidents which occurred between February 2018 to May 2018. We found all incidents consistently contained information regarding the event, the investigation, and actions. We reviewed minutes of the governance committee from February 2018 and April 2018, we found incidents had been discussed and actions agreed. We found actions were either completed or had a date for completion. We reviewed minutes of the staff meeting for March 2018 and found information regarding recent incidents was shared as part of wider learning.
- We were unable to see recorded evidence of feedback to individuals, however we asked a member of staff involved in an incident who told us he had received feedback and did each time a matter was reported.
- Systems were available to record incidents and learning when restraint was used. For all incidents, including those involving mechanical restraint, the journey log was reviewed to ensure the use of restraint was appropriate and justified with a clear rationale for use. All incidents involving restraint were reviewed, where the review concluded staff had provided appropriate care the decision was recorded, and incident closed. Any identification of the need for further action was followed up with the staff involved.
- The overview of incidents was used to develop the service. Where the committee found there was room for improvement a plan was made. For example, in April 2018 a trend was seen regarding vulnerable patients with complex needs whose mental health status changed during transfer. The provider had identified that the changes in patient status meant that the destination may no longer be able to cater for the patient's needs. For example, the patient may need a secure unit or intensive care. The committee intend to facilitate a multi-agency meeting to identify how the patient pathway can be improved to ensure the patient is referred to an appropriate service.

Mandatory training

- The management team ensured staff were completing mandatory training to keep patients safe. At our previous inspection in October 2017, we found that although staff were offered mandatory and provider specific training, not all training had been recorded as completed and some training was out of date. At this inspection, we found the provider had ensured all staff were fully trained in accordance with the Induction and Training Policy (February 2018) and records were up to date.
- The provider used a training matrix to provide an overview of staff compliance and monitor completion

rate. This prompted the management team to remind staff when training was due and book update sessions. Staff meetings and newsletters were also used to inform staff of new training opportunities and share the compliance rates for existing topics. We reviewed the training records for all staff employed by the provider. The record showed all staff were up to date with all areas of training, except for staff with a long-term absence.

- The provider sought the opinion of staff when considering the suitability of current training provision. Staff were involved in the review of policies including the training policy, and we saw staff meeting minutes which discussed the content of courses and additional needs for new equipment. An employee handbook was being compiled to inform staff of the providers expectations around training.

Safeguarding

- Procedures for safeguarding adults and children were available to keep patients safe and in keeping with the guidance for Safeguarding Children and Young People: Roles and Competences for Health Care Staff: Intercollegiate Document (Royal College of Paediatrics and Child Health 2014.
- During our inspection in October 2017, we found that although staff could identify the named person for safeguarding, the individual was not cited within company policies. The provider had taken steps to ensure the named person for safeguarding adults, adolescents and children was clearly identified within the relevant company policies we reviewed the policy at Kernow Ambulance Service for Safeguarding of Children and Adolescents (January 2018). The named person was identified alongside a summary of the role and responsibilities. We also reviewed the safeguarding policy for adults (January 2018), the document also detailed the named person and their duties to oversee safeguarding within the service.

Cleanliness, infection control and hygiene

- There was evidence to demonstrate the provider had taken the required steps to minimise the risk of infection by ensuring staff training was updated and clinical waste was managed appropriately.
- The overview of staff training identified that all staff had completed infection control training. This was an e-learning process, the content was appropriate to the needs of the service provided. Further hand hygiene audits were planned to ensure the training was effective.
- Since our previous inspection, the provider had put in place a service level agreement (a contract between two companies defining the provision of a service) with an external specialist company to ensure clinical waste was safely disposed of and contaminated linen was handled appropriately. Changes in practice were shared with staff through staff meetings and newsletters. The policy for Infection Control was revised in February 2018 to reflect the changes.
- At the previous inspection in October 2017 we identified that sharps boxes stored on vehicles for safe disposal of used were not correctly labelled. The labelling indicates the contents the date the box was assembled and by whom. During our visit in June 2018, we checked the sharps box on one vehicle and found the labelling to be fully completed. We were told sharps boxes were disposed of through a local chemist; there was no contract with the chemist, but no disposal had ever been needed since the service started.

Assessing and responding to patient risk

- The provider had made significant improvements to identify, communicate, and manage risks during patient transfers. At our last inspection, we could not be assured that risk assessments undertaken prior to transfer were sufficient to ensure the safety of the patient or staff. The action plan sent to us in January 2018, outlined a new risk management process which had been developed to include gathering of information about the patient and ensuring that sufficient information was available before the transfer was agreed.
- During this inspection the assessment of patient risk was completed and recorded so patient safety could be assured. A new referral form was implemented to capture a previous history and the current presentation of the patient. A risk assessment was then conducted to identify key risks factors and ascertain a risk score. The risk assessment was used to consider the staff level and skills needed to ensure a successful and safe transfer. We reviewed 20 patient records found all complied with the provider's policy.
- There were systems and processes for identifying deteriorating patients during transfer. The ambulance

crew recorded the patient's condition on arrival and assessed whether any variances should be escalated to the senior managers. Discussions regarding the patients current needs and potential management strategies were clearly recorded by the ambulance crew on the scene. Once the journey had commenced, the patient was continuously re-assessed throughout the transfer to monitor for changes in behaviour and check their needs were met.

- Mechanical restraint was well managed, recorded and audited to ensure its appropriate use. Mechanical restraint is a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control. For example, the provider used a five-point safety harness for the transport of some patients. This was sometimes applied due to aggressive and violent behaviour and use of the harness was part of the physical intervention training course.
- The Mental Health Act Code of Practice (2015) states that mechanical restraint may only be used in exceptional circumstances and the patient must be monitored when restraints are applied. The provider had previously been unable to assure themselves that mechanical restraint was used when all other options had been discounted. A dedicated document to record the use of mechanical restraint was introduced as part of the patient journey log (last updated June 2018). The provider policy for the management of Violence and Aggression (November 2017) had been updated to reflect these changes, and staff were now required to contact the management team if restraint was applied for over an hour.
- During our previous inspection, we found little evidence that patients had been monitored to ensure their safety during the application of restraint. As part of the action plan to address our concerns, the provider had provided additional staff education to improve monitoring and the documentation of patient checks.
- We reviewed 20 patients transfer records which had included both verbal and physical aggression. We saw evidence of patient assessment from the point of referral to handover of the patient. The record showed the rationale for restraint and we saw monitoring observation undertaken every 15 minutes until the removal of the restraint. The quality of information regarding the patient, their needs, the actions of the crew and communication had significantly improved since our previous inspection.
- All incidents were used as learning opportunities for staff. Each transfer involving restraint was recorded as an incident, which was reviewed at the governance assurance meeting to consider if practice had complied with company policy, and the underpinning legislation.

Staffing

- Recruitment procedures had been reviewed and the provider had taken corrective action to ensure that checks, such as references of good character, were undertaken for all staff employed by Kernow Ambulance Service. It was evident that considerable work had been undertaken to ensure that staff personnel files were monitored and updated. The completion of pre-employment checks and induction training was recorded on a database. A member of the management team oversaw the recruitment process and escalated to managers when issues occurred. During our inspection we test sampled the records to check both the contents and the accuracy of the electronic database. We found both the files to be correct and the information correlated to the electronic record.
- The allocation of staffing numbers to ensure the needs of a patient were met remained a challenge due to the fluctuation in behaviour. Following our previous inspection in October 2017, the provider told us they had considered the use of a tool which used the outcome of an assessment of patients needs to indicate the number of staff required during a transfer. We were told of research undertaken by the senior managers to explore existing methods for the transfer of patients with mental health needs. The management team decided that the allocation of staff level should be on an individual basis after discussion with the referring clinician and a review of risks identified at referral. We were told any staffing issues would be monitored through feedback from the staff during meetings and via the incident management process.
- We had previously identified that variance in staff training which meant not all staff were equipped with the same skills. We raised concerns that staff were unable to identify the correct use of mechanical restraint or provide the support should a patients needs

change. The provider had taken steps remove any gaps in skill mix by providing additional training to ensure all staff received equal training to enable to meet the needs of those in their care.

- There was an improvement in staff safety, as Ambulance Healthcare Crew adhered to the company policy regarding rest and breaks. As part of staff safety and under the provider's policy, crew were expected to rotate every two hours. A journey log was maintained which included who was driving at any given time, any stops and any delays. In the 20 records we reviewed at this inspection; we found that the driver did rotate every two hours and appropriate breaks were taken.

Are patient transport services effective?

Evidence-based care and treatment

- The monitoring of restraint had improved and provided evidenced based care and treatment. We found a new process had been introduced, for example the use of restraint was discussed with the mental health professional at the point of referral and the detailed information was shared with ambulance crew. We reviewed twenty records of patient journeys; nine involved the use of mechanical restraint. We saw information received during the handover of the patient on arrival was considered as part of management plans. We found a recorded rationale for the use of restraint, including why de-escalation and other methods had failed. As part of the record of restraint, the patient was monitored every 15 minutes as required by the code of practice.

Assessment and planning of care

- The provider had improved the management of risks associated with the safe transportation of patients. However, there was no process in place to manage the risks associated with longer journeys where breaks at service stations and facilities may be required.
- Following our inspection in October 2017, the provider had undertaken a clinical risk assessment of patient transfers; this was captured on the company risk register and monitored by the senior management team to ensure control measures remained effective.
- Kernow Ambulance Service undertook long distance transfers, for example from Cornwall to London. At the previous inspection, staff told us that patients with a forensic mental health history would be transferred without stops being made. However, for other patients we previously found little evidence to identify how patients' needs during the journey were planned, for example toilet breaks and meal planning. During this inspection, we found no improvements had been made to prepare for the risks associated with longer journeys where comfort breaks and stops may be required.
- The provider did not have agreed safety practices with other providers who used their services.Under the Mental Health Act Code of Practice 2015 the provider should agree what type of restraints can be used with commissioners. In response to our previous findings, the provider had drafted a document to outline the company policy regarding restraint. The provider could demonstrate that clear attempts had been made to formalise safety practices with commissioners and other providers. The management team told us they are currently pursuing an agreement with the commissioning organisations.

Response times and patient outcomes

- As identified during our previous inspection in October 2017, the provider did not collate information to determine key performance indicators. This was because the service was specific to mental health patients and so varied information such as journey times would not be comparable. During our inspection in June 2018, the provider told us they had reviewed data relating to journey but again found data was so variable that it was not possible to draw meaningful conclusions related to performance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Kernow Ambulance Service regularly transported patients under the jurisdiction of the Mental Health Act (1983). At our previous inspection we had identified that practices set out in company policy and procedures did not reflect the updated Mental Health Act Code of Practice 2015 and associated code of practice. In response to our concerns, the provider had updated documents held within the quality management system to reflect the current legislation and introduced a system for monitoring the appropriate use of restraint.
- Patient capacity and consent was now considered to ensure whenever possible the patient understood and agreed with the journey. We found the provider had

taken steps to improve how mental capacity and consent was always considered as part of each patient's health status. We reviewed twenty patient records, we found consent was documented in each case. An assessment of mental capacity was made by the referring clinician when making a booking and by the ambulance crew before the transfer commenced. Where the patient was undergoing transfer under the Mental Health Act (1983), the legal authority to act was clearly documented within the patient record and a copy of the record located in the patient notes.

Are patient transport services responsive to people's needs?

Learning from complaints and concerns

- Systems had been put in place and used to develop the service provided. Although no complaints had been received since our last inspection, the provider had a process for managing complaints including a review of any concerns and learning as part of a governance system. This system then cascaded the information through staff meetings and newsletters to distribute the learning.
- Complaints were managed by the registered manager in line with the company policy. No complaints had been received since our last inspection. However, the provider had designed and produced a leaflet for all patients which was handed out after each journey. The leaflet advised patients how to complain and what they could expect from the provider, including their response.

Are patient transport services well-led?

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- Clinical governance arrangements had been developed to ensure oversight of quality and safety across all areas of the service. An underpinning assurance framework had been implemented to monitor compliance to company policy and the safe introduction of new procedures. Although the new structures and processes were still in development, the senior management team told us they felt more informed and able to evidence the standard of care and compliance with evidence based practice.
- The Information Governance and Storage of Data policy (February 2018) detailed quality assurance arrangements. The policy provided information about how governance arrangements in the company provided oversight to the senior management team. The provider had considered the role and function of three key meetings held within the company. The bi-monthly Governance Assurance Committee (GAC) was underpinned by set terms of reference which outlined the purpose and outcomes of the meeting.
- Staff meetings and management meetings both reported into the GAC. We reviewed the agenda and minutes for meetings held between January and April 2018. We found standing agenda items such as incidents, feedback and learning opportunities were consistently discussed. We also saw communication between the key meetings ensured information was escalated or shared as required. For example, in minutes of the GAC meeting held in February 2018 an audit had identified issues with the handling of medication between hospitals. The committee discussed the audit and agreed the findings should be shared with staff. We reviewed the minutes from the staff meeting held in March 2018, the correct handling of medicines was discussed with staff and a demonstration of the documentation to be completed given to improve practice.
- An independent governance consultant had been appointed to provide an external view and provide challenge. The governance consultant role included reviewing compliance and service delivery within the newly formed governance meetings. This review included looking at aspects of the service, not in isolation but as part of a governance process. For example, the provider had created a patient transport risk register (February 2018). The register contained clinical risks related to the transfer of patients such as lack of training and equipment failure. The register was evaluated introducing governance committee meetings to assess, monitor and mitigate risks associated with service delivery. The review considered data collated from assurance activities such as incident reports, service user feedback, and audits to determine if a risk was managed to an acceptable level.

Patient transport services (PTS)

- The incident management process ensured incidents were considered as part of the governance assurance framework. The learning from the review of each incident, or following the identification of trends and themes from analysis is shared at management meetings, staff meetings and through staff newsletters. This ensured that incident reporting was used to develop the service and provided learning for staff.
- A series of audits had been implemented to monitor the service and included auditing the patient journey, patient experience, management of medicines and aspects of hygiene. The clinical audit outcomes were reviewed quarterly looking for themes and trends and any areas of concern were escalated to the risk register. The audits included a review of 50 patient records each month to include how staff had recorded medication, consent and capacity. The provider confirmed that clinical auditing had found shortfalls which prompted an action plan with timescales for improvement.The next audit had been able to show improvements and changes in levels of risk. The audit had identified changes in scoring which the provider had investigated and continued to use for development of the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should consider how risks associated with longer journeys, for example stops for driver rotations or patient comfort breaks, are identified and managed prior to departure.