ALDERNEY AMBULANCE
Emergency Ambulance Service

Alderney Ambulance Service: Review

December 2019

Richard Webber, Strategic Advisor

Summary Findings:

This review has found that the Alderney Ambulances contained a number of pieces of life-saving equipment that did not work. Both Ambulances had several pieces of medical equipment that had either never been serviced or were years past their manufacturers recommended service date. There were numerous consumables that were past their expiry date. There were medications on the Ambulances, despite a clear instruction for their removal following the resignation of the Medical Director earlier this year. There was some equipment in use that was beyond the scope of practice of an Ambulance Technician.

The clinical practice reviewed was unsafe due to the inadequate clinical assessments of patients. There are decisions being made to leave patients at home without an adequate assessment, safe clinical rationale or appropriate safety netting by referral to another Health Care Professional.

Introduction:

This review was requested by the Board of Alderney Ambulance Service and supported by the Chief Executive of the States of Alderney. The review was requested to assess the service as the Guernsey Chief Ambulance Officer and some operational staff provided cover in mid-August and raised a number of significant concerns. It also follows a number of previous reviews that made recommendations as to the most appropriate operational and organisational arrangements for the future.

The review was also required to assess the readiness of the Service for their forthcoming HSC local Governance inspection in line with the Care Quality Commission reviews undertaken in the UK. The previous Medical Director had expressed the view that the service would not meet the standards against which they were likely to be assessed.

As part of the scoping exercise, the Independent Consultant met with the Board and the States of Alderney CEO and representatives at the beginning of November to agree the areas for review. The review was undertaken at the end of November and beginning of December.

The Terms of Reference for the review were:

1. Review of March 2019 “Sustainability and Future Operations Strategic Plan” and CAO proposal
2. Review and comment on current operations
3. Provide advice on future service delivery

Current Operations:

The review commenced with a meeting with the Chief Ambulance Officer (CAO) and many of the volunteers to understand how the service operates. The service currently operates with two vehicles which are covered 24 hours a day. There is a first on call crew of two with a back-up crew available. The volunteers are currently paid 60p per hour for 1st on call and 30p per hour for second on call. The volunteers are paid £15 per hour when attending calls. The administration is undertaken by the CAO and some other staff who are paid for circa 160 hours per month.

The volunteers are mostly trained and assessed as competent by the former Medical Director at Emergency Medical Technician level with two new staff operating as Ambulance Care Assistants. There is refresher training which is provided in-house one evening weekly. In addition there is some ad hoc training with outside groups such as from the Mignot Memorial Hospital (MMH) Emergency Department and Maternity staff. There is on line training undertaken with EDMS (the company run by the previous Medical Director). The training is across 11 areas such as Safeguarding and Capacity. Reassessments are undertaken annually

comprising a day of face-to-face training and two days of assessments. These are supposed to occur annually, but they last occurred in June 2018.

The cover is currently provided by nine staff; of which four come from one family. This is clearly a significant risk as if there is a family occasion then there can be a shortfall in cover. An example of this occurred in the summer when support was provided from Guernsey. During this visit, by three staff which included the Guernsey Ambulance CAO, a number of significant issues were identified and a follow-up report was produced for the Board and CAO.

It was stated that recruitment of new staff can be difficult. The staff perception was that this was due to the current onerous on-call commitment.

Activity:

During the scoping visit the activity data from January to October 2019 was provided. An analysis of this data showed that in addition to some event cover, the numbers of calls attended are:

999 calls- 161 with a monthly range between 12 and 27 per month
PTS Calls- 86 with a monthly range between 5 and 17 per month and are usually undertaken by the back-up crew.

In terms of breakdown of calls by category there were:
Category A- 69 calls
Category B- 32 calls
Category C- 31 Calls
Emergency Medivacs- 35

This means that the year-to-date average number of call attended by month, are as follows:
999 calls- 16 per month
PTS Calls- 9 per month

The CAO and some volunteer staff provide additional administration support, including vehicle checking, DNACPR management and roster covering.

Staff Perspective:

The volunteers feel that they are poorly remunerated for being on-call. It is disruptive on home and social life and examples were given whereby previous volunteers had ceased volunteering in order to gain better remunerated employment. They felt payment should be significantly increased; perhaps up to £3 per hour on-call.

It was proposed that there would be benefits in having some paid staff, particularly to cover the daytime, when volunteers find it most difficult to provide assistance as it requires leaving work. The volunteers were very resistant to this approach. Most of the volunteers who attended the discussion stated they wished to maintain the current approach; whereby the CAO and some of the staff provide administration support which includes vehicle checking, DNACPR management and roster covering.

The staff stated that whilst they were unhappy with the amount of on-call required, they strongly wanted to maintain a back-up on call Ambulance. They are now accepting of the change to only have two people

on first on-call, but that as new people come on line then they should consolidate their knowledge by working as a third person on the crew for an agreed period.

External Perspective:

There were various perceptions noted externally. These included crews spending too long on scene undertaking what were perceived as unnecessary assessments. It was stated that the crews did not always alert the MMH of an incoming patient. This was a particular issue out of hours when staffing is lower and often requires staff to be called back in or moved around. It was noted that there is generally poor joint working with other agencies.

There were cases cited where the levels of clinical care delivered were below that expected given the training and scope of practice of the crews. There were also some occasions cited where some of the staff's approach and attitude was below that expected; which resulted in poor joint working. It was also noted that, in variance with the agreed procedures for transfers, there was a low use of vacuum mattresses.

Documentation:

There is a Patient Report Form (PRF) that is completed for each patient interaction. They are stored in one box per year which is held in a cupboard near the front door which has a number lock on it. There are over ten years of Patient records held. The PRFs are not clinically reviewed or audited.

The station computer has an excel file on it which is password protected with a limited number of the volunteers being aware of the password. The file contains information regarding all calls attended and has a significant amount of personal data on it including name, address and Date of Birth. Do Not Attempt CPR (DNACPR) notification information is held on the PC and each vehicle contains a folder with photocopies of these signed forms.

The current situation represents a risk to GDPR compliance.

Station Inspection:

During the morning of the 30th November, a Station and vehicle Inspection was conducted. A number of issues were identified which gave cause for concern. There is no sluice available and Oxygen cylinders are stored loose in the garage rather than in an outside, ventilated store. It was stated that there are plans in place to rectify this.

The garage had several piles of equipment left on the floor. This was a mix of training and operational equipment; but gave a poor impression. There were two vacuum mattresses on the floor with none on either Ambulance. It was noted that there were four full large sharps boxes piled up in the garage. It was fairly evident that they had been there for some time which presents infection and Health and Safety risks.

In the crew area there was a Doctors bag, which previously had been kept on one of the Ambulances. It contained a range of Advanced Life Support equipment with some drugs which were mostly in date. It contained a Chest drain kit that expired in 2017. There was also a Mini-Trach 2 Kit (used to insert a tube directly into the traches in the neck) that expired in 2016.

Vehicle Inspections:

There were a significant number of issues noted on the older Ambulance; which is the one most frequently used. Some of the equipment deficiencies noted were on life-saving equipment. The issues were:

Vehicle 1:-

1. AED- Not serviced and Battery flat. It was so low it did not even turn on
2. Defibrillator- Not serviced at all and battery expired in 2012
3. Suction Unit- Not serviced and did not turn on when taken off the charging base
4. Entonox- No service date on giving set
5. Oxygen piping in Ambulance- No evidence of ever having been serviced
6. Gloves- Small size were Latex and date expired in March 2015
7. NP Airway size 20ch (5ml) – Out of scope for UK Ambulance practice
8. Clinical waste bin full
9. Sharps bin- Large and full with several needles containing blood- Likely to be in use for over 1 year
10. Disprin 300mg pack of tablets (all medications have been withdrawn)
11. Patient Specific Alerts folder contained one PSA that was due for review in April 2016
12. DNACPR folder had a high number of photocopied forms in it
13. On a previous visit there was an EZ-IO kit (Intra-osseous bone drill and needles) which staff state they can use whilst supporting a Doctor
14. Bandages- A number were past their use by date.

Vehicle 2:-

1. Defibrillator serviced in 2013 and sticker states next service due December 2013
2. AED Defib pads expired in August 2019.
3. No spare pads in AED
4. Clinical Waste Bin full
5. Sharps Bin not dated and clearly had been in use for some time

Patient Report Form Documentation and Clinical Care:

A review of a large number of PRFs that had been completed over the course of 2019 was undertaken as part of the review. The general quality of completion was poor. Several of the PRFs had no observations recorded on them and there were some that stated none were taken. It was also identified that the PRFs were not audited for compliance with the patient treatment protocols or quality of completion. Most of the Observations that were taken did not have the times they were taken noted. In most instances only one set of observations were recorded and these did not contain the complete range required to perform a satisfactory patient assessment as stipulated in the JRCALC Clinical Practice Guidelines.

It was also noted that there was much less information recorded than expected with regards Previous Medical History and Medications that the patient was taking. This is of particular relevance for when patients have fallen and are on blood thinners as they need to be conveyed for further assessment.

As part of the review, the level of documented care was assessed. There were several instances where inadequate assessment was documented and thus has to be assumed was not undertaken. In several of these cases the patient was left at home with no follow-up noted.

It must be highlighted that within this review there were some very high quality forms identified which demonstrate the desired benchmark for optimal patient care.

Vehicles and Station Overview:

The review indicates very poor Infection Prevention and Compliance (IPC) with several sharps bins in use or left on station that are considerably above the normal safe practice period of 3 months with none having the date started use written on as should be normal practice. The storage of Oxygen is inadequate and the lack of a sluice is a concern.

The vehicles both had life-saving equipment on them that did not function, had never been serviced and where it had was several years past its review date. There were consumables in use that were past their expiry dates and would not be safe to use. The stretchers and carry chairs had no evidence of having been serviced; out of line with manufacturers' recommendations of an annual service by a competent person. It was noted that there are newer chairs on the station.

There were medications found on the station and Ambulances despite a clear instruction for all medication to be removed and not used since the departure of the Medical Director some six months previously.

Clinical Practice:

The documented level of patient care is significantly below the level of care expected of a Technician. The Strategic Plan dated March 2019 produced by the former Medical Director states-

The current training and competencies of Emergency Medical Technicians include far better patient assessment skills than ever before. EMT's are able to:

a. Take a basic history from a patient
b. Assess patients for stroke, sepsis, cardiac, respiratory, diabetic, asthmatic and other conditions
c. Measure heart rate, respiratory rate and pupil response
d. Assess the level of consciousness
e. Measure blood pressure
f. Measure Blood Glucose levels (for all types of patient)
g. Perform a Peak Expiratory Flow rate (for asthmatic patients)
h. Perform a 12 lead ECG
i. Measure oxygen saturation with a pulse oximeter
j. Assess a patient's mental capacity

The Patient Report Forms reviewed did not reflect many of the criteria stated above. Few had Blood Pressures recorded and none had information regarding an ECG. In fact only one in the entire year of the reviewed PRFs had an ECG strip attached.

Crews, as part of the feedback process on the 1st December, were asked about their knowledge of medications and they were unable to recognise some commonly prescribed blood thinners (Apixaban and Rivaroxaban). This is an essential requirement for leaving patients at home who have fallen and have certain clinical signs.

The JRCALC Clinical Practice Guidelines (the standard for Ambulance Service use in the UK and used in Alderney) state that a minimum of two sets of observations should be undertaken and recorded. It states that the persons medical history, current medications, vital signs and NEWS2 score, lying and standing blood pressures if appropriate and cardiovascular and neurological signs should be recorded. It states that where clinically significant postural hypotension is found it requires further investigation. It also states that a 12-lead ECG should be undertaken in all cases of a syncope and lists three "Red flags" which if seen would

result in a need for the patient to be conveyed for further assessment. There are a number of “Red criteria” noted which if present means that the patient must be immediately transported to hospital. This includes any patient on current anti-coagulant therapy such as Warfarin.

Areas for Immediate Action:

There are several areas that require immediate action. This was fedback verbally to the Staff, Service and States of Alderney at the end of the review.

1. Defibrillators must be serviced
2. Defibrillator Pads must be kept in date with a spare set kept with each defibrillator
3. Suction Apparatus must be serviced and kept charged
4. Entonox and Oxygen equipment must be serviced in line with manufacturers recommendations
5. Sharps bins and Clinical waste must be disposed of in line with IPC guidelines
6. Gloves- Latex ones must be removed
7. Vacuum Mattresses must be serviceable, placed on vehicles and used for all Medevacs
8. Appropriate assessments must be undertaken for all patients
9. Safety netting must be used for patients left at home
10. Review no lift policy at CCH and consider using “ISTUMBLE” & lifting devices by care home staff

Considerations for the Service going forwards:

The review did consider the recommendations made in the March 2019 review. However, due to the current state of the service the recommendations made of employing three staff and sending a Technician to undertake an initial assessment are not currently appropriate. The areas for consideration were presented to the Board and the States verbally on 2nd December and are as follows:

- Immediately implement clinical safety netting with no patients left at home unless seen or the patient discussed with a registered clinician
- Mobilise a Doctor or Paramedic to all Category A & B calls
- All Category C calls to be conveyed or discussed with an HCP
- Consider seconding a Paramedic for 3 months to provider a safer service and to develop and mentor the volunteers
- Review all PRFs and provide feedback to staff
- Appoint a new Operational and Training Lead
- Appoint a new Medical Director
- Review the current training provision
- Reinstate annual mandatory training and assessments

In the longer term, given that the average call rate for 999 calls is one call every two days and one PTS conveyance every three days, then the Service could reduce to only operating one vehicle at a time with the second maintained for event coverage and to be available in cases of Significant Incidents occurring. In order to ensure timely mobilisation then there should be 3 personnel on call. It is also recommended that there is an increase in on-call allowances. The recruitment of new staff should occur once the new models have been agreed.

Richard Webber
Independent Consultant
10th December 2019