**Great North Air Ambulance Service**

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Tel: 01325487263  

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We inspected the following standards as part of a routine inspection. This is what we found:

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<th>Standard</th>
<th>Met this standard</th>
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</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>✓</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>✓</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✓</td>
</tr>
<tr>
<td>Complaints</td>
<td>✓</td>
</tr>
</tbody>
</table>
## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>Great North Air Ambulance Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Manager</td>
<td>Mr. Kevin Hodgson</td>
</tr>
<tr>
<td>Overview of the service</td>
<td>The Great North Air Ambulance Service (GNAAS) is a charity operating a fleet of three helicopters across an area of 8,000 square miles. GNASS offers a 10 hour day, 7 days per week Helicopter Emergency Medical Service (HEMS) providing a consultant led trauma team and a team of highly trained paramedics who are employed by the service. The helicopter fleet and staff teams are based at a purpose built centre at Durham Tees Valley airport and at Langwathby in Cumbria.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Ambulance service</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Diagnostic and screening procedures</td>
</tr>
<tr>
<td></td>
<td>Surgical procedures</td>
</tr>
<tr>
<td></td>
<td>Transport services, triage and medical advice provided remotely</td>
</tr>
<tr>
<td></td>
<td>Treatment of disease, disorder or injury</td>
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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 November 2013, observed how people were being cared for and talked with staff.

What people told us and what we found

Due to the nature of the service provided by the air ambulance of transporting time-critically injured or ill patients to specialist trauma hospitals, Great North Air Ambulance Service (GNAAS) cannot seek the views of patients using the service at the time. The service does follow up on patient progress with the hospitals concerned and receives many thank-you cards and messages from people and their families who have used the air ambulance. The website for the Great North Air Ambulance Service also shows how this service which is entirely funded from public donations, has helped many people receive high quality pre-hospital critical care.

Medicines were securely stored and monitored and there were systems in place to ensure they were checked regularly.

Health and safety at the service was monitored effectively and risk assessments and checks were in place to reduce the risk of any incident or accident.

The service worked well with other providers to ensure the safe and effective transfer of patients and information.

The provider had quality assurance systems to ensure the safety and wellbeing of staff and patients and also reviewed the effectiveness of the service on a regular basis.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>✔</td>
</tr>
<tr>
<td>People should get safe and appropriate care that meets their needs and supports their rights</td>
<td></td>
</tr>
</tbody>
</table>

Our judgement

The provider was meeting this standard.

Patients experienced care and support that met their needs and protected their rights.

Reasons for our judgement

The staff team of doctors and paramedics usually worked during the house of 8am-4pm during winter months and there was a different shift system that operates in the summer months when the service works longer hours. We saw the staff based in the control room where the duty doctor, pilot and two paramedics were monitoring the system that brought in potential calls to the air ambulance. We saw staff taking turns to monitor all calls on screen that come into the North East Ambulance Service (NEAS) where they could potentially pick out possible air ambulance calls for example, at a remote location or a vehicle accident. Staff also had an emergency red telephone that brought in any calls directly to the air ambulance from NEAS. The Airways Point to Point radio system ensured paramedics maintained constant contact with control so messages can be relayed ahead to the trauma centre on the patients condition.

The service had an electronic system across the two locations for recording patient information. Whenever the helicopter or rapid response vehicle was used a paper form called a patient report form (PRF) was completed that detailed incoming patient details from the ambulance service, and then specific details about patient observations and treatment given by the air ambulance crew before a signature of handover was obtained from the receiving hospital. These details were then transferred to a secure electronic system by the paramedics on return to the base. All patient records were seen to be securely stored in a locked cabinet in an office that was also locked. A system called "Call Connect" recorded the times that initial calls came into the service, the arrival and departure times at the scene and also hospital arrival time. The service also liaised closely with the North East Ambulance Service (NEAS) on a daily basis to inform them of staff on duty as well as other ambulance controls, the RAF and hyperbaric centre. Staff told us that they had recently reviewed the design of the patient report form to include further detail on timed observations and to enable clearer recording of the medications used.

Staff had clinical governance days every two months where they discussed issues pertinent to trauma care, aviation and had an open forum. We saw from records that
recent events had covered an update from the medical director, a review of the recent rapid response vehicle trial and an open forum which included discussion on adverse event reporting and training.
Cooperating with other providers  

Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

There were arrangements in place to protect the health, welfare and safety of patients in the coordination of emergency procedures.

Reasons for our judgement

The service worked with doctors who were already employed within the NHS and so maintained good relationships with local trauma centres. The organisation was part of the Northern Trauma network group and also worked closely with the North East Ambulance Service (NEAS).

Whenever the helicopter or rapid response vehicle was used a paper form called a patient report form (PRF) was completed that detailed incoming patient details from the ambulance service, and then specific details about patient observations and treatment given by the air ambulance crew before a signature of handover was obtained from the receiving hospital. This ensured an effective transfer of information from the service to the trauma centre.

The service accessed training for its staff via James Cook hospital and the Royal Victoria Infirmary as well as participating in clinical discussion events.

The service had recently worked with Teesside University and all paramedic staff undertook a BSc Hons degree in paramedic science of which five staff had completed this year.

The service additionally had links with other emergency services such as Durham Fire Brigade where it was hoped that the Great North Air Ambulance may provide clinical governance and training in the future.

The service had recently undertaken a three month trial of utilising its rapid response cars to provide specialist pre-hospital trauma care on a Friday and Saturday night between 18.00 and 02.00 hours. This was done in consultation with NEAS and operated in the Darlington and County Durham areas. This trial had been fully evaluated by the service and the team attended 184 incidents of which 4 patients were critically injured and required anaesthetising prior to being transported to hospital and 43% of patients were discharged at the scene thereby preventing admission to an accident and emergency unit. The service hoped that this service could be taken forward in the region on a more permanent basis.
Management of medicines  

Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

There were appropriate arrangements in place for obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

Reasons for our judgement

We discussed the management of medicines with a paramedic who had responsibility for the ordering, storage and monitoring of drugs at the service.
All drugs and medical equipment were stored in a locked room on site with appropriate storage for controlled drugs and an available fridge. The keys for the controlled drugs were held in a key safe in the Operations room and only medical crews had the access code for this key safe as an additional security measure. Two of the paramedic staff checked the controlled drug stock daily and recorded this. Drugs were then transferred to the response bags that were taken on board the helicopter on each mission. Any medications used were recorded and this was transferred back to the stock check sheets with the patient name and batch number included.
The expiry dates of all drugs were recorded when they were received into the service and this file was checked monthly to ensure medications were up-to-date.
The staff member told us that they regularly monitored the stock of drugs every month with a clear record of what had been used, what had been returned and destroyed. All drugs were obtained through James Cook hospital in Middlesbrough and there was a secure transport system in place for the movement of drugs. Fridge temperatures were recorded daily as well as the contents of the response bags and oxygen equipment. Any drugs that were new to the service were discussed through the clinical governance meetings by the medical director so that staff were familiar with them and their administration.
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that patients received.

Reasons for our judgement

Due to the nature of the service provided by the air ambulance of transporting time-critically injured or ill patients to specialist trauma hospitals, GNAAS cannot seek the views of patients using the service at the time. The service does follow up on patient progress with the hospitals concerned and does receive many thank-you cards and messages from people and their families who have used the air ambulance that are scanned and saved.

The organisation had recently brought in a consultant who spoke to staff across the whole Great North Air Ambulance service including paramedics and doctors to ascertain staff satisfaction with the organisation and to seek any areas for improvement. This would then go before the organisations board of directors prior to any action plan being developed and implemented. This showed that the service was seeking the views of employees as to any improvements it could make.

One of the paramedics explained that the service had devised a new debrief form that would be completed with the team after each mission. The debriefing process enabled the service to ensure that both patient care and aviation issues were discussed after each job to learn from experiences and to immediately address any issues of risk. Staff said "Has everything been done that could have been done?". Staff also told us that anything that arose from debriefing was discussed in the regular Clinical Governance days. The debrief checklists would also be reviewed every six weeks along with all the patient report forms as part of the quality review process by the senior management team at the service. We reviewed the minutes of the organisation wide health and safety committee and discussed the measures place to monitor the health and safety of the service with the paramedic who was the lead for this area. We saw risk assessments in place that were specific to the service as well as regular checks on electrical and fire equipment that were recorded. We saw that through the health and safety monitoring of the service that issues such as improved outdoor lighting had been picked up and addressed.
Complaints

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

People know that their comments and complaints are listened to and acted on effectively.

Reasons for our judgement

The service regularly reviewed its systems of working both via the mission specific debrief and through its clinical governance and quality assurance processes. There was a section on the debrief form for a "complaint" which may include any issue from the receiving trauma centre or other emergency services as well as from the patient themselves. The service had a complaints policy and process that was recorded. Staff had regular appraisals and supervisions and there was also an open forum at the bi-monthly clinical governance meetings that were held for people to raise any issues or concerns.

The service worked closely with other emergency care providers, particular James Cook and the Royal Victoria Infirmary hospitals as well as the North East Ambulance Service (NEAS) and the registered manager said any issue would be discussed quickly through clinical discussions. There was also a memorandum of understanding document in place with NEAS to define each organisations responsibilities.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ Met this standard
This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed
This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken
If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.