British Red Cross Society

British Red Cross Birmingham

Quality Report

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Date of inspection visit: 26 March and 5 June 2019
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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.

Ratings

Overall rating for this ambulance location	Requires improvement
Emergency and urgent care services	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

British Red Cross Birmingham is operated by British Red Cross Society. The British Red Cross Birmingham provides urgent and emergency care.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 26 March 2019, along with staff interviews on Wednesday 5 June 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this service was urgent and emergency care.

We rated it as **Requires improvement** overall.

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

- **The service did not follow best practice when prescribing, giving, recording and storing medicines. However, patients received the right medication at the right dose at the right time.**
- **Staff did not always keep detailed records of patients' care and treatment. However, records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- **Staff did not consistently complete full risk assessments for each patient swiftly or repeat these as required. However, staff identified and quickly acted upon patients at risk of deterioration.**
- **Managers did not robustly monitor the effectiveness of care and treatment and use the findings to improve them. They did not compare local results with those of other services to learn from them.**
- **Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and monitor the effectiveness of the service. However, the service made sure staff were competent for their roles.**
- **The provider did not collect patient outcome data and analyse it to improve the quality of care. Staff could not find data they needed to understand performance and make improvements to the quality of care. However, the information systems in place were integrated and secure. Staff had access to the information needed to undertake their roles.**
- **Staff had limited information on how to support the care of mental health conditions.**
- **The service did not monitor response times or use this information to improve patient outcomes.**
- **The service did not have robust procedures for supporting staff development and challenging poor practice and behaviour.**
- **The service had limited engagement with the public to help shape services.**

However, we found the following areas of good practice:

Summary of findings

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- **The service provided mandatory training in key skills, including life support training to all staff, and made sure everyone completed it.**
- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- **The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- **The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**
- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- **Staff had the information needed to make the decisions about the right pathway of care for patients.**
- **All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.**
- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- **The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.**
- **People could access the service when they needed it and received the right care in a timely way**.

Summary of findings

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.**
- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress**
- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- **Leaders and staff actively and openly engaged with staff.**
- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices that affected urgent and emergency care. Details are at the end of the report.

Heidi Smoult
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Requires improvement 	British Red Cross Birmingham is managed by British Red Cross Society. The Birmingham location provides urgent and emergency care. The service has 13 ambulances and provides ambulance crews at events across the north west, midlands and south west of England. The service has volunteer ambulance crews and could utilise the skills and knowledge of specialist staff, for example paramedics. We rated the service as requires improvement overall with requires improvement rating in safe. We rated British Red Cross Birmingham as good for well-led and for the responsiveness of the service.

Requires improvement

British Red Cross Birmingham

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to British Red Cross Birmingham

British Red Cross Birmingham is operated by British Red Cross Society. The service had 13 ambulances and provided ambulance crews at events across the north west, midlands and south west of England. The service had volunteer ambulance crews and could also utilise the skills and knowledge of specialist staff, for example paramedics.

The service did not have a registered manager in post at the time of the inspection. The location was being overseen by two other managers, who were the registered managers for other British Red Cross Society location across England.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise as a paramedic. The inspection team was overseen by Victoria Watkins, Head of Hospital Inspection.

How we carried out this inspection

We visited the location on 26 March 2019 and undertook an onsite visit. Following this, we undertook a number of staff interviews by telephone on 5 June 2019.

Facts and data about British Red Cross Birmingham

The service is registered to provide the following regulated activities:

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

During the inspection, we visited British Red Cross Birmingham. We spoke with 10 staff including volunteers,

Detailed findings

ambulance crews, local and senior management. During our inspection, we reviewed two sets of patient records, which was 100% of patients transported to hospital from an event between October 2018 and March 2019.

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 has been inspected twice, and the most recent inspection took place in February 2014.

The location did not employ any staff directly. All staff and volunteers were employed centrally through the provider, British Red Cross Society. The location could access staff from across the country to assist at events where needed.

Activity during reporting period October 2018 to March 2019:

- Two patient journeys to hospital

Track record on safety

- Zero Never events
- Clinical incidents zero no harm, zero low harm, zero moderate harm, zero severe harm, zero death
- Zero serious injuries
- Six complaints

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Not rated	Not rated	Good	Good	Requires improvement
Overall	Requires improvement	Not rated	Not rated	Good	Good	Requires improvement

Emergency and urgent care services

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Good
Well-led	Good
Overall	Requires improvement

Information about the service

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The main service provided by this ambulance service was urgent and emergency care.

Summary of findings

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Emergency and urgent care services

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Emergency and urgent care services

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Emergency and urgent care services

Are emergency and urgent care services safe?

Requires improvement

We rated it as **requires improvement**.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- The service had had 84 incidents between April 2018 and March 2019. Of the 84 incidents reported, 45 related to equipment readiness or failure, 16 to mechanical issues with vehicles and five incidents related to medication (procedure not followed, out of date, wrong dose or drug administered, or medication not available).
- We reviewed three incident reports concerning ambulance crews from the Birmingham location reported between April 2018 and March 2019. None of the incidents affected patients or were classified as clinical incidents.
- We found staff had reported the incidents through the agreed method, and the incidents had been reviewed and lessons learnt identified.
- We reviewed the British Red Cross' incident reporting policy (implemented May 2018, due for review November 2019) and incident reporting and investigation procedure (implemented July 2018, due for review July 2021).
- We found both the policy and procedure to be detailed and set out clearly the requirements of staff. The policy set out clearly the specific incidents that must be reported through the incident reporting process, for example following the treatment of a patient suffering a cardiac arrest.
- The service used a recognised electronic incident reporting system. Staff could complete electronic or paper-based incident forms, and these were linked to individual patient report forms for tracking and monitoring purposes.
- We asked four members of staff about how and when they would report an incident. All four members of staff asked could clearly explain the escalation route during an event, and outside of event work.
- Staff knew what they should report and told us they felt confident and comfortable to raise concerns through the internal escalation process to their managers.
- The service reported no clinical incidents of no, low, moderate or extreme harm between April 2018 and March 2019.

Mandatory training

- **The service provided mandatory training in key skills, including life support training to all staff, and made sure everyone completed it.**
- The service provided all ambulance staff and volunteers with six mandatory training modules each year, including safeguarding and basic life support. In addition, the British Red Cross have provided a monthly mandatory module for all staff and volunteers to complete. From February 2018 to April 2019, the mandatory modules included:
  - Intoxicated patients at events
  - Fracture management
  - Patient report forms
  - Capacity and consent
  - Recognition of the sick and injured child and infant
  - Minor wounds
- The service had a mandatory training compliance target of 100%. Due to the location not employing staff or volunteers directly, no specific data was available with regards the compliance against this, directly linked to the Birmingham location.
- The leadership team told us that where a member of staff or volunteer had lapsed in an area of training, the shift booking system would not allow that person to book onto a shift. For example, ambulance crews

received intermediate life support training; however, first aiders within the British Red Cross received basic life support training. Where an ambulance crew volunteer had lapsed in intermediate life support, they could still book onto a 'first aid' shift; however, until they completed intermediate life support, they were unable to book onto an ambulance shift.

- All ambulance crew trained volunteers underwent driver training, provided by an external company. The training consisted of two levels – standard road driving and emergency driving using blue lights and sirens. Volunteers could not transport a patient as the driver until they had completed the driver training courses as appropriate to their role.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- The service provided safeguarding training to all ambulance crew volunteers. All staff needed to complete adult safeguarding level 2 and children's safeguarding level 3, in line with the requirements of the adult safeguarding: roles and competencies for health care staff (2018) and the safeguarding children and young people: roles and competencies for health care staff (2018).
- During the onsite aspect of the inspection, the senior leadership team were unable to confirm the level of training undertaken by staff in relation to the adult and children's intercollegiate documents. However, the leadership team told us they believed the number of hours and content would be equivalent to adult level two and children's level three safeguarding training.
- The leadership team provided information following the onsite visit that showed 100% of staff were compliant with both safeguarding adults and safeguarding children's training.
- The service had a lead for safeguarding who had completed safeguarding children level 5. A senior member of the British Red Cross was available 24 hours a day, seven days a week to provide advice and support to crews working at events where they had a suspected safeguarding concern.
- We reviewed the British Red Cross' safeguarding policies and procedures, including:
  - Safeguarding children and young people procedure
  - Safeguarding adults at risk procedure
  - Safeguarding policy
- All three policies and procedures had been reviewed and were within the next allocated review timeframe. We found that all three policies and procedures were extremely detailed and provided clear, concise, easily accessible information for staff to follow.
- The safeguarding children and young people procedure had a simply laid out and easy to follow diagram on the first page for staff to follow where they suspected a safeguarding concern in relation to a child or young person. The flow diagram was representative of the wider policy and procedure.
- Section two of the safeguarding children and young people procedure clearly set out what to do in the event of a child or young person making a disclosure to a volunteer. The guidance was clear and reflective of best practice, for example stating the child should be allowed to disclose but volunteers should not force information from the child or young person.
- The appendices within the procedure had a clearly set out table that listed each type of abuse, such as physical, child sexual exploitation and neglect, and stated the physical and behavioural signs that may indicate abuse or harm. This helped volunteers when assessing a child or young person to spot both the physical and behavioural signs that may suggest something of concern.
- We found the adult at risk procedure and the safeguarding policy were both as detailed and explicit in their content as the safeguarding children and young people procedure.
- We undertook staff interviews following the onsite inspection. During these interviews, we asked four members of staff about their responsibilities in relation

to safeguarding. All four members of staff were knowledgeable about the processes they would follow should they have concerns about a patient during an event or in transit to hospital.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- During the first day of inspection on 26 March, we found all the equipment on vehicles was visibly clean and stored appropriately to prevent contamination.
- Each vehicle had waste disposal equipment, including a clinical waste bin and a sharps disposal bin. We found these had been emptied when used on the vehicles returning from event work.
- The service provided staff with uniforms and all required personal protective equipment, including disposable gloves.
- Staff undertook checks before and after the use of each vehicle. These checks included the cleanliness of the outside, cab and treatment areas. During our first day of inspection, we reviewed previously completed checklists and found them to be fully completed and any concerns highlighted and rectified.
- The service had a contract with an external provider to deep clean vehicles every 12 weeks. The service provided evidence to show this had happened.

Environment and equipment

- **The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- The service had 13 ambulances, consisting of two 4x4 ambulances and 11 conventional road ambulances. The service also had one rapid response vehicle (RRV) and a number of other vehicles, including command and control units and mobile first aid units.
- We found all ambulances had service records, MOT and servicing certificates as required, and had up to date documentation to show ongoing maintenance as required. During out first day of inspection on 26 March, staff were making all vehicles ready again following event work the previous few days. Staff did complete one vehicle which we checked for completeness of equipment and road worthiness. We found the 'make ready teams' had restocked the vehicles in line with checklists set out by British Red Cross for standard equipment on vehicles. We found the vehicle was visibly in a road worthy condition, including tire condition, fully working external emergency and non-emergency lights, and all internal lights.
- During the first day of inspection, we reviewed equipment on the back of three ambulances. All ambulances were laid out in the same way, with equipment stored in the same cupboards and areas on each vehicle.
- We found each specific area of care had a different coloured bag and was clearly labelled with reflective badging, for example burns care was in red bags and infection control in orange bags. The leadership told us this had improved the ability for staff to know where equipment is, and direct other staff (such as NHS ambulance crews) using their vehicles quickly by knowing the colour of the bag required in an emergency.
- The layout of the vehicles promoted the safe transport of patients. We found the equipment most likely to be needed in an emergency readily available next to the attendant's seat, for example oxygen masks and oxygen ports.
- We found a simple but effective system in place for identifying when vehicles were off the road (VOR), needing restocking or were ready for a crew to use. The system involved a series of laminated signs that were clearly displayed in the front of vehicles, and were colour coded red, amber and green, with green, for example, signifying the vehicles was restocked and ready to be used.
- We found keys to all vehicles were stored safely in a key coded safe within the building. Only staff that should have access to vehicles had access to the safe code. Each set of keys was clearly labelled making for easy identification of which set of keys matched which vehicle.

- During the first day of inspection, we reviewed five pieces of equipment on the fully stocked vehicle, including the automated external defibrillator (AED), scoop stretcher, trolley, floor locking mechanism for the trolley and the tail lift. We found all of these pieces of equipment had been serviced within the last 12 months and had stickers to show this.
- Senior staff confirmed that all equipment was serviced on a yearly basis by the manufacturers. Senior staff also confirmed that six monthly Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) checks were carried on equipment that required this. During the first day of inspection, we saw records that confirmed both annual servicing of equipment and six monthly LOLER checks had been completed on equipment.
- The British Red Cross Birmingham location was utilised as a storage and restocking facility for equipment and vehicles. We found appropriate signage in place, for example around compressed gases and substances regulated by the Control of Substances Hazardous to Health (COSHH) Regulations 2002.
- We found that compressed gas cylinders were stored safely and in accordance with best practice. Empty and full cylinders were not stored together, reducing the risk of replacing an empty cylinder with another empty cylinder.

Assessing and responding to patient risk

- **Staff did not consistently complete full risk assessments for each patient swiftly or repeat these as required.** However, staff identified and quickly acted upon patients at risk of deterioration.
- We reviewed two patient report forms for patients that had been transported from an event to hospital between October 2018 and March 2019. We found that ambulance crews did not record two full sets of observations for either patient, which was not in line with the British Red Cross Society's guidance for completion of patient report forms.
- For one patient, who had presented feeling faint, the crew only undertook a blood glucose reading (BM) once, which showed an increased reading. The ambulance crew did not undertake any other observations (for example blood pressure, respiratory rate or pulse rate) to determine any other cause for the patient's presentation.
- The second patient presented with breathing difficulties and upper abdominal pain. The first set of observations taken did not include a blood pressure but did show a significantly increased respiratory rate. The second set of observations taken, 12 minutes later, only included a Glasgow coma scale assessment, pulse rate and blood pressure. The respiratory rate of the patient was not documented as having been reassessed.
- The service did not have clear embedded processes for managing patient with a mental health condition or disturbed behaviour. The leadership team told us they were in the process of reviewing the information available to ambulance crews, updating it and reissuing.
- Ambulance crews were issued with clinical skills and standards pocket guides that covered multiple areas, including resuscitation and clinical assessment. Ambulance crews had the training and skills to take basic observations, including blood pressure, pulse and respirations. Ambulance crews also had training in how to assess and provide immediate aid in trauma, child birth and Glasgow comer scale (GCS). All these skills allowed crews to form a judgement of the seriousness of patients' condition and escalate for additional support where required.
- Ambulance crews had undertaken training in the national early warning score (NEWS) system, and updates in accordance with NEWS2. NEWS is a system for identifying the early deterioration of patients and a simply way of escalating where patients do deteriorate. However, this was not recorded on patient report forms.
- The service had clear escalation pathways in place for deteriorating patients. Where the statutory ambulance service was in attendance, ambulance crews would refer patients of concern to paramedics from the NHS. Where the statutory ambulance service was not already in attendance, crews would escalate using the 999 system for additional support, advice and clinical expertise.
- Ambulance crews assessed patients in accordance with guidance from the Joint Royal College of Ambulance Liaison Chiefs (JRCALC), including the assessment of the deteriorating patient and of children.

Emergency and urgent care services

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment**.
- All staff working from the Birmingham location were volunteers. The service employed ambulance attendants and paramedics.
- The service was able to plan staffing based on upcoming event work that was pre-planned.
- The Birmingham location did not employ clinical staff or volunteers directly. All staff and volunteers were employed by the British Red Cross at provider level. Staff were offered work based on their skills and proximity to the event taking place or to the resources required. However, locally, the location did directly employ support staff.
- We found the service had enough staff with the right skills to undertake the level of work required. Senior leaders could access specialist support from paramedics for larger events where patient numbers or acuity of patients was likely to be higher.

Records

- **Staff did not always keep detailed records of patients' care and treatment. However, records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- The service completed paper patient report forms (PRFs) for each patient. We requested to view six PRFs from patients transported to hospital from events between October 2018 and March 2019. The service provided two PRFs and told us that only two patients had been transported to hospital during this time period.
- Each PRF had a unique identifying number. We reviewed PRFs ending in 962 and 556.
- We found ambulance crews had completed patient details on both PRFs. However, we found PRF ending 962 did not contain a complete set of observations, and no repeat observations were documented. PRF 556 did have two sets of observations taken; however, neither were a complete set of observations.
- This is not in line with the British Red Cross Society's guidance for completion of patient report forms which states that two full sets of observations as a minimum must be taken for all patients, except those presenting with an isolated blister or minor abrasion.
- On both PRFs, we found information with regards ambulance response and handover times missing. On PRF ending 962, the ambulance crew had not documented their arrival time at hospital, handover time within the emergency department or the time they left the hospital. PRG ending 556 did not contain the time called, time of arrival at scene or time left scene. The ambulance crew had also not documented the handover time or had a member of the emergency department sign the PRF to accept handover. The crew had not documented a hand over time.
- Both patient report forms were legible and clearly written.

Medicines

- **The service did not follow best practice when prescribing, giving, recording and storing medicines. However, patients received the right medication at the right dose at the right time.**
- During the inspection, we found vehicles used by non-healthcare professionals carried prescription only medication, including salbutamol inhalers, salbutamol nebulisers and glycerol trinitrate (GTN) spray. Staff told us, and we confirmed with the senior management team, that non-healthcare professionals and non-medical prescribers would carry and administer this medication without a prescriber present.
- The Human Medicines Regulations 2012 state that prescription only medication (POM) can be administered by any person providing that medication has been specifically prescribed for the individual. The senior management team confirmed that prescriptions would not be completed by a healthcare professional with the ability to prescribe before administration.
- We raised our concerns with the leadership team on site and requested assurance following the inspection around how the British Red Cross' processes and the administration of POM was in line with legislation and

regulation. The provider told us that they believed they were working within the requirements of the Human Medicines Regulations 2012 and did not believe they needed to change the working practices at this time.

- All ambulance crew trained volunteers carried non-prescription medication including paracetamol, ibuprofen and loratadine (a form of antihistamine). All vehicles also carried oxygen and nitrous oxide, a pain-relieving gas. We found all medication was stored safely within vehicles and kit bags. All medication was stored securely within the location, and only staff and volunteers that should have access to the medicines store did.
- The British Red Cross Birmingham location did not have a Home Office licence for the holding and use of controlled drugs. However, the leadership team told us that another British Red Cross location did hold a Home Office licence and all controlled drugs were managed from that location. We found all ambulances had a safe within them to securely store controlled drugs, when a paramedic or other suitably trained healthcare professional was on board.

Are emergency and urgent care services effective?

Not sufficient evidence to rate

We did not rate the effective key question.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**
- The service primarily used the Joint Royal College of Ambulance Chiefs (JRCALC) guidance for the basis of treatment pathways.
- The service issued all ambulance crew staff with a clinical skills and standards pocket book, which contained information on several subjects including trauma care, medical care, pain management and resuscitation.
- We reviewed the following sections of the pocket book and found these to all be in line with current guidance and best practice:
  - Adult resuscitation
  - Patient assessment (A to E assessment)
  - Children's pain assessment
- The leadership team told us that the service was currently reviewing the handbooks to update them with any recent changes, for example to include national early warning score 2 (NEWS2) within the pocket book.
- Ambulance crews had access to additional clinical advice, and this was different depending on the event covered. At larger events where the statutory ambulance service was also in attendance, ambulance crews could seek immediate support and advice from onsite clinicians. Where the event was smaller and the British Red Cross were the only supplier of aid, the ambulance crews could ring 999 for additional clinical support and guidance.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- The service assessed patients' pain well and administered pain relief as required.
- Ambulance crews received training in the assessment and treatment of pain.
- The service provided a range of pain relief that staff could use, including oral pain relief (namely paracetamol and ibuprofen) and inhaled pain relief (nitrous oxide). Paramedics also had access to morphine and other stronger analgesia for severe pain.
- We found pain was well documented on the patient report forms we reviewed, and staff reassessed pain as required following the administration of pain relief.

- Ambulance crews had access to alternative pain assessment for patients unable to speak and for children, for example the FLACC (face, legs, arms, cry, consolability) tool and Wong-Baker FACES pain rating tool.

Assessment and planning of care

- **Staff had the information needed to make the decisions about the right pathway of care for patients. However, limited information was available for staff in relation to the care of mental health conditions.**
- The leadership team told us that ambulance crews have access to information in relation to specialist centres, for example burns units and centre, and PCI centres, within event planning packs. The information would be available on each vehicle specific to the event, to enable ambulance crews to effectively decide the best location for the patient.
- Ambulance crews could 'see and treat' patients and then discharge them from the care of the British Red Cross. Ambulance crews had a set of protocols in place to ensure the safety of patients they discharged after treatment, without conveying to a hospital.
- The protocols included that ambulance crews must undertake at least two sets of observations to establish that patients had not deteriorated whilst under the care of the ambulance crew.
- The leadership team told us that the service has some limited guidance in place to support patients with a mental health condition, including the safe transportation of this patient group. However, the leadership team acknowledged that these guidelines were not embedded at the time of the inspection and more work needed to be done in this area.

Response times and patient outcomes

- **Managers did not robustly monitor the effectiveness of care and treatment and use the findings to improve them. They did not compare local results with those of other services to learn from them.**
- The leadership team were aware of the outcomes that would be beneficial for the service to monitor, for example survival to discharge following cardiac arrest, stroke outcomes and return of spontaneous circulation (ROSC).
- The leadership team told us they find it difficult to gather the information in relation to these areas as they work across such a large geographical area. Therefore, monitoring of outcomes was limited. The leadership team acknowledge that more work needed to be done to improve the monitoring of patient outcomes within organisation.
- We asked the provider about monitoring of ambulance handover times. The provider told us they do not formally monitor handover times between ambulance crews and emergency department. However, at larger events, ambulance crews would inform the event officer of their arrival and departure time at the hospital.

Competent staff

- **Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and monitor the effectiveness of the service. However, the service made sure staff were competent for their roles.**
- We asked the leadership team about staff appraisals and supervision. The leadership team told us that volunteers do not get appraised and do not undertake compulsory supervision in relation to their role.
- The leadership team told us that poor behaviour and consistent non-compliance with policies and procedures would be challenged informally by local group leaders. We were not assured that volunteers and staff had appropriate levels of supervision or appraisal of performance to ensure consistently effective care delivery.
- Ambulance crews underwent regular training and competency assessments in relation to their role. We found ambulance crews had undertaken 10 compulsory training sessions between February 2018 and April 2019. Some of the subject areas covered included:
  - Safety netting (national early warning score 2) training
  - Managing cardiac arrest

  - Capacity and consent
  - Fracture management update
- To ensure consistency across all ambulance staff and volunteers, the British Red Cross event allocation system did not allow staff or volunteers to sign up to undertake an event unless they had completed all necessary training and competencies required for the role.

Multi-disciplinary working

- **All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.**
- We did not observe patient care during the inspection process. However, staff told us that they worked closely with local emergency departments during handover of patients.
- Staff told us that they worked well with other agencies during events when transportation was required to a hospital, for example with the police, statutory NHS ambulance service and other voluntary ambulance services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.**
- We reviewed the organisations use of restraint guidance. We found this to be in line with national best practice and gave a quick reference guide to staff and volunteers as to when and how to use restraint. The guidance also contained a check list for staff to complete should they consider using restraint to ensure it was done legally.
- Following the onsite inspection we undertook interviews with staff. We asked four staff about their understanding of the Mental Capacity Act 2005 and assessing capacity. All four members of staff had a good knowledge of why capacity was important. All four members of staff knew how and when to ask for additional support where they suspected patients lacked the capacity to consent for themselves.
- Staff had a good knowledge of making a best interest decision and could explain when this would apply.
- All four staff asked had a good understanding on when and how to take consent. Staff understood why and how to support a patient to give informed consent.

Are emergency and urgent care services caring?

Not sufficient evidence to rate

We did not rate the Caring key question.

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We did not observe care delivery during the inspection. However, we spoke to four members of staff following the onsite inspection and asked them how they would promote the privacy and dignity of patients.
- All four members of staff showed a good understanding of how they would promote the privacy and dignity of patients. All four members of staff told us they would ensure the rear and side doors were closed when delivering care and treatment.
- All four staff told us they would utilise blinds to increase the privacy of patients where available.
- All staff could explain how they would promote the privacy and dignity of patients outside of the vehicle, for example using blankets to cover the patient and exposing as little skin as possible.
- We found each vehicle had blacked out windows and some had blinds to promote the privacy and dignity of patients.

Emotional support

Emergency and urgent care services

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- We asked four staff about providing care to patients whilst transporting them to hospital.
- All four staff could explain how they would support patients. For example, using kind, compassionate language when speaking with distressed patients and those close to them.
- Staff explained how they would alter their approach to different patients, for example when treating a patient with dementia or with a learning disability, to ensure they felt supported and safe.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- We asked two members of staff about how they would support patients and those close to them to be involved in decisions about their care.
- Both members of staff could give examples of how they would include patients in the decision-making process.
- Both members of staff told us if a patient refused to be transported to hospital, they would ensure the patient was fully informed of the risks and potential implications of not going to hospital.
- Both staff told us, where a patient refused to be transported to hospital, that other arrangements could be made. For example, staff told us they would encourage patients to attend a walk-in centre or GP service. Alternatively, they would encourage the patient to not be alone and stay with friends or family in case they deteriorated.

Are emergency and urgent care services responsive to people's needs?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- The provider supplied services through pre-agreed bookings only. Services were planned based on the requirements of the event.
- The British Red Cross worked in partnership with other agencies, including statutory NHS ambulance services, police forces and other third sector care providers, to ensure the correct level of cover was provided at events.
- The service had access to conventional road ambulances and specialist 4x4 ambulance for use in specific situations where a vehicle with off road capabilities would be required.
- The Birmingham location could utilise specialisms and equipment from across England to support in its activities. For example, a recent marathon event in the north west required additional staff and resources from across the country.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.**
- Each vehicle carried pictogram books for patients that were unable to vocalise. The books contained sections including pain assessment and what needs to happen, such as if the patient needs to go to hospital.
- We asked three members of staff about how they would support someone whose first language was not spoken English. All three staff told us they would utilise translation books which were available on each vehicle.
- The service did not have the ability to transport patients in their own wheelchairs in a British Red Cross ambulance. However, the service had procedures in place to transport these patients to hospital.
- We asked two members of staff about how they would support someone with a learning difficulty. Both members of staff could explain how they would support

someone, for example by using pictogram books instead of spoken or written words, ensuring the person felt safe by having those around them that they trusted (such as family or friends) and ensuring that where the person lacked capacity a best interest's decision was made.

- The leadership team told us that the British Red Cross Birmingham did not have access to bariatric equipment. However, the leadership team told us they would escalate this to the statutory NHS ambulance service and request support from them should bariatric equipment be required.

Access and flow

- **People could access the service when they needed it and received the right care in a timely way. However, the service did not monitor or use data to improve care.**
- The work undertaken by the British Red Cross was all event work; therefore, access to the service was available immediately as required at each event.
- We asked the provider about monitoring of ambulance handover times. The provider told us they do not formally monitor handover times between ambulance crews and emergency department. However, at larger events, ambulance crews would inform the event officer of their arrival and departure time at the hospital.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.**
- The service told us it had received six complaints between April 2018 and March 2019. The six complaints related to:
  - Two complaints about customer service in relation to booking the British Red Cross to provide cover at an event
  - Damage to private property whilst on an event
  - Manner of parking of an ambulance
  - Two complaints about the behaviour or attitude of British Red Cross staff
- We requested the investigation and outcome from two of the six complaints. However, following the inspection, the leadership team told us these six complaints were received nationally and did not relate specifically to the Birmingham location.
- The leadership team told us that should any complaints be received, they would be investigated fully according to the British Red Cross complaints policy.
- We asked two volunteers how a patient would make a complaint about care. Both volunteers told us they would listen to the patient and try to resolve the concerns locally. Where this wasn't possible, they would escalate to the event officer.
- Both volunteers knew that all vehicles carried complaints leaflets and that patients, or those close to them, could take these away and make a complaint in writing or over the phone at a later time.

Are emergency and urgent care services well-led?

Good

We rated it as **good.**

Leadership of service

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- During the onsite inspection, we found the leadership team to be open and transparent about the service, and responsive where concerns were raised.
- The Birmingham location was overseen by an operations manager based elsewhere in the country; however, visited the Birmingham location when required.

Emergency and urgent care services

- During times of care delivery, each event had a designated event officer who would take overall responsibility and line management during the event. All ambulance crews reported to the event officer during this time.
- We spoke with four staff about the support offered by the leadership teams across the British Red Cross. All four staff told us they felt well supported, and that the organisation had an 'open door' policy.
- All staff spoken to felt on events, event officers provided sufficient support at the time. All staff felt comfortable in approaching the senior leadership team with concerns.
- However, staff did tell us that the leadership team were sometimes difficult to get hold of as they were so busy. Staff did tell us that they did get a response, although this could sometimes be the next day.
- During the onsite inspection work, we spoke with the service delivery managers for the north and south regions, the national operations manager and the national operations lead. We found all four senior leaders had a good understanding of the organisation, it's strategic direction and where the Birmingham location fitted into the wider British Red Cross structure.
- We found the senior leaders had a good understanding of the challenges faced by the Birmingham location in monitoring and maintaining quality.
- At the time of the inspection, the location had no registered manager appointed. The previous registered manager left in December 2018. However, the service delivery managers for the north and south regions were both, at the time of the inspection, registered managers. They were jointly overseeing the day-to-day running and management of the Birmingham location until a suitable permanent registered manager was appointed.

Vision and strategy for this service

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.**
- The provider had a set of values that all staff and volunteers signed up to on commencement of work with the British Red Cross. The values were:
  - Inclusive
  - Compassionate
  - Courageous
  - Dynamic
  - We work to demonstrate respect, diversity, integrity, transparency and accountability in everything we do
- The provider had a 2015 to 2019 strategy in place. The provider wide strategy covered multiple areas, including:
  - The difference we make in the UK
  - The difference we make globally
  - Funding our work and our organisation
  - The difference our people make
  - The difference our voice makes
  - The difference our technology makes
- Each of the above sections had statements to achieve. For example, the difference our people make section included four areas which looked at encouraging the staff and volunteers to live the mission, values and principles, develop confident inspirational leaders, and nurture and recognise the efforts of the volunteers and staff.
- The service had a mission statement in place covering the event first aid part of the organisation, which was where the Birmingham location sat within the organisation. The mission statement was implemented January 2016 and included a vision for what the service wanted to achieve and several points to help achieve this.
- We found the vision for the event first aid part of the organisation linked into the wider provider strategy. There were clear links between the local and national vision, values and strategy.
- We found the strategy, or points within the mission statement to achieve the mission, was made up of eight points. Each point was clear as to how it impacted the overall vision for event first aid.

- The leadership team provided following the onsite inspection a service delivery plan for 2019. This included six points that were:
  - Safety and effectiveness
  - Our people and welfare
  - Those in crisis
  - Our impact
  - Market position
  - Each strategic intent focus point was accompanied by a description of what this involved.
  - The mission statement provided for event first aid was an overarching vision and strategy for the provider. However, the leadership team did not provide a localised vision or strategy for the Birmingham location.

Culture within the service

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, the service did not have robust procedures for supporting staff development and challenging poor practice and behaviour.**
- We spoke to four staff about the culture within the British Red Cross, and specifically working at the Birmingham location.
- All four staff told us they felt the culture was open and inclusive, and they had not had any concerns or problems with other staff.
- All four staff told us they felt comfortable to speak with any local or senior leader within the organisation should they need support.
- The organisation had local hubs and meetings for volunteers to attend on a monthly basis, with ambulance crews having an additional monthly meeting. This allowed remote workers to meet with colleagues and allowed for open discussion with peers about concerns and gave the ability for staff to share good practice.
- We found that all ambulance crews received the training and competencies they required. There was a culture of openness around staff asking for additional training and support, and we saw evidence of this during the inspection. However, the service did not undertake any appraisals for staff or structured conversations about progression within the organisation.
- We found a limited structure in place to challenge poor behaviour. Due to the lack of formalised routine appraisals, local group leaders were encouraged to challenge poor practice and behaviour locally. However, we found limited support mechanisms in place for group leaders in relation to this.
- We asked the senior leadership team what their understanding of duty of candour was, and all four members of the leadership team spoken to could demonstrate a good understanding and knowledge of duty of candour.
- Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- We found no incidents in the reporting timeframe that required duty of candour to be exercised.
- The senior leadership team told us that following any traumatic incident, individual ambulance crew were contacted and offered support. An example was given of a particularly busy event with a number of collapsed patients, and the leadership team ensured that all staff and volunteers were spoken to individually to ensure they were not adversely affected by the work.

Governance

- **Leaders operated effective governance processes, throughout the service and with**

partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- The service had a clear governance structure in place. Locally, the registered manager of the location led on governance and oversight.
- Where concerns arose, the local leadership would escalate through the organisation. At a senior level, the provider had a medical director, clinical governance manager, regulatory compliance manager and senior clinical manager who each chair an advisory group with the organisation.
- Each advisory group was responsible for a different area. We reviewed the minutes from the event first aid and ambulance support national equipment and standards advisory group (NESAG) from 10 October 2018. We found the minutes to be detailed and included a review of the previous minutes, a review of the NESAG risk register and clear actions assigned to individuals.
- We reviewed meeting minutes from the clinical and practice advisory group (CPAG) from the 4 October 2018. We found the minutes to be detailed and included a review of the previous minutes, a review of the CPAG risk register and clear actions assigned to individuals.
- The organisation also had a healthcare professionals manager in post who oversaw the scope of practice of all healthcare professionals, for example paramedics, within the British Red Cross.
- During and following the onsite inspection visit, staff demonstrated a clear understanding of their role and responsibilities in relation to the organisation, and raising and investigating risks, complaints and concerns.

Management of risk, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- We found a clear, contemporaneous risk register in place for the Birmingham location. The registered manager for the Birmingham location (and the north and south service delivery managers due to the vacant position) were responsible for maintaining and reviewing the risk register.
- The local risk register fed into a national risk register, allowing the senior leadership team within the organisation to have oversight of all local risks.
- Local and national risk registers were reviewed and updated monthly.
- During discussions with the senior leadership team, we found all four had a good understanding of the risks associated with the Birmingham location and more widely at a national level.
- We found innovative ways for reducing risk and promoting continuity and high-quality care across the organisation. For example, the electronic staff records system and booking systems worked together. This prevented any volunteer or staff member registering to undertake work that had not updated the required training for that role. This prevented those without up to date training attending and working at events.
- We found a systematic approach to undertaking clinical audits within the organisation. The audit system was managed nationally and reviewed multiple areas. However, we found that the service did not monitor clinical outcomes in line with national best practice. For example, the service did not monitor the outcomes of patients for conditions including return of spontaneous circulation (ROSC) and following strokes. This prevented the organisation from having a full picture to help improve clinical outcomes of patients.
- We found employment procedures for volunteers promoted an open and safe culture. We found all volunteers underwent an enhanced DBS check and references were required before they commenced ambulance attendant roles within the organisation.

- The service offers emergency ambulance provision, including the ability to use blue lights and sirens. The leadership told us that all non-emergency drivers complete a training package provided by the Royal Society for the Prevention of Accidents (RoSPA). All emergency drivers underwent further training provided by a third-party organisation. The provision of specific emergency and blue light driving ensured that the organisation and individual drivers were compliant with Section 19 of the Road Traffic Regulations Act 2006.
- We found concerns throughout the inspection that had not been recognised previously by the leadership teams. We found documentation was not always in line with the British Red Cross policies on record clinical observations.
- We found concerns with regards the prescribing and administration of medication. We spoke with the senior leadership team who were unaware they were not acting in accordance with the Human Medicines Regulations 2012. Following the onsite inspection visit, the provider did not provide assurance that they understood the requirements of the Human Medicines Regulations 2012.

Information Management

- **The provider did not collect patient outcome data and analyse it to improve the quality of care. Staff could not find data they needed to understand performance and make improvements to the quality of care. However, the information systems in place were integrated and secure. Staff had access to the information needed to undertake their roles.**
- We found that quality and sustainability were priorities for the organisation, and we found a culture to achieve high standards. However, the gathering of information and data to support this was lacking.
- We found the organisation did not collect patient outcome data. The leadership team told us this was due to the organisation covering a large geographical area and the complexities of accessing information from multiple NHS providers.
- We found the service did not have clear and robust service performance measures in place. For example, the service did not routinely monitor handover times within emergency departments or monitor response times to patients to help inform and improve the timeliness of care both internally and across the wider system, for example at larger events.
- We found a robust system in place to ensure the confidentiality of patient information. All patient identifiable information was kept secure, either through a paper copy or electronically. All staff asked knew how to keep personal information safe and could explain the systems in place at the Birmingham location to support this.
- Staff had access to the information they needed in order to undertake their roles. For example, each vehicle contained localised information in relation to specialist centres relevant to the geographical location of the event. For example, at a recent marathon in the north west of England, the vehicles contained information for crews on the nearest PCI centre, trauma centre and children's hospital. This allowed crews to transport patients to the most suitable emergency department or hospital for their condition.

Engagement

- **Leaders and staff actively and openly engaged with staff. However, we found limited engagement with the public to help shape services.**
- The service engaged well with staff. We asked three staff about the engagement from the organisation. All staff asked told us that they receive enough information from the provider regarding updates and general information.
- The provider sent monthly updates via email to all volunteers via mailing groups, with specific ambulance crew information only going to ambulance staff, but all staff receiving general updates.
- Staff we spoke with told us that the updates were read out and reviewed at monthly group meetings too. This provided a 'catch all' approach so all volunteers had the chance to receive information in two ways.

- Staff were encouraged to feedback to the organisation about ways to improve the service.
- We found limited engagement with service users. The service collected feedback in an ad hoc way, with no specific patient public involvement groups or strategy in relation to the provision of event first aid.

Innovation, improvement and sustainability

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**
- The service was implementing a new electronic patient report form in 2019. User acceptance testing was due to begin in May 2019, with a full roll out across the service by October 2019.

Outstanding practice and areas for improvement

Outstanding practice

We found the providers system to prevent untrained members of staff or volunteers from booking onto a shift outstanding. The automated system prevented anyone who was out of date for mandatory training from booking onto a shift that required that skill or training. Until the staff member of volunteer had completed this training, they were unable to book onto another shift. The system ensured that only trained and competent staff and volunteers could book onto ambulance crew shifts.

Areas for improvement

Action the service MUST take to improve

- The provider must ensure the proper and safe management of medicines, including the supply, prescribing and administration of medication. Regulation 12(2)(g)
- The provider must ensure that patients receive appropriate risk assessments and clinical observations, and these are documented on patient report forms, for their presenting condition. Regulation 12(1)
- The provider must ensure staff and volunteers completing patient report forms maintain an accurate, complete and contemporaneous record in respect of each patient. Regulation 17(2)(c)
- The provider must ensure that staff receive appropriate professional development, supervision and appraisal to enable them to carry out their duties they are employed to perform. Regulation 18(1)(2)(a)

Action the service SHOULD take to improve

- The provider should review how it undertakes patient outcome monitoring to ensure it maximises the information received to shape learning and improvements across the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment** **Care and treatment must be provided in a safe way for service users.** **The registered person must ensure the proper and safe management of medication. The registered person must ensure that medication is prescribed and administered in accordance with current legislation and regulation.** **We found non-healthcare professional staff carried, dispensed and administered prescription only medication without the required authority or prescription, which is not inline with the requirements of the Human Medicines Regulations 2012.** **The registered person must ensure that service users have sufficient clinical checks and risk assessments undertaken to support care delivery and clinical decision making.** **Staff did not always follow the British Red Cross Society policies on undertaking clinical observations. We found patients did not have complete or repeat sets of observations undertaken.** **Regulation 12 (1)(2)(a)(g)**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance**

This section is primarily information for the provider

Requirement notices

Systems and processes must enable the registered person to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The registered person must ensure that all staff and volunteers completing patient report forms do so fully, and document all information relating to the care and treatment of the service user.

The registered person must ensure that information relating to the chronology of the care and treatment provided to service users is clearly and completely documented within the patient report form relating to that service user.

Regulation 17(2)(c)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing Persons employed by the service must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Requirement notices

The registered person must ensure that volunteers and staff receive regular appraisals, reviews and supervision in order to support their development needs, and provide a structure to challenge poor behaviour and practices.

Regulation 18(1)(2)(a)