K.F.A Medical Ltd

KFA Medical

Inspection report

Branwell House
Park Lane
Keighley
BD21 4QX
Tel: 01535601748

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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 well-led?	**Inspected but not rated**

Summary of findings

Overall summary

Due to the nature of the inspection we inspected but did not rate the service.

We found the following areas where the provider needs to improve;

The provider still did not have a mandatory training policy. There was no assurance mandatory training and key skills was provided to all staff. We found no evidence of any completed training in one staff file.

Staff could not demonstrate they understood how to protect patients from abuse. There was no evidence the service worked with other agencies to do so. The provider's safeguarding policy contained no clear guidance for staff to follow as to the correct procedure to report a safeguarding concern.

The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. Staff were unable to evidence they were operating a safe infection prevention and control system.

The design, maintenance and use of facilities, premises, vehicles and equipment did not keep people safe. Equipment, vehicles and premises were visibly dirty.

Staff completed risk assessments for patients, but the provider had no specific eligibility criteria to ensure patient transport services (PTS) staff were competent to meet patient's needs.

Staff did not have the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Some disclosure and barring service (DBS) checks of employees were not up to date or had not been obtained when employees applied to work for KFA Medical Ltd. This meant we could not ensure staff were fit and proper and of the necessary character to work for the provider.

The service could not demonstrate it followed best practice or used systems and processes safely when recording and storing patient's own medicines. The provider's medications policies were confusing and did not reference one another.

The service did not manage patient safety incidents well. There was no formal process in place to share learning from incidents.

Leaders could not demonstrate they had the skills and abilities to run the service.

Leaders could not demonstrate how they operated effective governance processes. The registered manager could not answer questions in relation to company policies. The provider had drafted first versions of over 30 new policies and procedures since our last inspection on 10 March 2021. The majority of the provider's policies remained generic and were non-service specific with references to reporting and recording systems the provider did not have. The policies lacked vital detail on processes and guidance staff should follow.

Leaders and teams could not evidence how they used systems to manage performance effectively. They could not articulate how they identified and escalated relevant risks and issues.

Summary of findings

The service did not collect reliable data or analyse it. Staff confirmed the provider had no retention of records policy.

After this inspection we served the provider a notice of decision under Section 31 of the Health and Social Care Act 2008 to formally notify them their registration as a service provider in respect of the above regulated activities will be further suspended from 11 June 2021 until 11.59pm on 6 September 2021. This followed the provider's original suspension period from 15 January 2021.

We were concerned given the lack of improvements seen to date since our inspection in January 2021 of the service being managed. As a result, we proposed to cancel the registration of the manager and provider in respect of the regulated activities; Transport services, triage and medical advice provided remotely and; Treatment of disease, disorder or injury. This notice was served under Section 26 of the Health and Social Care Act 2008. There was no representations submitted following the notice of proposal and as a result, we issued a notice of decision to cancel the registration of the manager and provider in respect of the regulated activities; Transport services, triage and medical advice provided remotely and; Treatment of disease, disorder or injury was served under Section 26 of the Health and Social Care Act 2008.

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	Due to the responsive nature of this inspection we did not rate the service. We found the following areas where the provider needs to improve; The provider still did not have a mandatory training policy. There was no assurance mandatory training and key skills was provided to all staff. We found no evidence of any completed training in one staff file. Staff could not demonstrate they understood how to protect patients from abuse. There was no evidence the service worked with other agencies to do so. The provider's safeguarding policy contained no clear guidance for staff to follow as to the correct procedure to report a safeguarding concern. The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. Staff were unable to evidence they were operating a safe system. The design, maintenance and use of facilities, premises, vehicles and equipment did not keep people safe. Equipment, vehicles and premises were visibly dirty. Staff completed risk assessments for patients, but the provider had no specific eligibility criteria to ensure patient transport service (PTS) staff were competent to meet patient's needs. Staff did not have the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Some disclosure and barring service (DBS) checks of employees were not up to date or had not been obtained when applying to work for KFA Medical Ltd. This meant we could not ensure staff were fit and proper and of the necessary character to work for the provider.

Summary of findings

The service could not demonstrate it followed best practice or used systems and processes safely when recording and storing patient's own medicines. The provider's medications policies were confusing and did not reference one another.
The service did not manage patient safety incidents well. There was no formal process in place to share learning from incidents.
Leaders could not demonstrate they had the skills and abilities to run the service. The external governance consultant expressed doubts about the registered manager's abilities and understanding in how they carry out their role.
Leaders could not demonstrate how they operated effective governance processes. The registered manager could not answer questions in relation to company policies. The provider had drafted first versions of over 30 new policies and procedures since our last inspection on 10 March 2021.
Generally, the provider's policies were generic, non-service specific and some read as if for a larger organisation with references to reporting and recording systems the provider did not have. They lacked vital detail on processes and guidance staff should follow.
Leaders and teams could not evidence how they used systems to manage performance effectively. They could not articulate how they identified and escalated relevant risks and issues. The provider's designated lead in multiple areas was one person not directly employed by the provider
The service did not collect reliable data or analyse it. Staff confirmed the provider had no retention of records policy.
However, we did find the following areas of good practice;
The service had a designated or nominated lead for safeguarding, infection prevention control (IPC), investigations, complaints, freedom to speak up, litigation, governance and risk management. This lead planned to share their governance approach and experience with staff until the service was self-sufficient.
The service had a vision for what it wanted to achieve.
Staff we spoke with felt respected, supported and valued.

Summary of findings

Contents

Summary of this inspection

Background to KFA Medical

KFA Medical first registered with the CQC on 14 June 2013. The service is an independent ambulance service based in Keighley, West Yorkshire.

The company provided a range of services including; urgent and emergency paramedic and first aid medical coverage at both private and public events; blood and organ transport; first aid training, repatriation of patients all of which are not currently regulated by CQC. The company also provided patient transport services which is regulated by CQC.

In January 2021, CQC received information of concern about KFA Medical Ltd. A decision was made to carry out an unannounced focused inspection of the safe and well-led domains to investigate the concerns.

Following the January 2021 inspection, we issued the provider with a notice of decision on 15 January 2021, to urgently suspend the provider's registration to carry out regulated activity until 14 March 2021. This was due to risks identified regarding patient safety identified during the inspection. We told the provider that it must take 24 actions to comply with the regulations and should take one action even though a regulation had not been breached, to help the service improve.

Following the unannounced inspection on 10 and 11 March 2021, we issued the provider with a notice of decision on 12 March 2021, to urgently suspend the provider's registration to carry out regulated activity until 14 June 2021. This was due to risks identified during the inspection regarding patient safety. We told the provider that it must take 20 actions to comply with the regulations and should take one action even though a regulation had not been breached, to help the service improve.

This inspection was an unannounced focused inspection of the safe and well-led domains to gain assurance the provider had acted in response to the issues highlighted in the notice of decision to urgently suspend the provider's registration to carry out regulated activity.

How we carried out this inspection

KFA Medical Ltd are registered to carry out the following regulated activities:

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

During the inspection conducted on 7 June 2021, we visited Branwell House, Park Lane, Keighley, West Yorkshire BD21 4QX, which is the provider's operating base and undertook interviews of staff onsite and remotely.

At the time of this inspection the provider employed only three members of staff.

The staffing consisted of; a managing director who was also the registered manager, a company accountant who worked four hours per day Monday to Friday, a patient transport service (PTS) driver, and an operations manager. Since our last inspection the provider had commissioned an external governance consultant who had a service level agreement (SLA) in place.

Summary of this inspection

During the inspection we spoke with the registered manager, operations manager, and PTS driver. We interviewed the external governance consultant by video call the day after our inspection. We also reviewed four staff files and inspected two ambulances the service planned to use for PTS.

The service had been suspended from carrying out regulated activity since 15 January 2021. However, prior to that;

Activity (April 2020 to January 2021);

- In the reporting period, there were 6477 patient transport journeys undertaken between two NHS hospitals. Five children were transported. At the time of inspection, the service was suspended, and no patient journeys had been undertaken.
- In the reporting period, there were no emergency and urgent care patient journeys undertaken.
- The provider does not store or use controlled drugs.

Track record on safety:

- No never events reported
- Clinical incidents; none with no harm, none with low harm, none with moderate harm, none with severe harm, and no deaths reported.
- No serious injuries reported
- No complaints reported.

The team who inspected the service comprised of a CQC sector delivery and oversight manager, four CQC acute inspectors and an inspection manager. The inspection team was overseen by Sarah Dronsfield, head of hospital 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

None.

Areas for improvement

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

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with legal requirements. These actions related to Patient Transport Services.

The provider's registered manager must demonstrate full understanding of their responsibilities in carrying out and managing regulated activities and meeting the standards required by the Health and Social Care Act Regulations. **Regulation 7.**

Summary of this inspection

The provider must ensure that all staff employed are of good character and have the appropriate qualifications, competence, skills and experience fit and proper to undertake the role they are employed to perform. **Regulation 7.**

The provider must keep all equipment, vehicles and premises clean by supporting staff to use equipment and control measures to protect people who use services and themselves free from infection. **Regulation 12.**

The provider must ensure infection prevention and control procedures are aligned to current best practice guidelines. The provider must carry out infection prevention control (IPC) audits. **Regulation 12.**

The provider must ensure staff's regular lateral flow tests undertaken are recorded in their staff files in line with their COVID-19 guidance and procedure policy and Department of Health and Social Care national guidance, Coronavirus (COVID-19) workplace testing: guidance for private-sector employers and third-party healthcare providers. **Regulation 12**.

The provider must have current and appropriate disclosure and barring checks (DBS) for all staff for the role in which they are employed. **Regulation 13.**

The provider's recruitment policy must include information about what to do in the event of a positive DBS disclosure. **Regulation 13.**

The provider's designated lead in multiple areas must be someone directly employed who has undertaken training for these roles. **Regulation 13.**

The provider must have an effective system and process to ensure the maintenance and use of facilities, premises, vehicles and equipment to keep people who use services and staff safe. **Regulation 15.**

The provider must have the correct equipment for the patients transported in their vehicles with the associated systems and staff training in place for the safe operation of that equipment. **Regulation 15**.

The provider's operating premises must have a fire risk assessment, clear evacuation plan and fire extinguishers which have been tested, labelled and are ready for use. **Regulation 15.**

The provider must have policies specific to the service which cross-reference other policies and national guidelines where relevant. **Regulation 17.**

The provider must demonstrate they have an effective risk and governance system that supports safe and quality care. **Regulation 17.**

The provider must develop a systematic programme of clinical and internal audit to monitor quality, operational and financial processes. **Regulation 17.**

The provider must have clearly defined job specifications and governance oversight of the management roles in the company. **Regulation 17.**

The provider must recruit all staff in accordance with Schedule 3 requirements of the Health and Social Care Act 2009 (Regulations) 2014. **Regulation 19**.

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	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Patient transport services

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

Are Patient transport services safe?

Inspected but not rated

Due to the focused nature of this inspection we inspected but did not rate the service.

Mandatory Training

There was no assurance mandatory training and key skills was provided to all staff. In addition, there was no assurance staff had completed it.

There were gaps identified in the training records of all four staff files reviewed. None had current basic life support training or secure patient transport training. Only one staff member had completed *Confirmation of participation COVID-19: How to don and doff (put on and remove) personal protective equipment (PPE).*

The registered manager's training records showed 11 expired modules which they had not yet updated.

The registered manager confirmed that no staff training would take place until the current suspension had been lifted. However, this meant we could not be assured that staff had the skills, knowledge and experience to undertake their roles.

One staff member was identified as the training lead, but there was no evidence of the training they had undertaken to fulfil this role.

Mandatory training was previously identified as a breach at our previous inspection on 10 March 2021. We told the provider it must maintain an accurate record of the mandatory and statutory training of staff. This was identified as a signed off action on the provider action plan on 30 April 2021, however we did not see evidence of this on our inspection on 7 June 2021.

We reviewed the provider's training and development policy dated February 2021. However, the policy did not clearly indicate the expectations for staff in completing training. There was no documentation of the frequency of training or role specific training requirements. The mandatory training areas outlined for staff during induction were mostly e-learning. The policy stated mandatory training would be delivered 'by reading, discussing and online learning'. It was unclear how staff would be assessed or tested to ensure their competence and knowledge. Staff we spoke with were not aware a mandatory training and development policy had been developed.

We told the provider it must introduce a mandatory training policy at our inspections on 12 January and 10 March 2021. In the action plan submitted on 10 June 2021, identified a training policy had been created. The action plan identified a mandatory training spreadsheet had been created to be used 'as an '*assurance document at monthly management*

meetings' and would be a standing agenda item. Both actions were completed and closed on 30 April 2021. However, we found evidence on our 7 June 2021 inspection there were still gaps in staff's training records. We also reviewed the minutes of the May and June 2021 governance management meetings where there was no evidence the training spreadsheet had been developed or used to provide assurance.

The patient transport service (PTS) driver undertook refresher driving assessment training only if they had an accident. The driver was unsure how frequently their competencies for all mandatory training had to be refreshed. We reviewed the PTS driver's end of induction sheet from 5 March 2021. Their 'correct way of clamping clamps to a wheelchair' checklist form had been left blank. This meant we could not ensure the driver had completed all required competencies during induction.

We reviewed the *Introduction to KFA* pack for new staff. The front page stated the operations manager reviewed this pack every two years. However, further into the pack it read; '*policies are reviewed on at least a 12-month basis or as and when needed'*. This meant it was not clearly defined by the provider as to when policies would be updated. The grievance procedure only allowed staff to report any complaints to their line manager, or senior manager. No alternative or external contacts were given. The policy did not state how staff grievances about management would be investigated. This meant issues about management may go unreported and unknown to the service.

We reviewed the staff induction program training on clinical waste, equipment and incident reporting. We were not assured staff would feel competent or able to clearly follow provider processes from these documents. Both the clinical waste and soiled linen checklist and equipment checklist only had room for the trainer initials, assessor name and date. Staff could not add comments or suggestions. This meant we could not assess their effectiveness, or ensure staff completed these checklists correctly with useful outcomes for improvement. The incident reporting training checklist gave no definition of what the provider considered a reportable incident, what information to include on the risk assessment form or what relevant information to give the hospital, relatives or others. This meant we could not ensure staff would clearly define or confirm the process for reporting or reviewing incidents and may miss key detail as a result.

Safeguarding

Staff could not demonstrate they understood how to protect patients from abuse. There was no evidence the service worked with other agencies to do so. There was limited evidence of staff safeguarding training on how to recognise and report abuse nor could they articulate they knew how to apply it.

We had ongoing concerns in relation to KFA Medical Ltd having an effective recruitment process in place. This was identified during the inspections held on 12 January and 10 March 2021. However, during the inspection on 7 June 2021, gaps in the provider's recruitment processes were still evident. This meant they were not compliant with Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations). This was a 'must do' action and part of the reason we suspended the provider for a three-month period following our last inspection.

The action plan from 10 June 2021 stated on 30 May 2021 they had reviewed the recruitment policy and processes in full, and their policy and application form now reflected best practice. They also stated they had updated the systems to reflect Safer Recruitment processes from this date in the recruitment of staff. The provider's action plan also indicated they would conduct a full review of current staff files and ensure full compliance before the suspension end date. The action plan also showed the action to ensure staff had been recruited in full accordance with Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations) was completed on 30 May 2021. However, we found contradictory evidence to these updated actions on 7 June 2021 as gaps in the staff files remained.

Patient transport services

The latest recruitment policy did not mention staff's need to be fit and proper, or of good character as per regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations), or the need for recruitment files to include full staff training records. The registered manager stated their new version does reference regulation 19, but they were unable to provide evidence of this for us to review.

We reviewed some of the provider's job descriptions. The operations manager job description outlined their roles and responsibilities. However, it did not identify who they would report to, what qualifications were required, or what previous experience was desirable for the role. There was no mention of a probationary period or how someone new in the role would be assessed as to their progress. There was also no mention of an appraisal or mentoring to support new staff in their role.

The patient transport service (PTS) driver job description mentioned *'contact with distressed patients, carers and relatives requiring a level of emotional support'*, and *'occasional exposure to distressing scenes and verbal abuse from patients or relatives'.* However, staff had no emotional support, conflict resolution or de-escalation training or debriefs for their psychological/mental wellbeing to help them better handle and recover from events. This job description also did not mention a specific safeguarding training level of competence required for the role as per the national intercollegiate document. The job description was not specific about what the provider's zero-tolerance approach referred to, or which policies and procedures the PTS driver must abide by. In addition, the job description contained no reference to any level of safeguarding training being required to undertake the role

In three of the four staff files reviewed, the reason why their previous employment had ended was not identified. One of the four staff files reviewed did not have a full employment history to confirm their suitability. This meant the provider did not have full oversight of staff's background. One staff file did not contain a copy of the back of their driving license. Therefore, it was unknown whether that member of staff had category C1 or D1 on their license. To drive an ambulance the driver would need a minimum of a C1 license due to the weight of the vehicle. The Cat D1 license allowed a person to drive a vehicle with 8 passenger seats or more such as a minibus and was the preferred category for anyone looking to transport patients to and from hospitals such as NHS Patient Transport Services.

The provider failed to demonstrate all staff employed by the provider and working were of good character and had the appropriate qualifications. The recruitment policy did not include information about what to do in the event of a positive DBS disclosure. During their interview the registered manager stated the applicant would not be employed. However, we saw one DBS check had returned two historical offences. There was no evidence of a risk assessment being completed and retained. This meant that the provider had not followed the actions they had indicated they would follow in these circumstances.

We found evidence of continued issues with DBS checks; therefore, we were not assured the required improvements had been made to be compliant with the regulations. On 7 June 2021 we continued to have concerns the registered manager did not have an appropriate disclosure and barring service (DBS) check in place. At this inspection, there was confusion around when the new DBS submission had been completed. There was reference to the registered manager's DBS in the governance meeting minutes and that it had been requested in April 2021 but had not yet been received. However, the registered manager told us he applied for the enhanced DBS on 2 June 2021, but it was not yet received. Our concerns surrounding the issue of the registered manager's DBS formed part of the Warning Notice issued on 8 September 2020.

We initially identified concerns about the provider's DBS check appropriate for job roles, including that of the registered managers at the review undertaken on 15 June and 14 August 2020 and the inspections on 12 January and 10 March.

Inspected but not rated

Patient transport services

During the inspection we found of the four staff files we reviewed, one staff member had a volunteer DBS check on file, which is not the correct level for this type of service. This had been raised with the provider at our previous inspections.

The action plan KFA submitted on 10 June 2021 identified the required action was '*three members of staff had volunteer checks including the registered manager*'. This action was marked as completed on 30 May 2021 and stated all staff now had the correct DBS. However, this was still outstanding on our inspection on 7 June 2021 due to the registered manager still not having a DBS check in place.

We reviewed the provider's DBS policy (April 2020) which would be reviewed annually. The policy's equality statement stated the provider '*would take every possible step to ensure that this procedure is applied fairly to all employees regardless of the afore mentioned protected characteristics'* and that '*Employees exercising their rights and entitlements under the regulations will suffer no detriment as a result'* but did not state how.

The safeguarding children and adults at risk policy outlined the six principles of safeguarding under the care act 2014, and the five principles of the mental capacity act (MCA). However, the policy was not compliant with the Royal College of Nursing (RCN) intercollegiate document 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' guidelines (2019). The policy mentioned whistleblowing and complaints but had no detail about how or where staff should raise these. The policy contained some relevant information, but the reader could not easily understand the provider's safeguarding process. The policy did not inform staff how to alert and inform the safeguarding lead or contact the local authority. The policy also did not stress the importance of accurate record keeping and ensuring staff did not leave people who use people who use services at risk.

The designated safeguarding lead was an external governance consultant trained who reported they were level four safeguarding trained. However, they were only contracted to work for the service five days a fortnight. The safeguarding lead told us they were not involved with safeguarding reports as the provider would conduct these internally. They raised several concerns and expressed doubts about staff's knowledge of the statutory notification process.

We were told the operations manager was the provider's deputy safeguarding lead. The operations manager had not completed level 3 adult safeguarding training. The registered manager's level 3 safeguarding training had expired. We were told he was completing this online a week after our inspection.

The registered manager told us the external governance consultant was available by phone at any time to provide safeguarding support and advice. They explained the safeguarding process was that staff rang the consultant who rang them back the same day, then would respond formally with an action plan within two days. This meant no service staff onsite knew how to respond or escalate any concerns identified. In addition, this process was not outlined in the service's latest safeguarding policy we reviewed.

Staff did not complete safeguarding training to the minimum level recommended by the Royal College of Nursing (RCN) intercollegiate document 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' (2019). We also noted the RCN intercollegiate document training certification was due to expire and no arrangements to undertake the required training had been made.

Cleanliness, infection control and hygiene.

The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. Equipment, vehicles and premises were visibly dirty.

Inspected but not rated

Patient transport services

During this inspection no ambulances were operational. The service had hired two ambulances from another independent ambulance provider which arrived onsite from 14 May 2021.

Staff told us equipment to go onto the vehicles had yet to be cleaned, and it would take six weeks to get the vehicles ready to undertake regulated activity. However, we found no evidence any cleaning had been undertaken in accordance with the cleaning schedule in place for the vehicles or equipment carried on them.

Staff informed us the cleaning schedule included all vehicles being externally cleaned weekly or more frequently if required, all patient contact points being wiped clean, including equipment and the ambulance crew deep cleaned vehicles monthly, or after every COVID-19 positive patient. However, we received no documented evidence of when this had been completed. We did receive blank copies of the provider's vehicle cleaning audit spreadsheet and vehicle cleaning post COVID-19 audit checklist.

Both vehicles had rust on the chair floor fixings and tail lift. The gel dispenser on one of the ambulances was visibly dirty with residual gel blocking the dispensing hole. This meant we could not ensure staff would be able to effectively clean their hands before any patient contact. The steering wheels and arm rests in both vehicles were worn with breaks in the surface covering materials this meant staff would not be able to adequately clean them to reduce the risk of infection.

We reviewed the provider's regulation 12 COVID-19 folder. Their "4 weekly deep cleaning, C19 positive suspected cleaning sheet", "C19 vehicle cleaning, hand hygiene assessment", and "vehicle washing" audits were all blank, with no references to best practice. This meant we could not assess the effectiveness, or ensure staff completed these correctly with useful outcomes for improvement. The provider's "C19 risk levels" document contained no references to evidence risk classification, was not version controlled and did not have a review date.

The provider's "C19 vehicle cleaning" explained an audit must be carried out at least monthly. It must cover a sample check of 5% of the total number of cases recorded that month. However, as the provider had been suspended since January 2021, they could not evidence how they would complete this. The form had 12 questions for the auditor to complete but did not explain who the auditor was. We asked the operations manager for a complete version which they could not provide as the two new ambulance vehicles had not yet been cleaned.

The last "4 weekly deep clean" record was dated 1 June 2021. We reviewed this record which stated 'wipe down' but did not specify which cleaning product/agent or how much. We saw the provider had not aligned IPC procedures to current best practice guidelines in relation to COVID-19, which exposed staff and patients to the risk of harm. The COVID-19 policy did not clarify how COVID-19 was transmitted.

Equipment the provider planned to use on the vehicles was dirty and not fit for purpose. Four evacuation carry chairs were stored in the logistics area on a visibly dusty floor. They had been left on the floor near the corner of the storage room which had a wall sign displayed stating 'Quarantine area – not to be used'. It was not clear if the four evacuation chairs should be used or not. Chalk dust from the ceiling had fallen onto wheelchairs and a grab bag.

We saw a high-visibility ambulance staff jacket was very dirty and in a poor degraded condition. Three of the six patient cushions we checked were dirty. Staff told us they used no checklists for patient cushion cleaning, and they confirmed this equipment would usually be on the vehicles. This meant we could not be assured they were suitable for patient use.

Patient transport services

The building had no sink or running water in the logistics store. The only sink in the registered location for staff to wash their hands was in the first-floor toilet, despite there being a poster on the ground floor explaining to staff how to wash hands. This posed a risk of infection as staff would have to walk through the building touching door handles with dirty hands before being able to wash them.

The logistics storage area for the equipment was visibly dirty with damp surfaces. This area stored sterile equipment, tools and other non-sterile equipment. There were no separate clean and dirty utility areas, and sterile supplies were not stored appropriately. We found a box marked 'eye wash station' on a work surface covered in brick dust next to various nuts, bolts and screws. Two black pouches containing boxed cardiopulmonary resuscitation (CPR) facemasks, echocardiogram (ECG) pads and monitoring leads were visibly dirty. We saw a first aid kit was not tagged or sealed. We saw cardboard pulp vomit bowls, bed pans and urinals were stained and stored in a visibly dirty box. We found hand gel which expired in January 2021. This meant we were not assured equipment was clean and fit for use.

We found four clean linen blankets were stored on one of the ambulance vehicles. The operations manager told us staff used their contracted hospital's blankets, so these did not need to be cleaned.

Mops and buckets were not labelled and stored correctly. We found a single use yellow mop had been used but not disposed of. One mop bucket contained standing dirty water which could pose an IPC risk. None of the buckets used for cleaning were stored in line with best practice. This was identified as a concern on our last inspection on 10 March 2021 and was signed off as a completed action on the provider action plan

There were no waste disposal bins in reception, just a red bag taped to the worktop of a side table.

The provider's action plan identified that 'vehicles are now clean, and a system put in place to enable oversight and governance of IPC procedures. This was sent to the CQC on 31 May 2021 as a completed action. However, we found this was still outstanding on our inspection on 7 June 2021.

The provider's action plan also identified a full review of infection prevention and control (IPC) procedures had been undertaken, including the policy, daily, weekly and monthly audits, cleaning procedures and staff qualifications with a completion date of 30 April 2021. In addition, staff also told us all actions relating to IPC were completed by 30 May 2021. These actions mainly related to systems and processes staff put in place to provide assurance however, during our inspection on 7 June 2021 we found these processes were not effective due to the extent of IPC concerns identified.

The registered manager could not articulate the IPC procedures, practices or where improvements had been implemented since the previous inspections on 12 January and 10 March 2021. For example, they could not describe how the provider would protect patients from asymptomatic COVID-19 staff.

Staff told us they registered and logged their lateral flow tests (LFTs) on the direct.gov website. However, out of the four staff member files we reviewed, only one staff member had evidence of a LFT recorded in their staff file. Staff's lack of access to LFTs was not in line with the KFA Medical Ltd COVID-19 guidance and procedure policy (2021). This was also in contravention of current COVID-19 Department of Health and Social Care national guidance, Coronavirus (COVID-19) workplace testing: guidance for private-sector employers and third-party healthcare providers. This placed staff and people who use services at risk of infection from COVID-19.

However, the patient transport service (PTS) driver did request proof of the inspection teams' negative LFTs on the morning of our inspection. This highlighted that the provider requested our inspectors to adhere to higher COVID-19 testing standards than their own staff.

Patient transport services

The Staff COVID-19 LFD Test Registration Form document was no more than a page containing personal contact information, the first and second COVID-19 vaccine date, the polymerase chain reaction (PCR) test date and if it was positive or negative. The form did not mention what happened if staff tested positive for Covid-19. However, the provider's Covid-19 guidance and procedure policy stated staff who tested positive, anyone they lived with or in their support bubble had to self-isolate for 14 days. The form was not protectively marked even though it contained confidential personal information. The form did not mention where it should be submitted, and when or who will review it.

The provider had a uniform agreement, but no policy to ensure these were washed at appropriate temperatures. Staff laundered their own uniforms. The operations manager told us staff were given two uniforms each, but when we asked if this was enough, he agreed they would need more in order to wear clean uniforms daily. They said they would wash their uniform on a 90-degree cycle after any shift, but no temperature was stated in the agreement.

The operations manager told us all staff completed a basic e-learning IPC module. However, they could not articulate who the IPC lead was, and said the external governance consultant may fulfil this interim role until staff were trained. No staff had undertaken any specialist IPC training at the time of our inspection.

Staff were unable to evidence they were operating a safe IPC system. We reviewed cleaning checklists and audits including their vehicle log sheet audit, a clinical waste laundry and mop audit, a hand washing audit, vehicle washing post-COVID-19 patient audit and vehicle cleaning audit spreadsheet. However, all these audit forms were blank. This meant we could not assess their effectiveness, or ensure staff completed these correctly with useful outcomes for improvement. There was no evidence how these would work in practice and it was not clear who would complete them. The provider sent us the two audits mentioned within the policy however these were blank. This meant we could not assess their effectiveness, or ensure staff completed these correctly with useful outcomes for improvement.

At our previous inspections in January and March 2021, we told the provider it must ensure there was a robust IPC policy in place. However, we found, although there was now an IPC policy in place, there was still concerns around it. For example, there was no identification to how frequently staff should receive training in IPC, and we found the policy read more like an action plan than a policy in relation to the training element. The policy contained no references to appropriate guidance such as the health and social care act 2008 or the department of health's essential steps to safe, clean care.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment did not keep people safe. Staff were not trained to use them. Staff did not manage clinical waste well.

The two provider vehicles inspected were not fully equipped or ready to be used to undertake regulated activity. On the day of our inspection, provider staff had to jump start one of the vehicles due to a flat battery. The blue emergency lights on both ambulances did not work.

Staff explained the carry chairs and stretchers on vehicles would be removed, as these belonged to a different independent ambulance provider. We were told the ambulance would be stocked with the provider's own equipment. However, there was no plan in place as to when this would take place.

Patient transport services

We found the vehicle wheelchair straps lying in a container at the back of the ambulance. These were visibly dirty with signs of fraying and rust on the metal parts. Staff told us none of the straps had been tested to ensure they worked correctly. However, the straps were now identifiable as they were each asset tagged. This was an improvement and embedded practice from our inspection on 12 January 2021 inspection, where we found the provider's previous vehicle straps were not identifiable which made tracking of maintenance of the straps very difficult.

We saw vehicle keys were kept on the operating manager's office desk. Staff told us these were usually kept in a safe. However, there was no sign in or out logbook, to assure the manager who always had the keys. The PTS driver confirmed staff had no spare keys if the main ones were lost or mislaid.

We reviewed the provider's fleet servicing and repairs policy. It explained the steps, from completing a vehicle checklist to having the vehicle repaired. There was no mention of any auditing or quality assurance of the vehicle checklists by managers.

Equipment for the vehicles was stored in the logistics storage room. The room had two racks full of different equipment. Staff explained one rack was for events, but this was only labelled as 'Racking 2'. Rack 1 held PTS equipment over three shelves, but there was no 'step-up' ladder to reach the high shelves. We found the ladder was kept in the boiler room.

The provider's operating premises did not have a fire risk assessment, clear evacuation plan or any fire extinguishers which had been tested, labelled and ready for use. We had previously identified the provider's lack of a fire risk assessment on our 10 March 2021 inspection and the registered manager was aware. We subsequently told the provider they must carry out fire risk assessments in line with regulation 15 of the Health and Social Care Act 2008.

The lack of a risk assessment had also been discussed at a management meeting on 28 May 2021. Notes from this meeting stated all fire extinguishers in the building were out of date and staff needed to rectify this before they were inspected again. No action had been taken at the time of the inspection to rectify this; however, we were told extinguishers were missing due to their refurbishment. This exposed staff to an unsafe working environment.

The front reception area had a hydro spray (fire extinguisher) sign but no appliance. In addition, we also saw personal protective equipment (PPE) was available but no signage of how staff or visitors should use or apply this.

The building had evacuation signs, but these were confusing, for example, the green running man sign was pointing away from the most accessible exit.

Upon arrival at the provider location, we were not asked by any staff to sign in. This meant in the event of a fire, staff could not confirm who was on the premises.

We reviewed the management meeting minutes from 28 May 2021 which stated a manual handling course was taking place on bank holiday 31 May 2021. However, the registered manager told us the provider was not doing training until the suspension is lifted. We found no evidence on files training was delivered on this date.

We found a laminated sign under the shelf of defibrillators which read 'out of service – do not use' as it required a new battery, this was unattached to any pack. It was unclear which defibrillator the sign referred to. We also found 'Defib 1' (asset number L007770) had an adult/child plus 10kg multifunction electrode pad which expired on 31 December 2020. This meant there was a risk to patients that a staff member could use an out of service defibrillator or expired electrode pad which may be faulty in the event a patient deteriorated or suffered a cardiac arrest, resulting in severe risk of harm.

Inspected but not rated

Patient transport services

During our inspection the service were unable to provide documented evidence or assurance of their equipment servicing. An external clinical engineer had undertaken a service of all provider equipment which they tagged with asset numbers on 20 May 2021. We reviewed the engineer's service report which the operations manager sent us the day after our inspection. The report showed all the equipment tested passed. However, we saw one of the defibrillators needed a new battery and test wire. The engineer also supplied and fitted parts to two fire extinguishers and a stretcher. However, the engineer had failed to replace an expired defibrillator pad but found it to have no test wire.

Chemical cleaning products were stored separately in a metal fireproof cabinet, but not locked away as per the control of substances hazardous to health (COSHH) 2002 regulations. There was no key in the lock and the cabinet door was open. Car cleaning products were kept separate from other branded cleaning products. We found other containers of substances were left out accessible to all. For example, all-purpose car polish which read on the label 'may be fatal if swallowed'. COSHH data sheets were kept in the operating manager's office. The cleaning materials were pre-diluted and fit for use from containers. However, cleaning materials used did not have Hazchem symbols. The yellow clinical waste bin was stored next to clean equipment on the 'Racking 2' shelves.

At this inspection we had concerns around the provider's first aid procedures. Staff we asked were unclear who the trained first aiders were and did not know where the first aid box could be found. We saw a first aid sign on the back of the storage room door. The sign stated two ex-employees were the provider's trained first aiders. It also stated the box should be in the kitchen, when in fact it was on the reception windowsill. Wipes contained inside the box had expired in January 2021. At this inspection we did not find evidence the required improvements had been made to be compliant with the regulations.

Assessing and responding to patient risk

During our inspection the provider was not undertaking regulated activity so we could not review how well staff were assessing patient risks.

We reviewed the deteriorating patient policy (February 2021) and, although it referenced the latest joint royal colleges ambulance liaison committee (JRCALC) clinical guidelines pocketbook (2021) on the cover it did not refer to the guidelines in any context. This meant we could not ensure staff would follow best guidance if a patient deteriorated. Staff were advised to complete an incident report form detailing any patient deterioration event. However, the policy gave no information about what details PTS staff should handover or report to emergency staff or paramedics upon transfer. Subsequently the policy gave no assurance of the provider's deteriorating patient process to ensure patient safety, share learning for improvement or ongoing staff competence.

If someone deteriorated onboard an ambulance, staff told us they would dial 999. Staff confirmed were given patient history from hospital ward staff, for example around do not attempt cardiopulmonary resuscitation (DNACPR). However, there was no formalised handover process or documentation. This meant we could not ensure staff were given all relevant information before transporting patients.

The patient booking and PTS risk assessment forms did not include any inclusion/exclusion criteria, beyond if the patient was detained or on oxygen. There was no space to detail any complex needs patients may have or provide further background information. It was unclear how staff would follow any risk assessments made on the information provided, as no outcomes were outlined.

Patient transport services

Staff we spoke with admitted their risk assessment process was not very robust as staff confirmed patient details verbally by phone. They explained staff did not always know which straps would fit patients until they arrived onsite. Staff told us they completed patient risk assessments to ensure their straps worked on patient chairs. The provider's patient risk assessment included a box for staff to ensure patients were strapped in 'with whatever is possible'. However, as the provider had undertaken no regulated activity, they could not evidence this.

The patient booking form was a two-page document used to gather information about the patient who was to be transported. The questions were generic, however based on this information it was decided whether or not to transport the patient. However, it was not clear who was accountable for the decision or how staff would determine patient suitability based on the booking form. There was no assurance the forms would be used to identify the risk a patient presented. The multi-patient transport information did not give assurance the risk of transporting more than one patient at a time would be identified or acted upon. The patient booking system and how it was operated meant patients being transported could have a higher acuity than staff were trained to care for, therefore, placing patients at risk.

The safe transportation of patient's policy (February 2021) stated staff would follow the international practice guidelines when transporting wheelchair-bound patients. Pictorial diagrams were included to show staff how to transfer patients safely. The policy also referred to the COVID-19 policy.

The provider used a breakdown cover company and their breakdown procedure was in the vehicle packs. If a patient was onboard when an ambulance vehicle broke down, staff told us they had an agreement with another provider to collect the patient and fulfil their onward journey. However, we saw no service level agreement or evidence of this.

Medicines

The service could not demonstrate it followed best practice or used systems and processes safely when administering, recording and storing medicines.

The provider did not stock any medicines; however, they did transport patient's own medicines, details surrounding this were included on patient risk assessments. Staff told us they planned to ask patients to sign their risk assessment when reaching their destination. This was so patients knew medication had arrived with them and where it was located. Staff placed medications for patients who lacked capacity in a cupboard at the patient's residence out of patient's reach if they were unable to sign for their carer or guardian to administer. However, nothing about risk assessments was documented in the provider's transiting of medications policy.

We reviewed the provider's transiting of medicines policy. The policy was non-service specific and confusing for the reader. For example, it referred to TTO drugs (tablets to take out), then had a titled section; TTOs (Prescribed medication) & all other medicine. There was no mention of what 'other medicine' was and why TTOs were described differently. The policy mentioned staff's need to place medication out of reach of patients with no capacity at their residence to reduce the risk of them overdosing. However, if a patient lacked capacity, they would not be left alone and certainly not with medication. The policy had section titles and bullet points which were not relevant to this provider.

We reviewed the *confirmation of consent for medication* form. The form did not link to its title, as staff did not give patients medication or seek their consent to give medication. The form had various patient information questions and the following statement; '*The nurse must sign for the handing over of the Medication to the crew due to the patient not having the capacity to sign for their own medication*'. Staff's last piece of information to obtain was where the patient's

medication is stored. This was not easy to follow as the medication was not going to be stored, it was transported with the patient. The form did not cover who received the medication when the patient transport service (PTS) journey was completed. This was of particular importance where patients lacked capacity. The form did not link or reference the providers' transiting of medications policy.

The provider did not carry oxygen on vehicles and had no oxygen on site. Their patient booking form advised PTS staff they could not take patients on oxygen.

At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations.

Incidents

The service did not manage patient safety incidents well. Staff did not know how to recognise or report incidents and near misses. Managers failed to investigate incidents or share lessons learned with the whole team, the wider service and partner organisations.

The incident reporting policy had several omissions and errors. The policy was unclear as to how staff reported an incident as it stated '*The incident should be reported using an incident reporting form*' with no further explanation if the forms were paper or digital format, or where staff could locate them.

There was also no explanation in the incident reporting policy of what constituted a serious incident. The risk assessment matrix used in the policy was out of date and referenced an organisation which no longer existed. The policy gave no explanation as to how or when staff training would be carried out. In summary the policy was not specific to incident reporting which made it difficult for staff to follow.

As the provider had not undertaken any regulated activity, there had been no incidents reported since January 2021. We were told the external governance consultant would oversee all provider incidents. However, this was a one-year interim solution until staff were more experienced. They told us they would conduct a thorough investigation if necessary and offer the provider advice on any future incident categorised as 12 or above.

Staff were due to partake in a two-day course on incidents, including route cause analyses (RCAs) from an external training company in July 2021.

We asked the registered manager to describe the provider's incident investigation process. This included several steps not detailed in the policy. The process was convoluted and reliant on external resource.

The provider had no formal process in place to share learning from incidents. The provider's designated incidents lead had no experience or examples of learning from incident investigations. He could not recall the name of the staff member who had the relevant PTS and clinical lead experience to investigate serious incidents. The registered manager told us learning from incidents was shared by staff training, newsletters and talks.

The register manager could outline what duty of candour (DoC) entailed but could not explain what the provider's responsibilities were. We requested the DoC policy and staff training compliance on DoC, but this was not provided. However, we observed the last page of the DoC policy outlining purpose and process printed on the registered manager's rear office wall as a reminder.

Inspected but not rated

Patient transport services

The provider relied on the consultant to report notifiable incidents as notifications to CQC. If the consultant was on leave or holiday, the registered manager said they had a new paramedic from an acute trust as their clinical lead, to start once the suspension was lifted.

At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations.

Are Patient transport services well-led?

Inspected but not rated

Due to the focused nature of this inspection we inspected but did not rate the service.

Leadership

Leaders could not demonstrate they had the skills and abilities to run the service. They could not articulate they understood and how they managed the priorities and issues the service faced.

Staff told us leaders were visible and approachable in the service for patients and staff. They supported staff to take on more senior roles, for example the operations manager who had only been in post a few months. However, leaders did not always help staff develop their skills through training and development.

The registered manager could not answer any questions in relation to company policies stating they did not write them and didn't know what was in them. For example, they could not explain what the references to databases meant in the data protection policy. They also did not know what the reference to QR codes or patient advice liaison service (PALS) meant in the complaints policy. Some staff felt the registered manager should have more knowledge of the processes involved.

The registered manager was unable to explain some significant elements of their role, defaulting most answers to the external governance consultant.

At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations as highlighted in our previous inspections in January and March 2021.

Governance

Leaders could not demonstrate how they operated effective governance processes, throughout the service and with partner organisations. Not all staff were clear about their roles and accountabilities.

We found throughout our inspection that policies and procedures contained information that was difficult to follow, contradictory or not specific to the service. The governance policy (May 2021) was contradictory stating on the cover sheet the policy would be reviewed quarterly, however, the review section stated the policy would be reviewed annually. It referenced the Health and Social Care Act regulation 17 around good governance. However, the policy gave no detail

of how it planned to respond to '*concerns raised by the CQC during inspection*' beyond mentioning the improvements reflected in the quality strategy 2021-3. This meant the provider had no joined up approach in how their strategic objectives being met would be reflected in improved governance. The policy stated monthly management meetings will be held and chaired by their governance lead with key team members.

There was no formal process for managing and monitoring service level agreements (SLAs) with third parties. Despite there being only two SLAs in place at the time of inspection, staff told us there was another SLA was in place for the ambulance owners from whom they rented the vehicles on loan. However, this was a hire agreement and did not include either parties' responsibilities.

The provider's external governance consultant oversaw several governance processes, including safeguarding, risk management and whistleblowing for staff. A few days before our inspection the consultant agreed to be the provider's infection prevention control (IPC) lead from June 2021. However, they told us they had had little involvement with this to date. The SLA with the external governance consultant was dated from 26 April 2021 from when the consultant had begun working with KFA Medical. However, the registered manager told us he had not yet seen the contract written by the consultant, which meant the SLA had not been formally agreed.

The provider had recently established monthly governance meetings which was an improvement from our previous inspections on 12 January 2021 and 10 March 2021. Various assurance reports, including safety and compliance had been introduced. Staff told us they were learning more around trends and themes. For example, the importance of reducing any themes around incidents and complaints such as IPC or clinical audit data.

The provider did not have a robust governance and accountability structure in place. An example of this was the action plan at 10 June 2021 governance meeting minutes identified that the action for all policies and procedures to have a full review was marked as completed on 30 May 2021. In addition, changes were discussed at this meeting to give assurance that the company was aware of the changes made and the reasons for them. However, we found concerns relating to all 13 KFA Medical Ltd policies reviewed as part of the inspection.

During our inspection, the registered manager could not offer clarity or explain anomalies around new policies recently implemented as a result of previous inspections. During our interview with the registered manager on 7 June 2021 they assured us all policies were of an acceptable standard.

The policies were generic, non-service specific and some had reference for a larger organization, such as, including references to QR codes, patient advice and liaison service (PALS) and green and red medicine bags, which were not relevant to KFA Medical Ltd.

There were no effective systems in place to assess and monitor the quality of care for people who used services. The registered manager was unable to demonstrate a full understanding of their responsibilities in carrying out or managing regulated activities and meeting the standards required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations.

The nominated health and safety representative had only completed online training and showed poor understanding or awareness of the role. For example, the premises' lack of fire risk assessment, they had not carried out any walkaround assessments. Subsequently we found sterile, non-sterile equipment and clinical waste in unsuitable places such as the eye wash station. However, the operations manager summarised his role and responsibilities well.

Inspected but not rated

Patient transport services

During this inspection we found a data breach. One staff file we reviewed contained information about another member of staff, who was no longer an employee of KFA Medical Ltd.

The complaints policy from February 2021 read as if written for a larger organisation and was not service specific, it referenced roles and teams and processes which the provider did not have in place.

Vision and Strategy

The vision and strategy were not focused on sustainability of services or aligned to local plans within the wider health economy. Leaders and staff did not understand and know how to apply them and monitor progress. The provider's strategy did not clearly outline how it would turn their vision into action. However, the service had a vision for what it wanted to achieve.

The provider's aim was stated on their website as being 'to provide the highest standards and commitment to all our client's needs'. However, the provider's mission, vision, and core values were not on their website. They were only outlined on a few of their policies and procedural documents we reviewed, such as the recruitment policy from February 2021. This was reviewed every three years and referenced regulations 18 and 19 of the Health and Social Care Act 2008 along with other acts of legislation.

We reviewed the provider's quality strategy. This document did not have any provider business logo. There was no explanation for staff or readers who owned or was responsible for delivering the strategy. There was no version control, a date when the strategy was created, or who by. Therefore, we were not assured the strategy was developed and written by KFA Medical. This also meant it was unclear how the strategy would be achieved.

Culture

Staff felt respected, supported and valued. However, we were not assured staff were focused on the needs of patients receiving care as they had not transported any patients since January 2021.

The lone worker policy (February 2021) referenced the health and safety at work act regulations 1974 and 1999 along with manual handling operations regulations 1992. However, it did not include any information on sexual safety for staff, patients and other people. The policy did not consider staff or patient's protected characteristics. It also did not mention any other training or skills staff could access to further minimise risks when working alone, beyond manual handling. For example, conflict resolution, de-escalation or emotional support training. The provider did not carry out risk assessments for staff working in excess of their contracted hours. The provider could not show us lone worker risk assessments. This meant we could not be assured lone working risks, hazards or time was mitigated.

Staff told us there was an open-door culture, they were happy to speak to the registered manager. However, they felt the service was still not where they needed to be.

The external governance consultant was the provider's freedom to speak up guardian and whistleblowing lead. However, they were only contracted to work for the provider five days a fortnight and was not a direct employee. We were told the process was for staff to ring the external governance consultant and they would call them back if unavailable.

Staff we spoke with could not provide any examples of changes made as a result of staff feedback. They said they were working on a new annual staff survey. This included questions on approaching managers/leads, satisfaction, if staff would recommend the service, and if staff felt valued and respected. We reviewed this working document. Questions were open-ended and general, with no multiple choice so answers would be hard to quantify. Many questions were about staff's competence rather than cultural issues.

The service had no appraisal cascade system in place, so it was unclear how leaders were appraised. We found no documents in staff files relating to appraisals or one-to-ones. It was unclear how the registered manager was appraised. There was a drafted appraisal template for all staff to use; however, we did not see this in use. This included if the role and support staff were given met or did not meet their expectations.

Management of risks, issues and performance

Leaders and teams could not evidence how they used systems to manage performance effectively. They could not articulate how they identified and escalated relevant risks and issues.

Staff could not identify actions to reduce their impact. They did not have plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was no risk management policy or structure. This meant there was little regard to the management of risk to protect patients, staff, business assets and ensure financial sustainability.

The registered manager confirmed the company had a risk register but was unable to articulate what was on the register. One of the joint highest risks owned by the consultant and scored 16 was actually '*lack of knowledge of risk management processes*. This risk's timeframe stated 30 December 2020, but it was still open. In the provider's meeting minutes held on 10 June 2021 this risk was removed from the risk register as managers believed this was no longer a risk due to the consultant being in post.

The registered manager could not describe what the top three organisational risks were on the provider risk register (loss of CQC registration). When asked they described three other risks not evident on the risk register. We found similar concerns at our previous inspections on 12 January 2021 and 10 March 2021 and have not seen any improvements made. The risk register was introduced, completed and managed by the external governance consultant in consultation with the registered manager and operations manager.

The external consultant told us the provider was familiar with current risks but was not familiar with the system. They felt assurance the provider had oversight of their biggest risks. The external consultant told us the provider had a long list of risk register issues at present and had not removed any. They acknowledged the CQC suspension concern was the biggest challenge. The external consultant compiled the risk register with the registered manager and operations manager, then explained the detail to them.

The provider did not record or monitor any key performance indicators (KPIs). This meant they could not measure their performance for comparison against other similar services.

There was no programme of clinical and internal audit to monitor quality, operational and financial systems and processes. We saw the regional ambulance trust had completed a community public access defibrillator audit for the provider on 6 May 2021. In addition, the registered manager told us they had not undertaken any audits as there was nothing to audit whilst they were suspended.

Patient transport services

We asked the registered manager if the provider had planned any future audits. They mentioned all staff files for which they had a monthly checklist of everything that should be included. These were discussed at their monthly meeting. They also mentioned infection prevention control (IPC) and showed us how they checked staff wear all PPE and clean uniform correctly. However, on this inspection we found these audits and processes were not effective due to the extent of IPC concerns identified.

The 2021 audit schedule identified KFA Medical planned to undertake a different audit each month from May 2021 starting with a staff files audit. However, as all provider audit forms were blank, we could not assess their effectiveness, or ensure staff completed these correctly with useful outcomes for improvement.

The external governance consultant told us they had overall responsibility for provider audits, specifically to ensure they were up to standard and provided oversight in what they reported to management. They expected to see IPC audits, hand hygiene, and clinical supervision shifts with new/existing staff to ensure competency. They felt oversight was needed annually/quarterly around deep cleans for example. The external governance consultant planned to pick a deep dive subject monthly for audit assurance. They told us they had not checked the logistics storage, as this was not a priority.

At this inspection we did not find evidence that the required improvements had been made to be compliant with the regulations.

Information Management

The service did not have reliable data processes and systems or analyse it. Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were not consistently submitted to external organisations as required. However, information systems were integrated and secure.

Staff were unable to explain how long patient records and vehicle cleaning records would be stored before destruction. They also confirmed the provider had no retention of records policy. This meant the service were unsure how long to store old paperwork.

The provider's data protection policy from February 2021 was confusing and unclear. It stated *'all relevant databases are registered'* without naming any, or where they were registered. The operations manager was the provider's data protection officer. They confirmed the databases mentioned in the policy referred only to the information commissioner's office (ICO). We saw proof of the provider's ICO registration. However, the certificate's start date was the same date as our inspection, so this was not in place prior. The registered manager had not read the provider's data protection policy and was unsure of its content.

This section is primarily information for the provider

Requirement notices

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 17 HSCA (RA) Regulations 2014 Good governance The provider did not have policies specific to the service which cross-referenced other policies and national guidelines where relevant. The provider did not demonstrate they had an effective risk and governance system that supported safe and quality care. The provider did not have a systematic programme of clinical and internal audit to monitor quality, operational and financial processes. The provider did not have clearly defined job specifications and governance oversight of the management roles in the company.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not keep all equipment, vehicles and premises clean by supporting staff to use equipment and control measures to protect people who use services and themselves free from infection. The provider did not ensure infection prevention and control procedures were aligned to current best practice guidelines. The provider did not carry out infection prevention control (IPC) audits. The provider did not ensure staff's regular lateral flow tests were undertaken and were recorded in their staff files in line with their COVID-19 guidance and procedure

This section is primarily information for the provider

Requirement notices

policy and Department of Health and Social Care national guidance, Coronavirus (COVID-19) workplace testing: guidance for private-sector employers and third-party healthcare providers.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not recruit all staff in accordance with Schedule 3 requirements of the Health and Social Care Act 2009 (Regulations) 2014.

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 The provider did not have current and appropriate disclosure and barring checks (DBS) for all staff for the role in which they are employed. The provider's recruitment policy did not include information about what to do in the event of a positive DBS disclosure. The provider's designated lead in multiple areas was not someone directly employed or who had undertaken training for these roles.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not have an effective system and process to ensure the maintenance and use of facilities, premises, vehicles and equipment to keep people who use services and staff safe.

This section is primarily information for the provider

Requirement notices

The provider did not have the correct equipment for the patients transported in their vehicles with the associated systems and staff training in place for the safe operation of that equipment.

The provider's operating premises did not have a fire risk assessment, clear evacuation plan and fire extinguishers which had been tested, labelled and were ready for use.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers The provider's registered manager did not demonstrate full understanding of their responsibilities in carrying out and managing regulated activities and meeting the standards required by the Health and Social Care Act Regulations. The provider`s registered manager did not ensure that all staff employed were of good character and have the appropriate qualifications, competence, skills and experience fit and proper to undertake the role they are employed to perform.