Paramed Ambulance Service Limited

Paramed Ambulance Service Limited

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated the service as inadequate because:

Staff did not receive effective training in safety systems, processes and practices and there was insufficient attention to ensure staff received safeguarding training. Staff did not receive training on how to recognise if patients deteriorated during the ambulance journey. The service did not make sure staff were competent for their roles.

The service did not always control infection risks well. Standards of cleanliness were not maintained. The maintenance and use of equipment did not keep people safe and ambulance safety was compromised. The service did not have effective systems and processes to ensure medicines were always prescribed and administered safely.

There were limited risk assessments carried out for people who were conveyed by the service. Staff did not keep detailed records of patients' care and treatment when they provided patient transport services. There was limited use of systems to record and report safety concerns, incidents and near misses.

The service did not have 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 manager did not complete all necessary employment checks to make sure staff were of good character, competent and skilled to meet the needs of patients transported by the service.

The service did not provide care and treatment based on current national guidance and evidence-based practice.

Staff obtained verbal consent from patients receiving care, but this was not recorded. There were limited processes to assess and record if patients were subject to deprivation of liberty safeguards. The service was inclusive, but there were limited processes to assess and take account of patients' individual needs and preferences. There was no evidence to show people could access the service when they needed it.

The registered manager did not have all the skills, knowledge and experience needed to run the service safely and effectively. They did not demonstrate oversight of what was happening on the front line of the service.

The registered manager did not operate effective governance processes throughout the service and with partner organisations. The service did not monitor response times so they could facilitate good outcomes for patients. The service did not use systems to manage performance and risks effectively. The service did not collect reliable data and not all information systems were secure.

However:

Staff assessed patients' food and drink requirements to meet their needs during a long journey.

The service worked closely with systems partners, including another independent ambulance service and staff from the local NHS hospital who were responsible for patient discharges.

There were processes for people to give feedback and raise concerns about care received.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Inadequate 	We rated the service as inadequate because: • Staff did not receive effective training in safety systems, processes and practices and there was insufficient attention to ensure staff received safeguarding training. • The service did not always control infection risks well. Standards of cleanliness were not maintained. The maintenance and use of equipment did not keep people safe and ambulance safety was compromised. • There were limited risk assessments carried out for people who were conveyed by the service. Staff did not receive training on how to recognise if patients deteriorated during the ambulance journey. • The service did not have 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 did not make sure staff were competent for their roles. The manager did not complete all necessary employment checks to make sure staff were of good character, competent and skilled to meet the needs of patients transported by the service. • The service did not have effective systems and processes to ensure medicines were always prescribed and administered safely. • There was limited use of systems to record and report safety concerns, incidents and near misses. • The service did not provide care and treatment based on current national guidance and evidence-based practice. • The service did not monitor response times so they could facilitate good outcomes for patients. • There were limited processes to assess and record if patients were subject to deprivation of liberty safeguards. • The service was inclusive, but there were limited processes to assess and take account of patients' individual needs and preferences. There was no evidence to show people could access the service when they needed it.

Summary of findings

- The registered manager did not have all the skills, knowledge and experience needed to run the service safely and effectively. They did not demonstrate they had oversight of what was happening on the front line of the service.
- The registered manager did not operate effective governance processes throughout the service and with partner organisations. The service did not use systems to manage performance and risks effectively. The service did not collect reliable data and not all information systems were secure.

However:

- Staff assessed patients' food and drink requirements to meet their needs during a long journey.
- The service worked closely with systems partners, including another independent ambulance service and staff from the local NHS hospital who were responsible for patient discharges.
- There were processes for people to give feedback and raise concerns about care received.

Patient transport services

Inadequate

We rated the service as inadequate because:

- Staff did not receive effective training in safety systems, processes and practices and there was insufficient attention to ensure staff received safeguarding training.
- The service did not always control infection risks well. Standards of cleanliness were not maintained. The maintenance and use of equipment did not keep people safe and ambulance safety was compromised.
- There were limited risk assessments carried out for people who were conveyed by the service. Staff did not receive training on how to recognise if patients deteriorated during the ambulance journey. Staff did not keep detailed records of patients' care and treatment when they provided patient transport services.
- The service did not have 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 did not make sure staff were competent for their

Summary of findings

roles. The manager did not complete all necessary employment checks to make sure staff were of good character, competent and skilled to meet the needs of patients transported by the service.

- The service did not have effective systems and processes to ensure medicines were always prescribed and administered safely.
- There was limited use of systems to record and report safety concerns, incidents and near misses.
- The service did not provide care and treatment based on current national guidance and evidence-based practice.
- The service did not monitor response times so they could facilitate good outcomes for patients.
- Staff obtained verbal consent from patients receiving care, but this was not recorded. There were limited processes to assess and record if patients were subject to deprivation of liberty safeguards.
- The service was inclusive, but there were limited processes to assess and take account of patients' individual needs and preferences. There was no evidence to show people could access the service when they needed it.
- The registered manager did not have all the skills, knowledge and experience needed to run the service safely and effectively. They did not demonstrate oversight of what was happening on the front line of the service.
- The registered manager did not operate effective governance processes throughout the service and with partner organisations. The service did not use systems to manage performance and risks effectively. The service did not collect reliable data and not all information systems were secure.

However:

- Staff assessed patients' food and drink requirements to meet their needs during a long journey.
- The service worked closely with system partners, including another independent ambulance service and staff from the local NHS hospital who were responsible for patient discharges.
- There were processes for people to give feedback and raise concerns about care received.

Summary of findings

Contents

Summary of this inspection

Background to Paramed Ambulance Service Limited

At the time of this inspection, the service provided patient transport services, commissioned by local short-term contracting arrangements with healthcare providers and mainly for patients being discharged from a local NHS hospital.

The service was registered in May 2018 and this was the first inspection of this service. The service was set up to provide paramedic led acute transfer services for patients needing hospital to hospital transfer for emergency and lifesaving treatment. During the pandemic, the service has mainly been providing patient transport services.

The service is registered to provide the following regulated activities:

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

The inspection was announced to the provider with two weeks' notice and we shared the key lines of enquiry we use as part of our inspection framework. Prior to the inspection, we had held regular engagement meetings with the registered manager and the nominated individual as part of our monitoring methodology. Following information shared in these meetings, and with fundamental changes to the leadership, we instigated an urgent inspection. As we had not previously inspected the service, we undertook a comprehensive inspection, which also meant we could rate the service based on our findings. However, we were unable to inspect and rate caring as we did not have the opportunity to observe care provided by staff during the inspection.

There were no special reviews or investigation of the service ongoing by the Care Quality Commission (CQC) at any time during the 12 months before this inspection.

Activity (May 2020 to April 2021)

The service did not collect this data and could not tell us how many patient transport journeys had been completed over the last 12 months.

There was only one person employed by the service. The registered manager used bank staff to meet staffing requirements of the service. The service did not hold any controlled medicines.

Track record on safety:

- No never events
- No clinical incidents
- No complaints

How we carried out this inspection

During the inspection, we met with the registered manager. We spoke with the registered manager, a member of bank staff, one patient and one relative of a patient who had used the patient transport service.

Summary of this inspection

We reviewed policies and documents pertinent to the service, including employment checks and records relating to patient transport service they had undertaken.

We found areas of serious concerns, which led us to take enforcement action in line with our policy.

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.

Areas for improvement

Action the service MUST take to improve:

We told the service that it must take action to bring services in line with legal requirements. This action related to Paramed Ambulance Service Limited.

- The service must ensure staff receive mandatory training which covers the scope of the service being provided. (Regulation 18 (2) (a)).
- The service must ensure staff receive adult safeguarding and child protection training to the level required of their role by intercollegiate guidance, and compliance is monitored. (Regulation 18 (2) (a)).
- The service must ensure staff have the relevant skills, training and competency to recognise deteriorating patients and to deliver the services intended by the provider.(Regulation 18 (2) (a)).
- The service must ensure patient risks are assessed, recorded and managed for all patients, including information about specific care needs. (Regulation12 (a) (b)).
- The service must ensure evidence of employment checks are carried out for all employees, including bank staff as specified in Schedule 3. (Regulation 19 (3)).
- The service must ensure medicines are managed safely and that staff are trained to administer these, including administering of medical gasses (Regulation 12 (2) (g)).
- The service must ensure the ambulance and equipment is maintained to keep people safe (Regulation 12 (2) (h); 15 (1)).
- The service must improve the contents of policies to ensure they include enough, current and evidence-based information to provide guidance for staff, are regularly reviewed and available to staff when they need them.
- The service must ensure personal information about patients is managed in line with the General Data Protection Regulations.(Regulation 17 (2) (f)).
- The service must ensure there is a governance structure which enables full oversight of quality, safety and performance of the service. (Regulation 17 (2) (a)).
- The service must ensure there is a process to formally document risks and have effective risk management plans associated with the service. (Regulation 17 (2) (b)).

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, improvements need to be made to comply with a minor breach that did not justify regulatory action, to prevent beaching a legal requirement, or to improve service quality.

- The service should embed effective systems and processes for staff to follow when safeguarding concerns are raised.
- The service should encourage staff to report all incidents and near misses and improve systems to report safety systems.

Summary of this inspection

- The service should consider how best to improve documentation to consider all relevant information about patients, including information if patients are subject to deprivation of liberty safeguards.
- The service should ensure policies and guidance are available on the ambulance and easily accessible for staff.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Inadequate	Not inspected	Requires Improvement	Inadequate	Inadequate
Patient transport services	Inadequate	Inadequate	Not inspected	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not inspected	Requires Improvement	Inadequate	Inadequate

Inadequate

Emergency and urgent care

Safe	Inadequate
Effective	Inadequate
Responsive	Requires Improvement
Well-led	Inadequate

Are Emergency and urgent care safe?

Inadequate

We rated the service as inadequate.

Mandatory training

Staff did not receive effective training in safety systems, processes and practices.

The service did not have an overview of training staff had completed. There was no policy setting out what training was considered as mandatory training which all staff should complete and receive regular/annual refresher training. We reviewed four staff files and only one of these held copies of current training in basic life support. There was no evidence of any other current training completed by staff, including basic life support, infection prevention and control, health and safety, manual handling and conflict resolution. We could not be assured staff had the required knowledge and skills to keep patients safe.

Safeguarding

There was insufficient focus on ensuring staff received safeguarding training.

Not all staff had received safeguarding training for adults as outlined in their safeguarding policy or in line with national guidance: Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff (2018). The registered manager told us they had completed safeguarding training for adults at level 1 but we did not see any certificates stating when this was completed. The safeguarding policy did not include any information to describe what training staff were required to attain although it stated all staff would receive adult safeguarding awareness training. No staff member had completed any child protection training. However, there was a safeguarding policy which staff had signed to say they had read. The policy stated staff should inform the registered manager of any concerns to be escalated to the local hospital or the local authority. The policy included information about the signs and symptoms which may indicate safeguarding concerns and telephone numbers of who to inform. This policy was not available to staff on the ambulance when they were conveying patients and may be in need of the information included in the policy.

However, there were systems to report concerns relating to safeguarding. There was a form for staff to use to document their concerns and actions taken but the form did not include information of key contacts to support staff to raise concerns. The registered manager was aware of signs of different kind of abuse and how to escalate concerns. We heard of an example of when staff had escalated a concern regarding a failed discharge as the crew did not consider it safe to leave the patient at the destination/home address without adequate support.

There was insufficient assurance the service had carried out the right level of disclosure and barring service (DBS) checks. Two staff records showed only a basic check had been carried out rather than an enhanced check in line with UK eligibility as listed in the Police Act 1997. The storage of DBS documents concerning individuals was not in line with the General Data Protection Regulations (GDPR) Data Protection Act 2018 as detailed personal information was stored in personal files when only the overall outcome of the DBS check was required.

Cleanliness, infection control and hygiene

The service did not always control infection risks well. Standards of cleanliness were not maintained.

The ambulance and equipment were visibly dirty. This included the driver's door pocket, the footwells, the clinical equipment, the patient chair and the carry chair. There was a residue on the giving set for a medical gas which showed it had not been cleaned after use. The carry chair was unclean, and its wheels were rusted and dirty. The portable suction unit and oxygen tubing packet were both dirty and damaged. We observed used and dirty PPE in the cabin of the ambulance. There was no evidence to show staff had been tested to safely use filtering facepiece (FFP3) masks although the service had transported patients with COVID-19 to another hospital. Records also showed that on 29 March 2021, two patients who lived in the same post code had been conveyed together to save time.

Deep cleaning protocols were ineffective. There was a record which showed the ambulance had been deep cleaned once a week since January 2021. This showed the ambulance had been deep cleaned the day before our inspection. We were not assured the correct cleaning solutions were used as the registered manager was unaware there were different solutions and strength of solutions and cleaning sprays and wipes. We saw that one cleaning product, kept in an overhead compartment with other supplies had leaked and contaminated everything within. We did not find any Control of Substances Hazardous to Health (COSHH) risk assessments to show how products should be safely stored or managed in line with their COSHH policy. This policy and any risk assessments were stored in the office and was not readily available to staff on the ambulance.

We reviewed 80 entries made on the daily job sheet log between 5 April and 29 April 2021. Records showed the ambulance had been cleaned following 57 journeys. This meant for the remaining 23 journeys, there was no evidence to show, cleaning had been undertaken between patient journeys. In addition, records showed lack of cleaning/deep cleaning on 9 March 2021, when a patient, who was COVID positive, had been conveyed to a community hospital. There was no evidence recorded the ambulance had been cleaned/deep cleaned before picking up another patient from the same community hospital.

There were no audits to assess compliance with infection prevention and control measures. There was no evidence to show actions were taken when the daily job sheet lacked confirmation of cleaning of the ambulance and equipment between patient journeys. However, staff had access to enough personal protective equipment of good quality, which was provided by the local hospital. Staff had access to hand gel on the ambulance and to hand washing facilities when they were at the hospital, although the ambulance's hand gel dispenser was empty when we inspected. There was a verbal agreement to obtain clean linen and dispose of dirty linen and clinical waste at the local hospital.

The service had an Infection Prevention and Control Procedures Policy (2018) and a COVID-19 amended infection control policy. The amended COVID-19 infection control policy held information suggesting the policy had been written in April 2020. There was no evidence to show the policy had been reviewed and updated in line with developments and national guidance. For example, the policy did not include any reference to 'fit testing' for use of FFP3 masks or about COVID testing for staff.

However, we were told staff undertook twice weekly lateral flow tests (COVID-19) although the results were not collated and stored by the service.

Environment and equipment

The maintenance and use of equipment did not keep people safe. Ambulance safety was compromised, and we were not assured monitoring of the safety of the ambulance and the equipment was effective.

There was a daily vehicle checklist which was completed by the crew. We reviewed 18 vehicle checklists. There were no concerns highlighted on any checklists that we reviewed. However, we found some things had been ticked as being available which were not available on the day, we inspected the ambulance. For example, policies and procedures should have been available to staff but there was no folder containing these on the ambulance.

The seatbelts on the patient seat and the seat to the rear of the stretcher were partially broken and exposed wires were visible and posed a risk to safety. The lap belt on the carry chair was torn and could fail in use. The rear passenger seat had a rip, which meant it could not be properly cleaned. A plastic glide board (a manual handling aid) was worn, with a sharp edge that could damage a patient's skin. The hydraulic lift on the vehicle was broken and the step which was used to enter the ambulance was unstable and corroded. The rear light of the ambulance was broken and had sharp exposed edges.

The ambulance and equipment were not of a standard to facilitate these journeys safely. Monitoring equipment required to safely convey high-dependency (requiring increased monitoring and supervision) and acutely ill patients were not up to required standards. For example, the monitoring equipment could only produce a three-lead electrocardiogram (monitoring of the heart's electrical activity) and not a twelve-lead as recommended by the Faculty of Intensive Care Medicine (2019). There had been a monitor which could do this, but this had not been replaced when it was found to be faulty.

Staff reported faulty equipment in an incident book, which was introduced in January 2021, and this demonstrated actions taken to rectify the issues raised. For example, on 5 February 2021 there was an entry logging the back door being accidentally caught in the wind which cause the glass to be broken. The accident book stated the glass had been replaced but that there was an issue with the design, which had not yet been resolved and there was a risk it could happen again.

However, the ambulance had a current MOT certificate and correct insurance cover.

Assessing and responding to patient risk

There were limited risk assessments carried out for people who were conveyed by the service. Staff did not receive training on how to recognise if patients deteriorated during the ambulance journey.

Inadequate

Emergency and urgent care

The documentation used for patients being transported by the service, included limited information about patients' health, risks or specific care instructions. The was inconsistent recording of information about patient risks and information about vital signs were not recorded consistently.

Staff did not always have the information they needed to deliver effective care and support. There were no effective systems and processes to ensure information about specific care instructions, including decisions about resuscitation, was obtained and documented.

Staff did not receive training on how to recognise if patients deteriorated during the ambulance journey. There was no policy, protocol or standard operating procedure to provide information and guidance to staff about actions to take if a patient deteriorated during the journey in the ambulance. The service had some policies, but these were not available online to staff and were not on the ambulance for staff to access for guidance.

Staffing

The service did employ 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 registered manager was the only employed person, but they did not often carry out patient journeys. Instead, the service relied on bank staff to undertake patient transport journeys. The registered manager explained they were recruiting two paramedics to ensure there was enough staff to provide the patient transport service.

Staff employment files did not provide assurance that staff had the right qualifications, skills, knowledge and experience to carry out patient transport services safely.

Records

Staff did not keep detailed records of patients' care and treatment.

There was not enough information recorded about patients to ensure effective care during patient transfers was delivered.

We reviewed four patient clinical record forms for high dependency patients (requiring increased monitoring and supervision) transfers between 30 September 2018 and 25 May 2019. These forms were designed to hold more information about patients but were not completed in full. We were told the service had made three high-dependency patient transfers in March 2021, but we did not find any clinical patient records to demonstrate the care given during these transfers. Staff did not have current training and competence assessment to ensure they could undertake high-dependency patient transfers.

The service did not carry out any documentation audits to assess if records had been completed fully to demonstrate all required data was recorded.

Medicines

The service did not have effective systems and processes to ensure medicines were always prescribed and administered safely.

We inspected the ambulance and found evidence that medicinal gases had been administered. However, we could not find any records explaining why, to whom and by which staff the medicinal gas had been administered. We were told the medicinal gasses had not been administered by the only paramedic employed which meant staff who had not received any training to administer these, may have done so. Medicinal gasses can be administered by a qualified and registered healthcare practitioner such as a paramedic, without a prescription under Schedule 17 of the Human Medicines Regulation 2012. However, as the medicinal gas had not been administered by a paramedic, this had been administered without a prescription or an exemption under Schedule 17.

We reviewed a daily job sheet log dated 8 March 2021. This log showed a patient who required oxygen had been conveyed. The ambulance crew consisted of two non-registered persons. We did not find any evidence that staff had been trained to administer oxygen and this was therefore not in line with their policy: Medication Policy (March 2018). The record did not demonstrate if any monitoring was carried out during the transfer to ensure the patient's oxygen saturation levels met the parameters for this patient.

The medicines carried were not in line with the services policy. The policy included a list of medicines that should be carried on the vehicle, but this did not mirror what we found in the medicine's bag belonging to the paramedic. For example, the list stated two oral painkillers should be carried but one was not in the medicine's bag and one was only available as an intravenous infusion. The service did not carry any controlled medicines.

The list of medicines included a medicine given to patients in respiratory distress but was not included in the medicines carried by the paramedic. The medicine is not permissible to be administered by a registered healthcare professional under Schedule 17 of the Human Medicines regulation 2012. Therefore, this needed to be prescribed or given under a legal framework as a patient group direction without prescription. In addition to the listed medicines, the paramedic medicines bag also included medicines to be given in the event of a clinical emergency, but these were not listed in the policy.

The Medication Policy (2018) lacked detail including dosages of medicines which was carried by the paramedic and how and when these should be administered. The policy did not explain how and who should administer medical gasses (including oxygen and a medical gas used as a painkiller) and information to support staff giving the right dosage. It was not clear how these would be prescribed and who would be clinically responsible for the treatment provided.

There were records of checking medicines monthly (from January 2021) although this was not in line with the medication policy which stated stock checks should be undertaken weekly. We were told of secure storage of medicines when they were not in use. However, we found one bag of saline for intravenous infusion in an unlockable overhead compartment.

Incidents

There was limited use of systems to record and report safety concerns, incidents and near misses.

There was an incident book where staff could report incidents that had happened. This was a new system implemented in January 2021. Six safety concerns were recorded between February and April 2021; five concerns were raised about the ambulance and one concern was raised about ongoing issues with discharge of patients where staff were unable to use the trolley to access the patients' home/destination.

Inadequate

Emergency and urgent care

There were systems to record vehicle accidents, equipment damage/loss and theft report form and an employee incident report form, but we did not see any specific forms for staff to report clinical incidents. We were told there had been no clinical incidents in the past 12 months.

The registered manager was aware of the importance of candour and openness including offering apologies to patients if things went wrong in line with legislation. There had not been any incidents, including clinical incidents causing harm to patients where an apology was required.

However, there was no policy providing information about how to report an incident and how incidents, including clinical incidents, would be investigated to ensure learning and improvements were made if required.

Are Emergency and urgent care effective?

Inadequate

We rated the service as inadequate.

Evidence-based care and treatment

The service did not provide care and treatment based on current national guidance and evidence-based practice.

The service had some policies, but these were not always current and did not demonstrate they were based on national guidance. The policies were not always dated and did not include any information about when they should be reviewed; there was no version control to show changes made and they were not referenced to demonstrate they were based on current national guidance. We reviewed eleven policies, three of these included the date they were written but did not include any review dates.

Staff were required to sign they had read the policies when they started working for the service. Individual personnel records showed this form was not signed by all staff.

There were limited protocols available to staff to provide guidance in line with national recommendations. There was a copy of the Joint Royal Colleges Ambulance Liaison Committee: UK Ambulance Services Clinical Practice Guidelines (2013) available to staff stored in the ambulance. This was not the latest available version as the newest version was released in 2021 and updated guidance was also available in 2018 when the service was formed. This guidance is aimed to support paramedics and there were no local protocols to provide guidance for healthcare support staff.

There were no processes to check staff followed national guidance and staff did not receive any training on, for example, how to recognise a deteriorating patient.

We were told the service did not undertake any conveyance of patients detained under the Mental Health Act 1983. However, there were no formal document to define the eligibility or exclusion criteria for patients referred to the service and there were no formal booking processes to ensure staff could meet the needs of patients, including both physical and mental health needs.

Inadequate

Emergency and urgent care

The daily job sheet log showed staff had conveyed patients who were aggressive or living with dementia. However, there were no processes to ensure information about patients' capacity to consent to be conveyed was assessed and that informed consent was obtained.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey.

Bottled water was available on the ambulance. We were told if patients were transferred a long distance, staff made sure patients had food and drink as required. The service made adjustments for patients' religious, cultural and other needs as required.

Pain relief

There were processes for staff to monitor patients regularly to see if they were in pain.

The patient clinical record included assessment of patients' pain based on a scale of zero (no pain) to ten (most severe level of pain). However, we reviewed four patient records and found these were not completed consistently. Pain assessment had been completed once on three patient records but had not been repeated on any of the four records we reviewed. This meant there were limited options to administer pain relief if required. The ambulance carried a medicinal gas but there was no evidence to demonstrate all staff had been trained in how to administer this. The medication policy listed two different types of painkillers that should be carried by the paramedic; however, one of these were not included in the medicine's bag we checked on the day of inspection and the other one was only available as an intravenous infusion.

Response times:

The service did not monitor response times so they could facilitate timely patient transfers.

The responsiveness of the service was not monitored against any internal or contracted standards.

There were no booking processes to capture bookings of urgent and emergency patient transfers. The registered manager received a phone call to book the service which was accepted if the ambulance was free and there was another member of staff available to drive the ambulance. We reviewed four patient clinical records and found the time of booking had only been recorded on one form.

The service did not collect any data or records about the number of patient transfers or data about when these were booked and the response time when the crew arrived to pick up the patient. There were no agreed measures to benchmark against to determine if the response times met the needs of the patient and contractual arrangements.

Competent staff

The service did not make sure staff were competent for their roles. The registered manager did not complete all necessary employment checks to make sure staff were skilled, competent and had the right experience to meet the needs of patients transported by the service.

There was a 'New Employee Checklist and Policy', which listed checks to be completed before starting and items to include in an induction when new staff started working for the service. This list was not fully in compliance with the expected employment checks, which was in breach of the Health and Social Act 2008, Schedule 3. We reviewed personnel files for three staff employed as bank staff by the service and found there were significant gaps in pre-employment checks. For example, Schedule 3 requires employers to check for a full employment history and to ask for further information where there were gaps and to obtain two references from previous employment of which one should be the current employer. There was no full employment history in any of the three files we reviewed. We only found one reference instead of six in the three files; the reference we found referred to employment or work undertaken in 1998; this was therefore not current and in line with Schedule 3 requirements Photo identification was not available for all staff and there was not a photocopy of the driving license of all staff which meant we could not check if they had the required permissions included in their license.

The service did not keep personnel files for all staff who carried out work for them. The service also employed an accounts manager, but we did not see any personnel file for this employee. We reviewed 32 daily job sheets completed between 25 February and 1 May 2021. We found one job sheet (dated 6 March 2021) stating the names of two people who the registered manager did not know and for whom there were no personnel files.

When new staff started, there was a list of tasks to be completed on the enrolment day, which included information and training on equipment used by the service. However, records to demonstrate these had been completed were not included in all of the personnel files and meant the manager could not be assured and demonstrate staff had received the information and training required before joining colleagues to deliver patient transport services.

We did not see any evidence training for staff to provide assurance they were competent to support patients living with dementia or a learning disability. The registered manager told us staff received restraint training but there was no evidence of this, and we were told the service did not convey any patients detained under the Mental Health Act 1983.

Staff records did not provide enough information to confirm staff were skilled and competent to convey patients who were classed as patients requiring high dependency care (requiring increased monitoring and supervision). There was only one paramedic employed by the service with none of the bank staff being registered healthcare professionals. However, the paramedic's advanced life support refresher training had expired two years previously and there was no evidence that competencies had been assessed or refresher training attended to ensure they had the skills to provide enhanced care if required. The personnel files did not hold evidence that any staff were trained and competent to drive the ambulance under blue lights or at speed.

We found two daily job log sheets used for patient transport services (dated 15 April 2021), which showed a patient requiring a paramedic crew care has been conveyed by staff who were not registered healthcare professionals and without the right qualifications, skills, knowledge and experience to do so. Staff did not have skills and competencies to support and care for the patient in the event of a clinical emergency.

Multidisciplinary working.

The service worked closely with another independent ambulance service and staff from the local NHS hospital who were responsible for patient discharges.

The registered manager described good working relationships with external partners where this was required for example, if safeguarding concerns were raised.

Inadequate

Emergency and urgent care

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment.

The clinical patient record was designed so staff could indicate consent had been obtained. The four records we reviewed confirmed consent to receive care and treatment, had been obtained from patients.

Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment. Staff received a handover from NHS staff when they transferred high dependency patients (requiring increased monitoring and supervision) between hospitals. Staff used a patient clinical record to record information such as previous medical history, details of next of kin and patient consent.

There were limited processes to assess and record if patients were subject to deprivation of liberty safeguards. This information was not assessed or documented when staff were asked to convey patients. Staff did not obtain any information about patients who may have been deprived of their liberty, including information about previous medical history that my affect their ability to make informed decisions about consent. This meant staff could unknowingly be conveying people under an authorisation to deprive them of their liberty and without assurance of the legality of the applications.

There was a Mental Capacity Act (MCA) Policy which provided an explanation of what the MCA is, and the two-stage test used to assess people's mental capacity. The policy did not provide any guidance for staff about what they should do if they had concerns about a patient's capacity to make decisions for themselves.

There was no evidence staff received or had completed any training on how to obtain consent, Mental Capacity Act or Deprivation of Liberty Safeguards protocols.

Are Emergency and urgent care responsive?

Requires Improvement

We rated the service as requires improvement

Service delivery to meet the needs of local people

The service worked with system partners to meet the needs of local people.

There were no formal contractual arrangements to provide high dependency/critical patient transfers. We were told the hospital would phone the registered manager directly who would then mobilise staff to provide the patient transfer service but would generally be booked in advanced for the following day.

Wherever possible, the service was flexible and worked to meet the needs of patients. Feedback from external stakeholders confirmed staff were flexible. However, the vehicle specification limited the ability to convey people requiring bariatric equipment (specialist equipment for people with a high body weight exceeding weight limitations of standard equipment). The ambulance was not designed to provide safe transport of patients suffering a mental health crisis.

Inadequate

Emergency and urgent care

Meeting people's individual needs

There were limited processes to assess and take account of patients' individual needs and preferences.

We were told staff treated all patients as individuals and made adjustments where possible. There was an 'Equality and Diversity Policy which aimed to provide information for staff about how to recognise the diversity, values and human rights of people who used the service.

Staff received a verbal handover from other healthcare professionals, including information about patient's individual needs. However, there was no records to demonstrate this information was always received or asked for and therefore, the service could not be assured they always met individual patients' needs.

Staff did not receive training in how to meet the needs of patients living with dementia, autism or a learning disability. The provider could therefore not be assured staff would recognise complex individual needs and make reasonable adjustments to meet their needs.

There was no recorded evidence of assessment of patients' communication needs. The daily job sheet log did not include an opportunity for this to be assessed, recorded and shared to meet the needs of patients. This was a breach of the Accessible Information Standards 2016. There was no written information available for patients who may be deaf or for whom English was not their first language and we were told staff had trouble accessing online interpretation services.

Access and flow

There was no evidence to show people could access the service or that they received the right care when the needed it.

It was unclear if patient journeys booked as high-dependency (requiring increased monitoring and supervision) or time critical were responded to in a timely way. There were no written contractual standards to provide key performance indicators around response times. There was limited evidence to provide data which demonstrate response time from when the transfer booking was received to when the crew presented to pick up the patient. We reviewed four patient clinical records for patient transfer carried out in 2018/19; the time of booking was only recorded on one form and showed the response time as one hour from the time the transfer was booked to the time the crew arrived at the hospital.

There were no audits or monitoring of response times, journey times or data to demonstrate the number of transfers undertaken. The daily job sheet logs were not used to monitor, or audit performance and no evidence of actions taken when there were gaps in the information staff had recorded.

Learning from complaints and concerns

There were processes for people to give feedback and raise concerns about care they received.

Staff shared feedback forms with patients to offer an opportunity to provide comments or raise concerns. We looked at seven feedback forms from patients which all provided positive feedback about the service. The form asked seven key

Inadequate

Emergency and urgent care

questions including staff treating patients in a courteous and professional way, comfort, dignity and privacy, cleanliness, information shared, timeliness of the ambulance arriving and if patients would recommend the service to friends and family. The form also offered an opportunity for patients to offer any comments; one comment included a patient who had felt cold in the ambulance. The heater was faulty and had been replaced.

The service had a website which provided an opportunity for patients to offer feedback. However, the website had been taken down at the time of our inspection, because it needed to be updated.

We were told there had been no complaints made about care and treatment in the last 12 months.

Are Emergency and urgent care well-led?

Inadequate

We rated the service as inadequate .

Leadership

The registered manager did not have the skills, knowledge and experience needed to run the service safely and effectively. They did not have oversight of what was happening on the front line of the service. However, they understood some of the priorities and issues the service faced. They were visible and approachable in the service for staff.

The registered manager demonstrated compassion for patients, staff and the service. However, they showed limited awareness of their accountability in law for the service they provided. There were no written contractual agreements to clearly set out key performance metrics or accountability and there were no written policies and procedures to safeguard the ongoing business continuity in the absence of the registered manager. There was a contingency plan, but this did not include the absence of the registered manager and arrangements for completing and submitting statutory notification to the Care Quality Commission (CQC).

The registered manager did not demonstrate an understanding of healthcare governance and there were significant gaps in the collection of data and overview of the service and performance.

However, the registered manager demonstrated some understanding of challenges to the sustainability of the service. They discussed the need to explore the costs around acquiring a newer ambulance as with age the present ambulance could be less reliable and costly to maintain. They also discussed recruitment of staff and ensuring there was enough staff available to maintain safe patient transfers.

Vision and strategy

The service did not have a statement of vision for what it wanted to achieve or a strategy to turn it into action, developed with all relevant stakeholders.

Inadequate

Emergency and urgent care

The COVID-19 pandemic had influenced the business model as they did no longer regularly facilitate hospital to hospital transfers of high-dependency (requiring increased monitoring and supervision) and critically ill patients. Instead, they provided predominantly patient transport services. There had been significant changes to the structure of the company since the beginning of 2021. This meant the registered manager was the sole owner and director of the company.

The registered manager was unsure of how the company would develop over the next months. There was a verbal agreement to provide patient transport services until July 2021, but it was not known at the time of the inspection, if they would continue to provide patient transport services or return to hospital to hospital transfers for critically ill patients. However, the registered manager stated they were looking to purchase a newer ambulance and recruit more staff in the months that followed.

There was a disciplinary and grievance procedure to support effective leadership and people management in the delivery of safe patient transport services. The policy included examples of misconduct and disciplinary actions and the rights of employees to appeal.

However, the service had identified values which had been available on their website. The website was not available on the date of inspection as it had been taken down to be updated.

Culture

Without a permanent team of staff, there were limited opportunities for the registered manager to influence the culture of the service. The registered manager described the importance of staff welfare, to support staff undertaking ambulance journeys and during challenging times such as through the COVID-19 pandemic.

We were told the registered manager was available to staff at all times to provide guidance and support. They were also present in the discharge hub at the local NHS hospital four days a week to provide guidance and check on staff well-being. This included buying them a coffee and to discuss and provide debriefs for staff.

There was no provision for training or staff development opportunities. There were no processes to carry out regular appraisals to support staff development. However, there was a Supervision Policy which stated all employees would receive formal supervision with a designated supervisor at least six monthly. There was no documentation to demonstrate any supervision had been carried out, or plans for supervision had been discussed, agreed and planned with any staff who worked for the service.

The service had a Whistle Blower policy and a Workforce and Bullying Policy. The policies included information about how to raise concerns internally or externally to the Care Quality Commission and stated staff disclosing information in good faith should not suffer any personal detriment as a result of raising concerns about misconduct or malpractice.

Governance

There were no governance systems to provide evidence, oversight and assurance in clinical governance, including clinical effectiveness and audits, risk management, education and training, staffing and management of information and personal data.

The registered manager did not operate effective governance processes, throughout the service or with partner organisations. They were unclear about their accountabilities and of opportunities to meet, discuss and learn from the performance of the service.

Inadequate

Emergency and urgent care

There were no processes to assess, monitor or evaluate the quality and safety of the service provided, and limited processes to make improvements. We were not assured the registered manager had an overview of how the service performed and where specific improvements were required. The registered manager stated there were aspects to the service that needed to be improved but was unsure about which changes were required.

Management of risk, issues and performance

The service did not use systems to manage risks and performance effectively. However, they had plans to cope with some unexpected events.

There was no evidence of how risks were assessed and managed. There were no risk assessments, risk register or any other similar document to identify risks to the service. This meant there was no systems or processes to formally document risks or risk management plans associated with the service.

There were significant failures in performance management and audit systems and processes. The service did not collect reliable date to inform service delivery or where improvements were required. There were no audits undertaken. For example, the service did not audit compliance with infection prevention and control measures, including cleaning of the ambulance, documentation audits or collect data to evaluate performance metrics to support the safe delivery of patient transport services.

There was a contingency plan which included some unforeseen events or risks to the service. The plan included vehicle breakdown, equipment failure and theft. The plan provided some information about actions required but lacked details to make the plan efficient and easy to follow. For example, the plan stated that in the event of equipment failure, the provider had a service contract with a third party who could provide equipment if required but important contact details were not included, and we did not see the service contract.

Information management

The service did not collect reliable data and not all information systems were secure.

The registered manager did not collect data to inform their understanding of how the service was performing. There was no challenge of performance by staff or the registered manager as no valid and reliable data was collected for scrutiny. For example, there was a daily job log sheet, which was designed to provide information about journey times, cleaning of the ambulance between patients and issues (of note). We reviewed 80 and found these were not fully completed in 23 of 57 entries and with little consistency of the information obtained. We were told these were reviewed approximately once a week but there were no records of data being collected. There was no evidence of any actions taken when information was not recorded as intended by the design of the form. Data about the number of patient journeys were not collated and the registered manager could not tell us how many patients had been conveyed in the last week, month or over the last 12 months.

Information was not always managed in line with the General Data Protection Regulations (GDPR) tailored by the Data Protection Act 2018. The service had a Data Protection Policy and a Confidentiality Policy. The registered manager discussed the contents but on review we found they did not include up to date information specifically about how to share confidential information about patients securely. However, staff did not always act in accordance with legislation. We were told staff had used their personal mobile phones to email confidential patient information, when they reported patient safety concerns. The registered manager was not aware this was not allowed under the GDPR.

There were no electronic platforms where staff could access policies or information to support them in carrying out safe patient transport services. Paper copies were also not available on the ambulance on the day of our inspection.

We were told confidential information about staff and patients were stored securely in locked filing cabinets and not kept for longer than they should be in line with legislation.

Processes to ensure external bodies, including the Care Quality Commission, were notified as required were not effective. The registered manager had had a period of absence from the service in October/ November 2019, but the CQC was not informed of this which was in breach of Section 33 of the Health and Social Care Act 2008.

Engagement

Leaders and staff actively and openly engaged with patients, staff, local partner organisations and the local clinical commissioning group. However, systems to obtain constructive feedback to develop and improve services, were ineffective.

The registered manager described how they worked with another independent ambulance service and the local NHS hospital and stated they had built good working relationships with them. The registered manager was available to support staff in their work which was delegated to them by the independent ambulance service when they could not undertake the journey themselves.

Staff encouraged patients to provide feedback by completing a patient feedback form or online using the service's webpage but only received few completed forms by return. There were no formal processes for staff to provide informal feedback about how the service could be improved. Although the registered manager was visible and often met with staff, there were no planned staff meetings where performance was discussed and opportunities and ideas for service improvement actions could be discussed.

The service engaged with the external stakeholders. The registered manager explained there was regular contact with people they worked closely with to deliver efficient patient transport services. The service was commissioned to convey patient transport services five days a week from the local NHS hospital. This was a verbal agreement with local healthcare providers, which was effective until end of June 2021.

Following the inspection, we spoke with one patient and one relative of a patient who had been conveyed by the service. Both provided positive feedback about the kindness of staff and both would recommend the service to others. We reviewed seven patient feedback forms which all contained positive feedback about the service.

We obtained feedback from the clinical commissioning group and from the local NHS hospital. The feedback confirmed the service was able to transfer medically stable patients such as patients being discharged or transfer to 'same level' or step-down facilities. The service did not meet expectations considered to be essential to provide safe patient transfers of critically ill patients or patients requiring enhanced monitoring. There was not always a paramedic crew available who had advanced life support skills and equipment such as essential advanced monitoring equipment and response equipment in line with NHS emergency ambulance responses.

Learning, continuous improvement and innovation

There was limited focus and commitment to innovation.

Inadequate

Emergency and urgent care

At the time of our inspection, the registered manager was focussing on delivering patient transport services to meet the verbal agreement. The registered manager was focussing on re-building the service following the impact of the pandemic and significant changes to the organisational structure. The registered manager had ideas and ambitions but no clear strategy of how to achieve these. There was no formalised direction of how the service would operate and develop in the near future or over a longer period of time.

The registered manager identified work was required to establish systems and processes to improve governance and safety. They were looking to the results and report from this inspection to provide some guidance about the improvement that was required.

Inadequate

Patient transport services

Safe	Inadequate
Effective	Inadequate
Responsive	Requires Improvement
Well-led	Inadequate

Are Patient transport services safe?

Inadequate

We rated the service as inadequate.

Mandatory training

Staff did not receive effective training in safety systems, processes and practices.

The service did not have an overview of training staff had completed. There was no policy setting out what training was considered as mandatory training which all staff should complete and receive regular/annual refresher training. We reviewed four staff files and only one of these held copies of current training in basic life support. There was no evidence of any other current training completed by staff, including basic life support, infection prevention and control, health and safety, manual handling and conflict resolution. We could not be assured staff had the required knowledge and skills to keep patients safe.

Safeguarding

There was insufficient focus on ensuring staff received safeguarding training.

Not all staff had received safeguarding training for adults as outlined in their safeguarding policy or in line with national guidance: Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff (2018). The registered manager told us they had completed safeguarding training for adults at level 1 but we did not see any certificates stating when this was completed. The safeguarding policy did not include any information to describe what training staff were required to attain although it stated all staff would receive adult safeguarding awareness training. No staff member had completed any child protection training. However, there was a safeguarding policy which staff had signed to say they had read. The policy stated staff should inform the registered manager of any concerns to be escalated to the local hospital or the local authority. The policy included information about the signs and symptoms which may indicate safeguarding concerns and telephone numbers of who to inform. This policy was not available to staff on the ambulance when they were conveying patients and may be in need of the information included in the policy.

However, there were systems to report concerns relating to safeguarding. There was a form for staff to use to document their concerns and actions taken but the form did not include information of key contacts to support staff to raise concerns. The registered manager was aware of signs of different kind of abuse and how to escalate concerns. We heard of an example of when staff had escalated a concern regarding a failed discharge as the crew did not consider it safe to leave the patient at the destination/home address without adequate support.

There was insufficient assurance the service had carried out the right level of disclosure and barring service (DBS) checks. Two staff records showed only a basic check had been carried out rather than an enhanced check in line with UK eligibility as listed in the Police Act 1997. The storage of DBS documents concerning individuals was not in line with the General Data Protection Regulations (GDPR) Data Protection Act 2018 as detailed personal information was stored in personal files when only the overall outcome of the DBS check was required.

Cleanliness, infection control and hygiene

The service did not always control infection risks well. Standards of cleanliness were not maintained.

The ambulance and equipment were visibly dirty. This included the driver's door pocket, the footwells, the clinical equipment, the patient chair and the carry chair. There was a residue on the giving set for a medical gas which showed it had not been cleaned after use. The carry chair was unclean, and its wheels were rusted and dirty. The portable suction unit and oxygen tubing packet were both dirty and damaged. We observed used and dirty PPE in the cabin of the ambulance. There was no evidence to show staff had been tested to safely use filtering facepiece (FFP3) masks although the service had transported patients with COVID-19 to another hospital. Records also showed that on 29 March 2021, two patients who lived in the same post code had been conveyed together to save time.

Deep cleaning protocols were ineffective. There was a record which showed the ambulance had been deep cleaned once a week since January 2021. This showed the ambulance had been deep cleaned the day before our inspection. We were not assured the correct cleaning solutions were used as the registered manager was unaware there were different solutions and strength of solutions and cleaning sprays and wipes. We saw that one cleaning product, kept in an overhead compartment with other supplies had leaked and contaminated everything within. We did not find any Control of Substances Hazardous to Health (COSHH) risk assessments to show how products should be safely stored or managed in line with their COSHH policy. This policy and any risk assessments were stored in the office and was not readily available to staff on the ambulance.

We reviewed 80 entries made on the daily job sheet log between 5 April and 29 April 2021. Records showed the ambulance had been cleaned following 57 journeys. This meant for the remaining 23 journeys there was no evidence to show cleaning had been undertaken between patient journeys. In addition, records showed lack of cleaning/deep cleaning on 9 March 2021, when a patient, who was COVID positive, had been conveyed to a community hospital. There was no evidence recorded the ambulance had been cleaned/deep cleaned before picking up another patient from the same community hospital.

There were no audits to assess compliance with infection prevention and control measures. There was no evidence to show actions were taken when the daily job sheet lacked confirmation of cleaning of the ambulance and equipment between patient journeys. However, staff had access to enough personal protective equipment of good quality, which was provided by the local hospital. Staff had access to hand gel on the ambulance and to hand washing facilities when they were at the hospital, although the ambulance's hand gel dispenser was empty when we inspected. There was a verbal agreement to obtain clean linen and dispose of dirty linen and clinical waste at the local hospital.

The service had an Infection Prevention and Control Procedures Policy (2018) and a COVID-19 amended infection control policy. The amended COVID-19 infection control policy held information suggesting the policy had been written in April 2020. There was no evidence to show the policy had been reviewed and updated in line with developments and national guidance. For example, the policy did not include any reference to 'fit testing' for use of FFP3 masks or about COVID testing for staff.

However, we were told staff undertook twice weekly lateral flow tests (COVID-19) although the results were not collated and stored by the service.

Environment and equipment

The maintenance and use of equipment did not keep people safe. Ambulance safety was compromised, and we were not assured monitoring of the safety of the ambulance and the equipment was effective.

There was a daily vehicle checklist which was completed by the crew. We reviewed 18 vehicle checklists. There were no concerns highlighted on any checklists that we reviewed. However, we found some things had been ticked as being available which were not available on the day, we inspected the ambulance. For example, policies and procedures should have been available to staff but there was no folder containing these on the ambulance.

The seatbelts on the patient seat and the seat to the rear of the stretcher were partially broken and exposed wires were visible and posed a risk to safety. The lap belt on the carry chair was torn and could fail in use. The rear passenger seat had a rip, which meant it could not be properly cleaned. A plastic glide board (a manual handling aid) was worn, with a sharp edge that could damage a patient's skin. The hydraulic lift on the vehicle was broken and the step which was used to enter the ambulance was unstable and corroded. The rear light of the ambulance was broken and had sharp exposed edges.

Staff reported faulty equipment in an incident book, which was introduced in January 2021, and demonstrated actions taken to rectify the issues raised. For example, on 5 February 2021 there was an entry logging the back door being accidentally caught in the wind which cause the glass to be broken. The accident book stated the glass had been replaced but that there was an issue with the design, which had not yet been resolved and there was a risk it could happen again.

However, the ambulance had a current MOT certificate and correct insurance cover.

Assessing and responding to patient risk

There were limited risk assessments carried out for people who were conveyed by the service. Staff did not receive training on how to recognise if patients deteriorated during the ambulance journey.

The documentation used for patients being transported by the service, included limited information about patients' health, risks or specific care instructions. The daily job sheet log included information about where patients were transferred from and their destination, their name and their COVID-19 status but this information was not always documented.

Staff did not always have the information they needed to deliver effective care and support. There were no effective systems and processes to ensure information about specific care instructions, including decisions about resuscitation, was obtained and documented.

Staff did not receive training on how to recognise if patients deteriorated during the ambulance journey. There was no policy, protocol or standard operating procedure to provide information and guidance to staff about actions to take if a patient deteriorated during the journey in the ambulance. The service had some policies, but these were not available online to staff and were not on the ambulance for staff to access for guidance.

Staffing

The service did employ 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 registered manager was the only employed person, but they did not often carry out patient journeys. Instead, the service relied on bank staff to undertake patient transport journeys. The registered manager explained they were recruiting two further members of staff to ensure there was enough staff to provide the patient transport service.

Staff employment files did not provide assurance that staff had the right qualifications, skills, knowledge and experience to carry out patient transport services safely.

Records

Staff did not keep detailed records of patients' care and treatment.

There was not enough information recorded about patients to ensure effective care during patient transfers was delivered. Staff used the daily job sheet log as a recording tool bit the log did not hold enough information about patients to ensure their needs were met. Information about risks such as mobility risk assessments, the end destination (keys, food, care package arrangements) or how to ensure effective communication was not contained in the form.

The forms were not always fully completed and did not have the limited information they were designed for. The form was designed to demonstrate the time patients were picked up and dropped off, which was not always completed. For example, on 8 March 2021, the daily job sheet log showed five patient transport journeys were undertaken; the pick-up time was documented for the first two journeys but this was not documented for the remaining three journeys and no drop off time was recorded for any of the journeys.

The service did not carry out any documentation audits to assess if records had been completed fully to demonstrate all required data was recorded.

Medicines

The service did not have effective systems and processes to ensure medicines were always prescribed and administered safely.

We inspected the ambulance and found evidence that medicinal gases had been administered. However, we could not find any records explaining why, to whom and by which staff the medicinal gas had been administered. We were told the medicinal gasses had not been administered by the only paramedic employed which meant staff who had not received any training to administer these, may have done so. Medicinal gasses can be administered by a qualified and registered healthcare practitioner such as a paramedic, without a prescription under Schedule 17 of the Human Medicines Regulation 2012. However, as the medicinal gas had not been administered by a paramedic, this had been administered without a prescription or an exemption under Schedule 17.

We reviewed a daily job sheet log dated 8 March 2021. This log showed a patient who required oxygen had been conveyed. The ambulance crew consisted of two non-registered persons. We did not find any evidence that staff had been trained to administer oxygen and this was therefore not in line with their policy: Medication Policy (March 2018). The record did not demonstrate if any monitoring was carried out during the transfer to ensure the patient's oxygen saturation levels met the parameters for this patient.

The medicines carried were not in line with the services policy. The policy included a list of medicines that should be carried on the vehicle, but this did not mirror what we found in the medicine bag belonging to the paramedic. For example, the list stated two oral painkillers should be carried but one was not in the medicine bag and one was only available as an intravenous infusion. The service did not carry any controlled medicines.

The list of medicines included a medicine given to patients in respiratory distress but was not included in the medicines carried by the paramedic. The medicine is not permissible to be administered by a registered healthcare professional under Schedule 17 of the Human Medicines regulation 2012. Therefore, this needed to be prescribed or given under a legal framework as a patient group direction without prescription. In addition to the listed medicines, the paramedic medicines bag also included medicines to be given in the event of a clinical emergency, but these were not listed in the policy.

The Medication Policy (2018) lacked detail including dosages of medicines which were carried by the paramedic and how and when these should be administered. The policy did not explain how and who should administer medical gasses (including oxygen and a medical gas used as a painkiller) and information to support staff giving the right dosage. It was not clear how these would be prescribed and who would be clinically responsible for the treatment provided.

There were records of checking medicines monthly (from January 2021) although this was not in line with the medication policy which stated stock checks should be undertaken weekly. We were told of secure storage of medicines when they were not in use. However, we found one bag of saline for intravenous infusion in an unlockable overhead compartment.

Incidents

There was limited use of systems to record and report safety concerns, incidents and near misses.

There was an incident book where staff could report incidents that had happened. This was a new system implemented in January 2021. Six safety concerns were recorded between February and April 2021; five concerns were raised about the ambulance and one concern was raised about ongoing issues with discharge of patients where staff were unable to use the trolley to access the patients' home/destination.

There were systems to record vehicle accidents, equipment damage/loss and theft report form and an employee incident report form, but we did not see any specific forms for staff to report clinical incidents. We were told there had been no clinical incidents in the past 12 months.

The registered manager was aware of the importance of candour and openness including offering apologies to patients if things went wrong in line with legislation. There had not been any incidents, including clinical incidents causing harm to patients where an apology was required.

Inadequate

Patient transport services

However, there was no policy providing information about how to report an incident and how incidents, including clinical incidents, would be investigated to ensure learning and improvements were made if required.

Are Patient transport services effective?

Inadequate

We rated the service as inadequate.

Evidence-based care and treatment

The service did not provide care and treatment based on current national guidance and evidence-based practice.

The service had some policies, but these were not always current and did not demonstrate they were based on national guidance. The policies were not always dated and did not include any information about when they should be reviewed; there was no version control to show changes made and they were not referenced to demonstrate they were based on current national guidance. We reviewed eleven policies, three of these included the date they were written but did not include any review dates.

Staff were required to sign they had read the policies when they started working for the service. Individual personnel records showed this form was not signed by all staff.

There were limited protocols available to staff to provide guidance in line with national recommendations. There was a copy of the Joint Royal Colleges Ambulance Liaison Committee: UK Ambulance Services Clinical Practice Guidelines (2013) available to staff stored in the ambulance. This was not the latest available version as the newest version was released in 2021 and updated guidance was also available in 2018 when the service was formed. This guidance is aimed to support paramedics and there were no local protocols to provide guidance for healthcare support staff.

There were no processes to check staff followed national guidance and staff did not receive any training on, for example, how to recognise a deteriorating patient.

We were told the service did not undertake any conveyance of patients detained under the Mental Health Act 1983. However, there were no formal document to define the eligibility or exclusion criteria for patients referred to the service and there were no formal booking processes to ensure staff could meet the needs of patients, including both physical and mental health needs.

The daily job sheet log showed staff had conveyed patients who were aggressive or living with dementia. However, there were no processes to ensure information about patients' capacity to consent to be conveyed was assessed and that informed consent was obtained.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey.

Bottled water was available on the ambulance. We were told if patients were transferred a long distance, staff made sure patients had food and drink as required. The service made adjustments for patients' religious, cultural and other needs as required.

Response times

The service did not monitor response times so they could facilitate timely patient transfers.

The responsiveness of the service was not monitored against any internal or contracted standards.

The service did not collect any data or records about the number of patient journeys they had undertaken. Staff did not always record 'pick-up and drop-off' times on the daily job sheets. The service did not take bookings but had a verbal agreement to be available at the local hospital between 10am and 6pm to convey patients who were discharged. There was another local independent patient transport service who allocated patient journeys when they did not have capacity to convey in a timely manner.

Competent staff

The service did not make sure staff were competent for their roles. The registered manager did not complete all necessary employment checks to make sure staff were skilled, competent and had the right experience to meet the needs of patients transported by the service.

There was a 'New Employee Checklist and Policy', which listed checks to be completed before starting and items to include in an induction when new staff started working for the service. This list was not fully in compliance with the expected employment checks, which was in breach of the Health and Social Act 2008, Schedule 3. We reviewed personnel files for three staff employed as bank staff by the service and found there were significant gaps in pre-employment checks. For example, Schedule 3 requires employers to check for a full employment history and to ask for further information where there were gaps and to obtain two references from previous employment of which one should be the current employer. There was no full employment history in any of the three files we reviewed. We only found one reference instead of six in the three files; the reference we found referred to employment or work undertaken in 1998; this was therefore not current and in line with Schedule 3 requirements. Photo identification was not available for all staff and there was not a photocopy of the driving license of all staff which meant we could not check if they had the required permissions included in their license.

The service did not keep personnel files for all staff who carried out work for them. The service also employed an accounts manager, but we did not see any personnel file for this employee. We reviewed 32 daily job sheets completed between 25 February and 1 May 2021. We found one job sheet (dated 6 March 2021) stating the names of two people who the registered manager did not know and for whom there were no personnel files.

When new staff started, there was a list of tasks to be completed on the enrolment day, which included information and training on equipment used by the service. However, records to demonstrate these had been completed were not included in all of the personnel files and meant the manager could not be assured and demonstrate staff had received the information and training required before joining colleagues to deliver patient transport services.

We did not see any evidence training for staff to provide assurance they were competent to support patients living with dementia or a learning disability. The registered manager told us staff received restraint training but there was no evidence of this, and we were told the service did not convey any patients detained under the Mental Health Act 1983.

Inadequate

Patient transport services

We found two daily job log sheets used for patient transport services (dated 15 April 2021), which showed a patient requiring a paramedic crew care had been conveyed by staff who were not registered healthcare professionals and without the right qualifications, skills, knowledge and experience to do so. Staff did not have skills and competencies to support and care for the patient in the event of a clinical emergency.

Multidisciplinary working.

The service worked closely with another independent ambulance service and staff from the local NHS hospital who were responsible for patient discharges.

The registered manager described good working relationships with external partners where this was required for example, if safeguarding concerns were raised.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment.

We were told staff obtained verbal consent from patients using patient transport services, but this was not recorded. There was a consent policy regarding how to obtain and record patients consent to receiving care from the service. However, the policy did not include any information about how to record consent or how compliance would be assessed.

There were limited processes to assess and record if patients were subject to deprivation of liberty safeguards. This information was not assessed or documented when staff were asked to convey patients. Staff did not obtain any information about patients who may have been deprived of their liberty, including information about previous medical history that my affect their ability to make informed decisions about consent. This meant staff could unknowingly be conveying people under an authorisation to deprive them of their liberty and without assurance of the legality of the applications.

There was a Mental Capacity Act (MCA) Policy which provided an explanation of what the MCA is, and the two-stage test used to assess people's mental capacity. The policy did not provide any guidance for staff about what they should do if they had concerns about a patient's capacity to make decisions for themselves.

There was no evidence staff received or had completed any training on how to obtain consent, Mental Capacity Act or Deprivation of Liberty Safeguards protocols.

Are Patient transport services responsive?

Requires Improvement

We rated the service as requires improvement

Service delivery to meet the needs of local people

The service worked with system partners to meet the needs of local people.

Inadequate

Patient transport services

The service was commissioned by local short-term contracting arrangements with local healthcare providers to provide patient transport services for people who required transport when they were discharged. The main contract was with another independent patient transport provider, but the service worked with this provider and the local hospital to supplement capacity to provide patient transport services in a timely manner.

There were no formal contractual arrangements but a verbal agreement which required the service to provide an ambulance and two members of staff each day between 10am and 6pm to convey patients as required.

Wherever possible, the service was flexible and worked to meet the needs of patients. Feedback from external stakeholders confirmed staff were flexible. However, the vehicle specification limited the ability to convey people requiring bariatric equipment (specialist equipment for people with a high body weight exceeding weight limitations of standard equipment). The ambulance was not designed to provide safe transport of patients suffering a mental health crisis.

Meeting people's individual needs

There were limited processes to assess and take account of patients' individual needs and preferences.

We were told staff treated all patients as individuals and made adjustments where possible. There was an 'Equality and Diversity Policy which aimed to provide information for staff about how to recognise the diversity, values and human rights of people who used the service.

Staff received a verbal handover from other healthcare professionals, including information about patient's individual needs. However, there was no records to demonstrate this information was always received or asked for and therefore, the service could not be assured they always met individual patients' needs.

Staff did not receive training in how to meet the needs of patients living with dementia, autism or a learning disability. The provider could therefore not be assured staff would recognise complex individual needs and make reasonable adjustments to meet their needs.

There was no recorded evidence of assessment of patients' communication needs. The daily job sheet log did not include an opportunity for this to be assessed, recorded and shared to meet the needs of patients. This was a breach of the Accessible Information Standards 2016. There was no written information available for patients who may be deaf or for whom English was not their first language and we were told staff had trouble accessing online interpretation services.

Access and flow

There was no evidence to show people could access the service when they needed it

There were no formal booking arrangements to ensure the ambulance and staff could meet the needs of the patient. Patient transport journeys were allocated to staff onsite and this was recorded on the daily job sheet log. The record of the daily job sheet log was shared with the accountant who invoiced the local healthcare providers. Payment was based on hours the provider was available to provide patient transport services rather than on the number of journeys undertaken. It was not clear what happened to the daily record once the invoice had been issued and this could impact on the ability to investigate any concerns or incidents raised about patient safety, or any other concerns.

Inadequate

Patient transport services

There were no audits or monitoring of response times, journey times or data to demonstrate the number of transfers undertaken. The daily job sheet logs were not used to monitor, or audit performance and no evidence of actions taken when there were gaps in the information staff had recorded.

Learning from complaints and concerns

There were processes for people to give feedback and raise concerns about care they received.

Staff shared feedback forms with patients to offer an opportunity to provide comments or raise concerns. We looked at seven feedback forms from patients which all provided positive feedback about the service. The form asked seven key questions including staff treating patients in a courteous and professional way, comfort, dignity and privacy, cleanliness, information shared, timeliness of the ambulance arriving and if patients would recommend the service to friends and family. The form also offered an opportunity for patients to offer any comments; one comment included a patient who had felt cold in the ambulance. The heater was faulty and had been replaced.

The service had a website which provided an opportunity for patients to offer feedback. However, the website had been taken down at the time of our inspection, because it needed to be updated.

We were told there had been no complaints made about care and treatment in the last 12 months.

Are Patient transport services well-led?

Inadequate

We rated the service as inadequate .

Leadership

The registered manager did not have the skills, knowledge and experience needed to run the service safely and effectively. They did not have oversight of what was happening on the front line of the service. However, they understood some of the priorities and issues the service faced. They were visible and approachable in the service for staff.

The registered manager demonstrated compassion for patients, staff and the service. However, they showed limited awareness of their accountability in law for the service they provided. There were no written contractual agreements to clearly set out key performance metrics or accountability and there were no written policies and procedures to safeguard the ongoing business continuity in the absence of the registered manager. There was a contingency plan, but this did not include the absence of the registered manager and arrangements for completing and submitting statutory notification to the Care Quality Commission (CQC).

The registered manager did not demonstrate an understanding of healthcare governance and there were significant gaps in the collection of data and overview of the service and performance.

However, the registered manager demonstrated some understanding of challenges to the sustainability of the service. They discussed the need to explore the costs around acquiring a newer ambulance as with age the present ambulance could be less reliable and costly to maintain. They also discussed recruitment of staff and ensuring there was enough staff available to maintain safe patient transfers.

Vision and strategy

The service did not have a statement of vision for what it wanted to achieve or a strategy to turn it into action, developed with all relevant stakeholders.

The COVID-19 pandemic had influenced the business model as they did no longer regularly facilitate hospital to hospital transfers of high-dependency (requiring increased monitoring and supervision) and critically ill patients. Instead, they provided predominantly patient transport services. There had been significant changes to the structure of the company since the beginning of 2021. This meant the registered manager was the sole owner and director of the company.

The registered manager was unsure of how the company would develop over the next months. There was a verbal agreement to provide patient transport services until July 2021, but it was not known at the time of the inspection, if they would continue to provide patient transport services or return to hospital to hospital transfers for critically ill patients. However, the registered manager stated they were looking to purchase a newer ambulance and recruit more staff in the months that followed.

There was a disciplinary and grievance procedure to support effective leadership and people management in the delivery of safe patient transport services. The policy included examples of misconduct and disciplinary actions and the rights of employees to appeal.

However, the service had identified values which had been available on their website. The website was not available on the date of inspection as it had been taken to be updated

Culture

Without a permanent team of staff, there were limited opportunities for the registered manager to influence the culture of the service. The registered manager described the importance of staff welfare, to support staff undertaking ambulance journeys and during challenging times such as through the COVID-19 pandemic.

We were told the registered manager was available to staff at all times to provide guidance and support. They were also present in the discharge hub at the local NHS hospital four days a week to provide guidance and check on staff well-being. This included buying them a coffee and to discuss and provide debriefs for staff.

There was no provision for training or staff development opportunities. There were no processes to carry out regular appraisals to support staff development. However, there was a Supervision Policy which stated all employees would receive formal supervision with a designated supervisor at least every six months. There was no documentation to demonstrate any supervision had been carried out, or plans for supervision had been discussed, agreed and planned with any staff who worked for the service.

The service had a Whistle Blower policy and a Workforce and Bullying Policy. The policies included information about how to raise concerns internally or externally to the Care Quality Commission and stated staff disclosing information in good faith should not suffer any personal detriment as a result of raising concerns about misconduct or malpractice.

Inadequate

Patient transport services

Governance

There were no governance systems to provide evidence, oversight and assurance in clinical governance, including clinical effectiveness and audits, risk management, education and training, staffing and management of information and personal data.

The registered manager did not operate effective governance processes, throughout the service or with partner organisations. They were unclear about their accountabilities and of opportunities to meet, discuss and learn from the performance of the service.

There were no processes to assess, monitor or evaluate the quality and safety of the service provided, and limited processes to make improvements. We were not assured the registered manager had an overview of how the service performed and where specific improvements were required. The registered manager stated there were aspects to the service that needed to be improved but was unsure about which changes were required.

Management of risk, issues and performance

The service did not use systems to manage risks and performance effectively. However, they had plans to cope with some unexpected events.

There was no evidence of how risks were assessed and managed. There were no risk assessments, risk register or any other similar document to identify risks to the service. This meant there was no systems or processes to formally document risks or risk management plans associated with the service.

There were significant failures in performance management and audit systems and processes. The service did not collect reliable date to inform service delivery or where improvements were required. There were no audits undertaken. For example, the service did not audit compliance with infection prevention and control measures, including cleaning of the ambulance, documentation audits or collect data to evaluate performance metrics to support the safe delivery of patient transport services.

There was a contingency plan which included some unforeseen events or risks to the service. The plan included vehicle breakdown, equipment failure and theft. The plan provided some information about actions required but lacked details to make the plan efficient and easy to follow. For example, the plan stated that in the event of equipment failure, the provider had a service contract with a third party who could provide equipment if required but important contact details were not included, and we did not see the service contract.

Information management

The service did not collect reliable data and not all information systems were secure.

The registered manager did not collect data to inform their understanding of how the service was performing. There was no challenge of performance by staff or the registered manager as no valid and reliable data was collected for scrutiny. For example, there was a daily job log sheet, which was designed to provide information about journey times, cleaning of the ambulance between patients and issues (of note). We reviewed 80 and found these were not fully completed in 23 of 57 entries and with little consistency of the information obtained. We were told these were reviewed approximately

once a week but there were no records of data being collected. There was no evidence of any actions taken when information was not recorded as intended by the design of the form. Data about the number of patient transport journeys were not collated and the registered manager could not tell us how many patients had been conveyed in the last week, month or over the last 12 months.

Information was not always managed in line with the General Data Protection Regulations (GDPR) tailored by the Data Protection Act 2018. The service had a Data Protection Policy and a Confidentiality Policy. The registered manager discussed the contents but on review we found they did not include up to date information specifically about how to share confidential information about patients securely. However, staff did not always act in accordance with legislation. We were told staff had used their personal mobile phones to email confidential patient information, when they reported patient safety concerns. The registered manager was not aware this was not allowed under the GDPR.

There were no electronic platforms where staff could access policies or information to support them in carrying out safe patient transport services. Paper copies were also not available on the ambulance on the day of our inspection.

We were told confidential information about staff and patients were stored securely in locked filing cabinets and not kept for longer than they should be in line with legislation.

Processes to ensure external bodies, including the Care Quality Commission, were notified as required were not effective. The registered manager had had a period of absence from the service in October/ November 2019, but the CQC was not informed of this which was in breach of Section 33 of the Health and Social Care Act 2008.

Engagement

Leaders and staff actively and openly engaged with patients, staff, local partner organisations and the local clinical commissioning group. However, systems to obtain constructive feedback to develop and improve services, were ineffective.

The registered manager described how they worked with another independent ambulance service and the local NHS hospital and stated they had built good working relationships with them. The registered manager was available to support staff in their work which was delegated to them by the independent ambulance service when they could not undertake the journey themselves.

Staff encouraged patients to provide feedback by completing a patient feedback form or online using the service's webpage but only received few completed forms by return. There were no formal processes for staff to provide informal feedback about how the service could be improved. Although the registered manager was visible and often met with staff, there were no planned staff meetings where performance was discussed and opportunities and ideas for service improvement actions could be discussed.

The service engaged with the external stakeholders. The registered manager explained there was regular contact with people they worked closely with to deliver efficient patient transport services. The service was commissioned to convey patient transport services five days a week from the local NHS hospital. This was a verbal agreement with local healthcare providers, which was effective until end of June 2021.

Following the inspection, we spoke with one patient and one relative of a patient who had been conveyed by the service. Both provided positive feedback about the kindness of staff and both would recommend the service to others. We reviewed seven patient feedback forms which all contained positive feedback about the service.

Inadequate

Patient transport services

We obtained feedback from the clinical commissioning group and from the local NHS hospital. The feedback confirmed the service was able to transfer medically stable patients such as patients being discharged or transfer to 'same level' or step-down facilities.

Learning, continuous improvement and innovation

There was limited focus and commitment to innovation.

At the time of our inspection, the registered manager was focussing on delivering patient transport services to meet the verbal agreement. The registered manager was focussing on re-building the service following the impact of the pandemic and significant changes to the organisational structure. The registered manager had ideas and ambitions but no clear strategy of how to achieve these. There was no formalised direction of how the service would operate and develop in the near future or over a longer period of time.

The registered manager identified work was required to establish systems and processes to improve governance and safety. They were looking to the results and report from this inspection to provide some guidance about the improvement that was required.

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