Pre-Hospital Emergency Care Council

Governance Validation Framework

Assessment Report

Dublin Wicklow Mountain Rescue Team

April 2024

Pre-Hospital Emergency Care Council

Mission Statement

The Pre-Hospital Emergency Care Council protects the public by independently co-ordinating, developing, reviewing, regulating, and governing standards of excellence for the safe provision of quality pre-hospital emergency care.

QUALITY ASSURANCE PROGRAMME

Governance Validation Framework
Quality Review Framework

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1. Quality Assurance at The Pre-Hospital Emergency Care Council

The Pre-Hospital Emergency Care Council (PHECC) is an independent statutory body who set the standards for education and training for pre-hospital emergency care in Ireland. The Council publish clinical practice guidelines (CPG) and recognise CPG Service Providers to deliver the PHECC CPG. Council also recognise institutions to provide pre-hospital emergency care training and education.

The Pre-Hospital Emergency Care Council's (PHECC) mission is "to protect the public by independently reviewing, maintaining and monitoring standards of excellence for the safe provision of quality pre-hospital emergency care", to achieve this aim PHECC have developed a Quality Assurance Programme that consists of two key standards:

- The Governance Validation Framework (GVF), in place since 2018, monitors the CPG Service Providers that PHECC recognise to deliver pre-hospital emergency care in the community. Providers are required to be compliant with the GVF Standard (STN034) and its related criteria.

- The Quality Review Framework (QRF), in place since 2014, monitors the Recognised Institutions and Approved Training Institutions that PHECC recognise and approve to deliver education and training in pre-hospital emergency care. RI/ATI are required to maintain compliance with the Quality Review Framework (STN020) and its related standards.

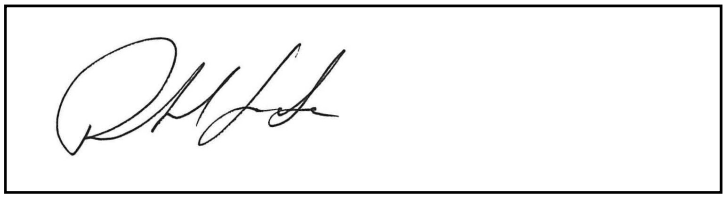
The GVF and the QRF relate to specific standards and identify the supporting components that PHECC recognised CPG service providers and approved organisations should have in place to ensure good governance and quality in delivery of education, pre-training, and operational hospital emergency care with a focus on protection of the public. To achieve this aim PHECC supports organisations by providing tools, such as the GVF/QRF Standards, and the Self-Assessment template, which are designed to underpin continuous quality improvement. Organisations' compliance with PHECC standards is assessed on a cyclical basis.

Assessments are planned, or they may be reactive. Once selected for assessment an organisation will complete a Self-Assessment template, rating themselves against the Standard. The Self-Assessment provides the context for the assessment process and the Assessment Team review submissions, engage with the organisation's management and staff, and specific aspects of the organisation's operations. The process is designed to reveal the organisation's compliance with the GVF or QRF Standard. During the process the organisation submits evidence material electronically. A report is produced for Council, which, once approved, will be published on the PHECC website.

It is important to note the provision of pre-hospital emergency care and its related education or training is constantly evolving, and quality improvement is a continuous process. However, this report formally records the Assessment Team's observations related to the specific time when the assessment was undertaken and is primarily based on the organisation's assessment submission against the Standard.

Organisations should note that once selected for assessment, they are strongly encouraged to provide the evidence of compliance with the Standard and its criteria at the time of submission as the assessment is a 'snapshot in time', therefore in this respect, specifically during the factual accuracy process, documentation and/or evidence submitted by the organisation that relates to improvement activity undertaken immediately post assessment cannot be considered to amend assessment outcome(s).

2. Assessment Report Overview and Validation

Organisation Name	This report relates to Dublin Wicklow Mountain Rescue Team, a PHECC Recognised CPG Service Provider, licensed to deliver pre-hospital emergency care services in Ireland since 2017. Dublin Wicklow Mountain Rescue Team is recognised by PHECC under S.I 109 of 2000 as amended by SI 575 of 2004 at the following clinical levels: ☑ Emergency Medical Technician ☑ Paramedic ☑ Advanced Paramedic ☑ Organisation also provides responder level services
Assessment Type	☑ Planned ☐ Reactive
Process	☑ Desktop Review ☐ Online Management Engagement ☑ Onsite Management Engagement Roundwood, Co Wicklow ☑ Practitioner Engagement Roundwood, Co Wicklow
Outcome Rating **Technical Weighting Applied** **Yes** ☐ **No** ☑	<table><tr><td>No of criterion assessed</td><td>44</td></tr><tr><td>Maximum score available</td><td>176</td></tr><tr><td>63% of Max =</td><td>111</td></tr><tr><td colspan="2">**Assessment Results**</td></tr><tr><td>Total score achieved</td><td>158</td></tr><tr><td>Total score as percentage</td><td>90%</td></tr><tr><td colspan="2"></td></tr><tr><td>**Assessment Outcome Rating**</td><td>**Acceptable**</td></tr></table>
Follow Up Action Required	☑ Continue with normal quality improvement activities ☐ Improvement notice - follow up evidence required ☐ Conditional Approval ☐ Suspension notice ☐ Delisting process intiated
Reassessment Costs	☑ Not Applicable
Validated and Approved for Publication **Director Signature** **Date**	 29/07/2024

3. Assessment Participants

Organisation	PHECC Assessment Team
Chairperson Team Lead	Lead Assessor
Medical Director (Medical Register No 124666) Medical Director (Medical Register No 261026)	Onsite/Practitioner Engagement Assessor
Medical Lead (Paramedic)	
Committee Member/Training Lead (Advanced Paramedic)	

4. Initial Feedback Given

PHECC acknowledged the participation of Dublin & Wicklow Mountain Rescue (DWMRT) in the GVF assessment and verbal feedback related to the Assessment Team's initial findings was provided to the Management of DWMRT by the Team Lead at the feedback meeting. There was broad agreement by the leadership of DWMRT with the Team's comments and indicative findings.

The following areas were identified as areas requiring improvement, or further potential for improvement areas: governance, risk compliance, equipment, staff training and GDPR compliance. The body of this report contains further information in each case.

5. Rating Scale and Outcome Rating

The rating scale that PHECC will use during assessment quantifies the compliance with the criteria. Each criterion will be assessed and assigned a rating that carries points 0-4.

Rating Scale	Rationale
N/A	Not Applicable. The Standard is not applicable.
0	Not Met: No Evidence of a low degree of organisation-wide compliance.
1	Minimally Met: Evidence of a low degree of organistation-wide compliance.
2	Moderately Met: Evidence of a moderate degree of organisation-wide compliance.
3	Substantively Met: Substantive evidence of organisation-wide compliance.
4	Fully Met: Evidence of full compliance across the organisation.

6. Weighting Tolerance

To ensure that standards are maintained above certain levels a technical weighting will be applied in situations where rating scores are deemed to be below acceptable levels. When this is completed, with the assigned scores from the Assessment Team, the requirements of the rating application and weighting automatically determines the overall outcome rating.

7. Outcome Rating

The outcome rating is determined by the rating scores applied by the Assessment Team to each criterion and includes the application of any associated technical weighting that may apply. An outcome rating is created using a rating matrix that brings the components of the assessment rating system together and calculates the assessment outcome rating based upon the combined rating achieved in the criteria and Standards, expressed as a percentage of the maximum available (100%). * An outcome rating is applied and the follow up and impact of the achieved rating on the organisation's recognition status is determined accordingly.
**Not applicable criterion will not be considered in these calculations.*

Rating	Outcome	Recognition Status Impact
Acceptable	**Outcome rating of ≥ 88% of max available**	• Unaffected
Moderately Acceptable	**Outcome rating of ≥ 63% <88% of max available**	• Unaffected
Conditionally Acceptable	**Outcome rating of ≥ 38% <63% of max available** Outcome score is within the weighted tolerance	• Immediate conditional approval
Not Acceptable	**Outcome rating of ≥ 25% <38% of max available** *Outcome score is outside the weighted tolerance = Technically Not Acceptable	• Notice of intention to suspend. • Improvement Notice will be issued (risk assessment dependent)
Unacceptable	**Outcome rating of < 25% of max available**	• Removal of PHECC recognition status (Delisting)

8. Assessment Findings

The following are points of note:

- During assessment a risk assessment and escalation procedure is utilised by the Assessment Team.
- It is recognised that not every criterion may be relevant or apply to each Provider. The judgement of the Assessment Team, in consultation with PHECC executive, will determine if a criterion should be considered applicable. If not , the rating system adjusts to accommodate.
- A criterion may be rated as fully met and yet attract an opportunity for improvement comment where a minor adjustment may yield further improvement.
- It should be noted that regardless of the Provider's outcome rating an improvement notice may be issued by PHECC related to the Assessment Team findings with regards to specific criterion that fall below the expected standard; particularly ones that may present a specific risk or pose a detrimental impact to safety.

Standard 1

Person-Centred Care and Support

The intent is to ensure the Provider has a patient-centred focus by providing services that protect the rights of patients, including empowering them to make informed decisions about the services they receive. The views of patients should be sought and analysed. Sources of this information include complaints, compliments, and patient feedback surveys. The feedback system needs to be transparent, and the information should be used to make improvements. Patients should be provided with instructions that are clear and relevant to their special needs and ethnicity.

Standard 1

Criterion

1.1 Patients have access to pre-hospital emergency care based on their identified needs and the Provider's scope of services.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider's organisation is wholly a volunteer organisation comprising of a diverse membership which includes, Advanced Paramedics, Paramedics, Emergency Medicine Technicians, Emergency First Responders, Medical Practitioners, a pharmacist and specially trained rescue dogs.

The Assessment Team is satisfied that there is a robust clinical governance system in place, which oversees CPG implementation. In discussion with the Assessment Team, the Medical Director and Team Lead described the process for escalation of patient care to a higher clinical level when and where indicated.

Area(s) of Good Practice

The Provider displayed dedication and commitment to an increasingly demanding voluntary service provision.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

1.2 Access to pre-hospital emergency care is not affected by discrimination.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Provider has ongoing education and training, which includes patient centred care and support.
Following a review of documentation submitted and discussion with Management, the Assessment Team are satisfied that the Provider ensures staff are adequately trained with respect to this criterion.

Due to the nature of call outs, which often involve patients who may be non-English speaking tourists, the Provider has access to foreign language translation services when required.

Area(s) of Good Practice

The Provider promotes a culture of dignity and respect within their organisation.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

1.3 The Provider ensures information from calls / activation is recorded accurately and dispatched according to priority.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Assessment Team evidenced a robust system that ensures information from calls and activations are accurately recorded. Volunteers are contacted via an online chat group to check their availability to respond.

Activations are usually initiated by An Garda Siochana or the National Ambulance Service (NAS) through a standard messaging system to the on-duty Callout Officer. Dependant on the nature of the call – rescue or medical rescue-availability of the volunteers, the Callout Officer will task volunteers to a meeting point. The Callout Officer will be off site and will act as control for the rescue team. From the meeting point, the on site rescue team lead communicates with a forwarding team, NAS team and Coast Guard through the use of a secure digital radio service.

The Assessment Team were satisfied that details of volunteers who respond to calls are recorded and saved on an electronic system specifically designed for emergency responders.

Area(s) of Good Practice

The Provider has a robust system in place that enables the team to respond to calls for assistance and pre hospital care in its area of operations.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

1.4 The Provider develops and implements a process to ensure best practice for patient identification.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☑	☐

Assessment Findings

The Provider did not submit a specific policy related to patient identification; however, the Assessment Team are satisfied that a process to ensure patient identification and patient confidentiality is contained within the Provider's Data Protection Policy.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should develop a specific policy that describes best practice in patient identification.

Standard 1

Criterion

1.5 The Provider has a policy for informed consent.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☑	☐

Assessment Findings

The Assessment Team did not evidence a specific policy for informed consent; however, the Provider has included the concept in the Code of Conduct for volunteers.

In discussion with Management, the Assessment Team determined that informed consent is sought when possible, unless a patient is unconscious.
During on-site visit the Assessment Team discussed the need for

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should develop a separate policy on informed consent, which should be supported by volunteer training in gaining consent from patients.

Standard 1

Criterion

1.6 The Provider has a policy in place in relation to the patient's refusal of treatment and/or transport.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider has a policy in place that describes the process surrounding a patient's refusal of treatment and/or transport.

During Practitioner Engagement (PE) practitioners stated they are aware of a refusal of treatment or travel policy. Practitioners were also aware that capacity assessments, when required, must be documented on the Patient Care Report (PCR).

Area(s) of Good Practice

The Provider developed this policy as part of their quality improvement plan post GVF Assessment in 2021.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

1.7 The Provider ensures all patients are treated with compassion, respect, and dignity.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider has submitted a Code of Conduct, which describes the expected behaviour of volunteers when treating patients.

During PE there were no opportunities to observe and report on practitioner interaction with patients, however, practitioners were aware of the code and familiar with expected behaviour when dealing with all patients.

Area(s) of Good Practice

The Provider promotes a culture of dignity and respect within their organisation.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

1.8 The Provider seeks feedback from patients and carers to improve services.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☑	☐	☐	☐

Assessment Findings

The Provider does not currently seek feedback from patients and carers who have accessed their service.

In discussion with the Assessment Team, Management stated that they frequently receive positive feedback in the form of an email, phone call or message through their social media platform that is complimentary of the service they provided to patients.

The Assessment Team were informed that a patient satisfaction /carer experience feedback system is currently a work in progress.

Area(s) of Good Practice

The Assessment Team acknowledge the positive feedback that the Provider has received as a result of their service provision.

Area(s) for Improvement

The Provider should continue to develop a mechanism by which to capture patient/service user feedback.

Standard 1

Criterion

1.9 Patients' complaints and concerns are responded to within an agreed timeframe and openly with clear support provided throughout this process.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Provider has a Complaints Policy in place.
Induction training incorporates open disclosure and complaint management.

Following a review of the evidence submitted, the Assessment Team are satisfied that the Provider has a mechanism to respond to complaints in a timely manner.

Area(s) of Good Practice

The Provider's induction process includes training on complaint management.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Effective Integrated Care and Safe Environment

The intent here is to evaluate if the Provider's environment supports safe services. Fire safety, security, and planned preventative maintenance programmes are some of the topics covered. Safe clinical care is evaluated including identifying high risk patients. Pre-hospital emergency care Providers have a crucial part to play in major incident planning and testing.

Standard 2

Criterion

2.1 The Provider has systems in place to ensure Practitioners utilise the PHECC CPG (Clinical Practice Guidelines) appropriate to their scope of practice.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Assessment Team reviewed the Provider's electronic system, which contains a register of practitioners, and records the monitoring of their upskilling and competency levels.

In discussion with the Assessment Team, Management described the process whereby PCR are monitored by the Medical Director to ensure compliance with PHECC Clinical Practice Guidelines (CPG).

Area(s) of Good Practice

The Provider ensures that volunteers utilise the PHECC CPGs appropriate to their level and scope of practice.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

2.2 The Provider has a standardised handover process in place to ensure the safe, timely, and structured exchange of information during handover of patients.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☑ Moderately Met ☐ Substantively Met ☐ Fully Met

Assessment Findings

The Provider does not have a specific written policy on patient handover, however, following discussion on practice with Management and practitioners, the Assessment Team are satisfied that practitioners utilise the PCR as a structured method of information exchange during patient handover to statutory providers where there is a requirement for higher level patient care.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should develop a specific policy that aligns with national guidelines on patient handover.

Standard 2

Criterion

2.3 The Provider has a system in place to ensure the safety of their vehicles in line with legislation.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Assessment Team inspected vehicles that are utilised to respond to incidents. Both vehicles had tax, insurance and CVRT discs displayed.

The Provider has a system in place that involves a weekly check of each vehicle by a nominated volunteer who will record the checks and results on a cloud-based document. This document supports vehicle maintenance and repair, which is carried out by a qualified mechanic who is a voluntary member of the Provider's organisation.

Area(s) of Good Practice

The Provider has a robust system in place to ensure the safety of their vehicles. The Assessment Team are satisfied that the Provider introduced a quality improvement related to vehicle maintenance, which was a recommendation following their GVF Assessment in 2021.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

2.4 Training is provided for staff to transport patients safely, including during emergency situations.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider has a specific two-day driver assessment and training module for volunteers, which specifically assesses driver suitability for driving during emergency situations.

During PE it was stated by a practitioner that the qualified driver trainer also provides a session in relation to safe driving for all volunteers.

Area(s) of Good Practice

The Assessment Team acknowledge the commitment demonstrated by the Provider to ensure safe driving during emergency situations.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

2.5 The Provider has a policy on the use of emergency lights and sirens.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Provider has in place a policy on the use of emergency lights and sirens. The policy is supported by the provision of driver training as per standard 2.4.

The Provider's Operational Team Lead is responsible for the monitoring of this policy and the Assessment Team verified that driver training records are being maintained and monitored.

Area(s) of Good Practice

The Provider displays good record keeping practices.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

2.6 The Provider has a fire safety plan for any physical environments owned or used by their organisation.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Provider submitted a detailed fire safety plan in relation to their depot headquarters.

Details of the plan were further discussed with Management and evidence of fire safety as part of induction and ongoing training of volunteers was witnessed by the Assessment Team.

Area(s) of Good Practice

Yhe Provider has a comprehensive policy and training in place in relation to fire safety.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

2.7 The Provider ensures there is a business continuity plan for their organisation.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider has a comprehensive business continuity plan in place to protect the services that it provides to the public.

Area(s) of Good Practice

The Provider demonstrated forward planning to maintain services.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

2.8 The Provider ensures plans are in place to deal with major incidents.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☑	☐

Assessment Findings

The Provider did not submit a major incident plan as a stand-alone policy document.

In discussion with Management, the Assessment Team established that the Provider undertakes comprehensive risk assessments as part of regular event planning and training scenarios. There was broad agreement within the Assessment Team that planning for major incidents frames much of the work of this organisation due to the type of services provided to the public.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should develop a specific written policy with supporting procedures to deal with internal and external emergency situations.

Standard 2

Criterion

2.9 The Provider has a 3-year programme of clinical and environmental audits in line with the services provided.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☑	☐	☐	☐

Assessment Findings

The Provider did not submit a 3-year plan of clinical and environmental audit.

In discussion with the Assessment Team, Management outlined the difficulties in clinical audit due to the limited number of yearly activations and subsequent patient interactions. However, the Assessment Team evidenced changes in practices that involved environmental and clinical initiatives specific to mountain rescue activities.

The Provider demonstrated a willingness to initiate a plan of audit which realistically reflected their service.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should develop a programme of clinical and environmental audit that reflects the unique nature of their service provision.

Standard 2

Criterion

2.10 The Provider submits a CPG Service Provider Annual Report,* which informs PHECC of clinical and other activities in their organisation. (*Calendar year).

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Provider submitted a CPG Service Provider Annual Report, a comprehensive report, which was compliant with PHECC requirements.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Safe Care and Support

The intent here is to evaluate risk management and reporting systems. Other safety issues are measured: Infection prevention and control (IPC), waste management, safeguarding, and medication management are patient safety issues that require specific attention in this standard. The sudden outbreak of transmissible diseases means practices have to rapidly adapt existing emergency plans to manage services and reduce the transmission of infection. Utilising PHECC CPGs provide important sources of best practice.

Standard 3

Criterion

3.1 The Provider describes in a plan or policy the content of the infection prevention and control programme.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Assessment Team evidenced a comprehensive Infection Prevention and Control Policy, which encompasses their waste management processes and arrangements.

Infection prevention and control training documents were also verified.

The Assessment Team observed that although the Provider is not a patient carrying service, they carry out infection management procedures to decontaminate their equipment and vehicles following an activation.

Hand gel dispensers, sharps disposal receptacles and a clinical waste disposal bin were evidenced at the Provider's base.

Area(s) of Good Practice

The Provider has good infection prevention and control processes in place.

Area(s) for Improvement

The Provider would benefit from improving its infection prevent and control management even further by securing all consumables and solutions in a storage box along with a copy of the Infection Prevention and Control Policy on each vehicle.

Standard 3

Criterion

3.2 The Provider segregates and manages waste according to hazard level and disposes of same, according to best practice.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

During PE the Assessor inspected a vehicle that had a clinical waste bag, disinfectant, paper towels and hand sanitiser available. Practitioners stated that the amount of the clinical waste accumulated at a scene is passed to the ambulance crew transporting the patient. However, in the event clinical waste is brought back to the base, it is disposed of in a locked clinical waste bin which, the assessor verified, contained appropriately tied clinical waste bags.

The Assessment Team evidenced documentation for the collection of clinical waste by a specialist waste company.

Area(s) of Good Practice

Although the Provider generates minimal clinical waste, they is a system in place to safely manage and dispose of hazardous waste material.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Criterion

3.3 The Provider ensures that medications are administered in accordance with the relevant laws and regulation.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider submitted a Medications Management Policy ,which the Assessment Team discussed in detail with Management.

The internal structures and Medical Director oversight of medication use was considered to be particularly robust.

The Provider has a qualified pharmacist as a voluntary member and this person is directly involved in the procurement and general oversight of all medications and in particular controlled drugs.

The Provider's HPRA licence for the use of controlled drugs was verified.

Records containing information on practitioners' privileging and training status for all levels of PHECC registered practitioners were evidenced by the Assessment Team.

Area(s) of Good Practice

The Provider has a robust system in place for the oversight of medications.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Criterion

3.4 The Provider has systems and processes to ensure safe medication practices including, but not limited to, availability, storage, administration, expiration, disposal, and recall alert.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

During PE the Assessor witnessed a sealed medication bag within each BLS bag on both vehicles. The medication bags were found to satisfactorily facilitate either EMT, Practitioner or Advanced Practitioner practice. The Assessor further verified that all medications checked were in date.

Medications are managed directly by a volunteer member who is a qualified pharmacist. The pharmacist is responsible for stocking, sealing medication bags and replenishing all medication stock when required. If medications are utilised on a call, the pharmacist is contacted directly by mobile phone and made aware of which drugs have been used. Once the medication stock is replenished the pharmacist contacts the team using the same mobile platform and advises that all stock has been replaced.

The Provider is licensed by the HPRA to stock controlled drugs. There is a robust process in place to facilitate the requisition, procurement and storage of controlled drugs. Only the pharmacist and Medical Director have direct access to the main safe where controlled drugs are stored.

The Provider ensures the safety of controlled drugs by utilising small mini safes containing specific medication within the main safe. A series of checks are carried out and documented as team members specifically privileged to sign out medications are tasked to transport controlled medications in rescue activations.

The Provider is registered with HPRA for alert communications, medication error, suspected adverse reaction and incident reporting. In discussion, the Provider also reported that they had worked closely with the HPRA to achieve a high standard of safety and risk minimisation with regard to the storage, control and supply of controlled drugs.

Area(s) of Good Practice

The Provider has systems and processes in place to ensure safe medication practices.

Area(s) for Improvement

The Provider would improve safe storage and identification of controlled drugs by labelling the mini safes Number 1 & Number 2.

Standard 3

Criterion

3.5 The Provider ensures that there are systems in place to ensure the availability of medical devices and consumables.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Assessment Team verified that the Provider has a procedure for checking medical equipment and devices and a process for reporting equipment issues.

Volunteers utilise a check list form when completing a pre-shift check on a vehicle. The first vehicle checked by the Assessor is utilised as a control vehicle during rescue activations. Secure digital radio service, VHF and Marine band communication is available, and the vehicle also has a BLS rescue bag and a medication bag for EMT level practitioner on board. The Assessor was satisfied that the BLS bag inspected had service tags and sealed medication bags with medication to support EMT practice.
A second vehicle inspected contained equipment that supports Advanced Paramedic practice. The BLS/ALS bag allocated to this vehicle contained medications relevant to paramedic and AP practice. A range of splints were also available on the vehicle and also a key safe and a mini safe for controlled drugs.
The vehicle allocated for paramedic/AP response utilises an appropriate defibrillator when on operations, which is serviced regularly. The Provider has a contract with an equipment company for servicing of defibrillators and suction units and service logs were verified by the Assessment Team .

The Provider has a pick store, which contains a quantity of equipment for immediate stock replacement. All consumables and replacement equipment are sourced through a number of ambulance equipment companies. Equipment manuals are made available for volunteers through the Provider's online platform.

In discussion with Management, it was stated that as a result of audit and volunteer feedback regarding the logistics of transporting large pieces of kit to every activation/call out – they have implemented a more rationalised approach to conveying their equipment depending on the type of rescue.

Area(s) of Good Practice

The Provider a has good equipment governance system in place.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Criterion

3.6 Employees, volunteers and/or contractors with the relevant competencies receive training on the safe use of the Provider's diagnostic and therapeutic equipment.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Assessment Team were satisfied that the Provider has a robust system in place for training volunteers in the safe use of diagnostic and therapeutic equipment. The Provider has designated trainers who co-ordinate training and familiarisation sessions scheduled across the calendar year.

During PE a practitioner gave the example of recent volunteer training in the rescue management of patients specifically requiring traction splint.

Training is recorded on an online software system specifically designed for emergency response teams.

Area(s) of Good Practice

The Provider ensures volunteers are trained throughout the year to ensure compliance with this criterion.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Criterion

3.7 The Provider has a safeguarding policy to deal with children and vulnerable adults.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Provider has a Safeguarding Policy in place to deal with children and vulnerable adults. A Safeguarding Statement was also submitted with a named executive designated with oversight responsibility.

Volunteers undertake mandatory training which is recorded on the Provider's online platform.

Area(s) of Good Practice

The Provider ensures mandatory training is undertaken by volunteers.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Criterion

3.8 The Provider can demonstrate follow-up and actions taken as a result of audit and monitoring findings.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☑	☐

Assessment Findings

The Assessment Team noted little written evidence of changes made based on the result of audit/monitoring practice. However, in discussion with the Assessment Team, Management gave several examples of how debriefing and feedback from volunteers immediately following an activation has led to improvements in the layout and content of equipment bags and patient /volunteer safety during rescue situations.

The Provider could demonstrate where follow up actions were taken as a result of monitoring situations.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should implement a system of audit, monitoring and follow-up that is specific to their unique role of a volunteer rescue service.

Standard 4

Leadership and Goverance

The Provider is responsibly governed to its defined purpose. A clear understanding of responsibilities and accountabilities lead to role clarity and will support the implementation of appropriate policies. Clinical and corporate governance are distinguished and the leaderships commitment to patient safety is evaluated. Risk management is included as it is a significant part of any governance framework and should include a reporting system. A robust communication policy can mitigate a number of adverse events and both internal and external systems should be in place.

Standard 4

Criterion

4.1 The Provider has a documented structure and accountability for corporate governance.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider submitted an organisational chart detailing lines of accountability for corporate governance within their organisation.

In discussion with the Assessment Team, Management elaborated further on the voluntary nature of the organisation where key roles within the organisation structure are driven by individual expertise such as finance, medical, pre-hospital and mountain rescue.

As the organisation is totally voluntary it relies on fund raising events and charitable donations to finance the running of the service which has approximately one hundred activations per year. The Provider has a website where they post public information about events and they have an active profile on Facebook, Twitter and Instagram.

Area(s) of Good Practice

The Provider has a good governance structure in place.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

4.2 The Provider has a documented structure and accountability for clinical governance.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider has robust structures in place that ensures safe and effective patient care, and has clear lines of clinical accountability.

The Medial Director chairs a medical working group, which comprises of PHECC practitioner and responder level volunteers. Training sessions are held twice a month and are scheduled in the evening to facilitate as many volunteers as possible who may be working during the day. The Provider has a named trainer at AP level and upskilling for EMTs is outsourced to a PHECC Recognised Institution.

Area(s) of Good Practice

The Provider has a clear clinical governance accountability structure in place.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

4.3 The Medical Director shall be registered with the Medical Council on the Specialist or General Register and have the competencies and experience to fulfil this role.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider is in the process of changing their Medical Director. Both Medical Directors are in compliance with the requirements of the PHECC Medical Director Standard (STN032).

The Assessment Team had discussions with both the outgoing and incoming Medical Director and are satisfied that both have the necessary competencies to complete their tole as Medical Director of a voluntary rescue organisation.

The Provider also has three volunteers who are medical practitioners who also have the competencies and experience to fulfil the Medical Director role.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

4.4 Written documents, including policies and procedures are managed in a consistent and uniform way.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☑	☐

Assessment Findings

The Provider did not submit a specific documentation control policy; however, the Assessment Team were satisfied that the Provider has improved their document control system following their GVF Assessment in 2021.

A desktop review of documentation submitted prior to the onsite assessment day, highlighted a number of policies that require amendment, updating and, or, completion. This was communicated to the Provider in the Desktop Observation Report compiled by the Assessment Team. It was noted that the Provider has commenced a review of the Assessment Team's observations.

Area(s) of Good Practice

The Provider has improved the general appearance and control system of their organisation's policy documents.

Area(s) for Improvement

The Provider should develop a document control policy that supports a consistent uniform approach to managing policies and procedures.

Standard 4

Criterion

4.5 The Provider has a system for monitoring and circulating new recommendations issued by PHECC, other regulatory bodies, and public health alerts.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Assessment Team verified that the Provider has a robust system for monitoring and circulating new recommendations issued by PHECC and other relevant agencies.

A process for confirming receipt of information by volunteers was evidenced by the Assessment Team.

Area(s) of Good Practice

The Provider has a system in place that verifies receipt of information by volunteers.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

4.6 The Provider develops a risk management plan that includes a reporting system and a process for identifying potential risks.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☑ Substantively Met ☐ Fully Met

Assessment Findings

The Provider has a comprehensive Risk Management Plan in place. The Provider developed a risk register following their GVF Assessment in 2021.

The Assessment Team were satisfied that the Provider carries out risk assessment for all rescue activations and has procedures for immediate post-call debriefing and incident reporting.

However, related policy documents require branding, updating and review as they are not consistent with other documents submitted by the Provider.

Area(s) of Good Practice

The Provider has a process for identifying potential risks.

Area(s) for Improvement

The Provider should further develop their risk management documents to align with other documents in a uniform way.

Standard 5

Workforce Planning

The intent here is to ensure staff are registered and trained to provide care appropriate to their role. Staff need to be trained on safety issues at the onset of employment and at regular intervals during their employment. Orientation, both organisational and role specific, should be provided to all new staff. Staff learning and professional development needs, specific to pre-hospital emergency care should be identified, documented, and addressed. A health and safety programme is concerned with protecting the wellbeing, health, and safety of people employed by the Provider.

Standard 5

Criterion

5.1 There is a staffing structure developed for the Provider that identifies the number, types, and required qualifications of staff required to provide the service.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Assessment Team were satisfied that the Provider has developed a resilience for callouts as described in Criterion 1.3. In discussion with the Assessment Team, Management stated that volunteer response to a rescue activation is generally not an issue for the organisation. Volunteers will respond by an online chat app to a request from the Callout Officer and as there are over 50 volunteers in the organisation activating a full crew is generally achievable. It was further stated that it would be unusual for the team to receive more than two calls at any one time but that in the event of this happening they would generally be able to respond to that activation also.

In the event of a protracted rescue period lasting overnight or several days the Provider would have a management plan in place to rotate volunteers and also seek the assistance of other mountain rescue teams.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

5.2 The Provider ensures that Practitioners are Licensed by PHECC, Credentialed, and Privileged prior to delivering pre-hospital care.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Assessment Team evidenced a process for privileging PHECC registered practitioners. The Provider maintains records related to CPG upskilling, Garda Vetting, and CFR certification, which were verified by the Assessment Team.

A sample privileging letter co-signed by the Medical Director was also evidenced.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

5.3 The Provider has a process in place to satisfy itself of the Practitioner's English language competency where English is not the Practitioner's first language.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider has an English Language Competence Policy in place.

When enlisting new team members, Interview is conducted by a senior member of the team.
Prospective team members whose first language is not English, if deemed necessary following interview, are required to undertake an English language competency test prior to being accepted by the Provider.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

5.4 The Provider ensures employees volunteers, and/or contractors understand their responsibilities in relation to the safety and quality of services.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

In discussion with the Assessment Team, the Provider reiterated that all personnel working within the Provider's organisation do so on a voluntary basis and that there is a waiting list for new members.

The Provider runs familiarisation evenings to give an overview of the service they provide to prospective members and then bring them on a mountain to familiarise them with this type of terrain. If still interested, the new member is allocated to a senior lead and is mentored through a structured induction programme over the following year.

Emergency First Response training is delivered when there is a significant number of new members and training is delivered by a PHECC Recognised Institution.

The Provider has a Code of Conduct for volunteers in place.

Area(s) of Good Practice

The Provider ensures volunteers have a good understanding of their responsibilities in terms of safety and quality of service.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

5.5 The Provider has an ongoing training and development programme in place to ensure employees, volunteers, and/or contractors have the required competencies to undertake their duties in line with their scope of practice.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider has a Training Infrastructure Policy in place.

The Assessment Team evidenced the Provider's training records, training schedules and event plans. Volunteers who work in statutory organisations at Practitioner and Advanced Practitioner level undertake CPG upskilling in the course of their regular employment and are privileged by the Provider's Medical Director to undertake duties in line with their scope of practice.

EMT training and upskilling is outsourced to a PHECC Recognised Institution and similar privileging arrangements are in place for EMT in line with their scope of practice.

Area(s) of Good Practice

The Provider has good training infrastructures in place to ensure volunteers are competent to undertake their duties in line with their scope of practice.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

5.6 The Provider has appropriate arrangements for the management and supervision of students (if applicable).

Rating

☑ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☐ Fully Met

Assessment Findings

This criterion is not application to the Provider.

Area(s) of Good Practice

Area(s) for Improvement

Standard 5

Criterion

5.7 The Provider has systems in place to promote and protect the wellbeing, health, and safety of employees, volunteers and/or contractors.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider has systems in place that promote and protect the wellbeing, health and safety of its volunteers.

The Provider demonstrated the 'Members Only' section on their website, which allows volunteers to access all policies, procedures and elements related to their practice within the organisation.

During PE, practitioners stated that they were aware of critical incident support available to them. They were also aware that a number of the team had received specialist training in this area and knew how to seek access to CISM if required.

The Provider has external arrangements in place for volunteers to confidentially seek professional support should it be required.

Area(s) of Good Practice

The Provider ensures its volunteers have access to confidential CISM when required.

Area(s) for Improvement

The Provider might consider posting a list of the peer support (CISM) team member details on their Members Only section of their website to allow direct access for volunteers.

Standard 5

Criterion

5.8 The Provider has processes for the performance management of employees, volunteers, and/or contractors.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☑ Moderately Met ☐ Substantively Met ☐ Fully Met

Assessment Findings

The Provider does not have a policy for the performance management of volunteers, however, in discussion with the Assessment Team, the Provider rationalised that due to the nature and remit of activities and its voluntary membership that it would be difficult to put such a policy into action. The Assessment Team were satisfied that there is constant supervision, peer review and feedback occurring at the debriefing sessions immediately following an activation and there are regular training sessions provided where opportunities exist for addressing poor or deficient volunteer performance.

The Provider has a process in place that addresses the PHECC Fitness to Practice system for PHECC registered volunteers.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should develop a formal process for recording and monitoring volunteer performance, this might be established in the form of an electronic template that could be populated immediately post activation at the debriefing sessions.

Standard 5

Criterion

5.9 The Provider creates opportunities for employees, volunteers and/or contractors to feedback on all aspects of the service.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☑	☐	☐

Assessment Findings

While the Provider does not have a formal process for volunteers to feedback on aspects of the service, the Assessment Team evidenced that feedback given by volunteers, and information gathered informally, has led to improvements in the Provider's organisation. An example given was the re-organisation and rationalisation of rescue bags, which has improved the overall logistical response to an activation.

Area(s) of Good Practice

The Provider is committed to seeking quality and safety improvement signals from volunteers.

Area(s) for Improvement

The Provider should develop a formal mechanism for actively seeking feedback from volunteers on quality and safety improvements within its organisation,

Standard 6

Use of Information

The intent here is to ensure that there are information management policies in place to support the Provider providing best practice patient care. All episodes of patient care should be documented, and these records audited to measure compliance.

Standard 6

Criterion

6.1 The Provider ensures appropriate documentation is maintained for all patient care in accordance with the current PHECC Clinical Information Standards.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The PE Assessor verified that PCR are completed for all patients requiring ambulance transport for higher level care. An ACR is utilised to document patient management for patients who are not transported to hospital. These are usually in place when the Provider is covering hill walking events.

Completed forms are placed in a locked box at the base and from there they are collected by the Medical Director and audited for compliance. Following audit, the PCR are stored in a locked filing cabinet in the Provider's depot.

Area(s) of Good Practice

The Provider ensures appropriate documentation is maintained for all patient care.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 6

Criterion

6.2 The Provider ensures confidentiality and security of data is protected.

Rating

☐ Not Applicable ☐ Not Met ☐ Minimally Met ☐ Moderately Met ☐ Substantively Met ☑ Fully Met

Assessment Findings

The Provider has a Data Protection Policy in place and a named executive with oversight responsibilities.

The Assessment Team evidenced best practice in the immediate and long-term security and storage of patient records.

Area(s) of Good Practice

Volunteers and executive directors are fully aware of the best practice principles in data collection and protection.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 6

Criterion

6.3 The Provider has systems in place to measure the quality of healthcare records.

Rating

Not Applicable	Not Met	Minimally Met	Moderately Met	Substantively Met	Fully Met
☐	☐	☐	☐	☐	☑

Assessment Findings

The Provider has systems in place to measure the quality of healthcare records.
The Medical Director outlined his responsibilities in terms of monitoring the quality of healthcare records and the development of quality improvement initiatives as a result of observations.

Volunteers are trained in clinical record keeping and are appraised of their performance in record keeping as part of continuous quality improvement related to healthcare records.

Area(s) of Good Practice

The Provider demonstrated their commitment to continuous quality improvement through monitoring of all healthcare records.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

9. Report Outcome and Rating Summary

The table below reports the scores achieved in each individual standard, and a total score plus the outcome rating in each individual standard.

COMBINED STANDARD SCORE						
Std 1	Std 2	Std 3	Std 4	Std 5	Std 6	TOTAL
31	34	31	22	28	12	158

STANDARD ACCEPTABLE/NOT ACCEPTABLE					
Std 1	Std 2	Std 3	Std 4	Std 5	Std 6
Acceptable	Acceptable	Acceptable	Acceptable	Acceptable	Acceptable

The table below communicates the GVF assessment outcome rating, which is expressed as a percentage, and its associated result expressed on a scale of acceptableness as outlined in Section 7, page 4 of this report.

No of criterion assessed	44
Maximum score available	176
63% of Max =	111
Assessment Results	
Total score achieved	158
Total score as percentage	90%
Assessment Outcome Rating	**Acceptable**

In accordance with the GVF Rating System and the assessment outcome, this GVF site-assessment does not trigger a formal requirement for PHECC to issue an improvement notice or attach conditions, and Council recognition of Dublin Wicklow Mountain Rescue Team in accordance with Council Policy for Recognition to Implement Clinical Practice Guidelines (POL003) is unaffected.

Dublin Wicklow Mountain Rescue Team should continue to develop their Quality Assurance (QA) systems and are required to develop and submit a Quality Improvement Plan (QIP) to gvf@phecc.ie. The QIP will address any areas highlighted in the 'Area(s) for Improvement' within this report. The QIP will identify and outline improvements to be actioned or planned at Dublin Wicklow Mountain Rescue Team in the upcoming licensing period.

Dublin Wicklow Mountain Rescue Team

Pre-Hospital Emergency Care Council

Assessment Outcome Rating

Acceptable

Standard 1: Person-Centred Care and Support

Statement – The intent here is to ensure the Provider has a patient-centred focus by providing services that protect the rights of patients, including empowering them to make informed decisions about the services they receive. The views of patients should be sought and analysed. Sources of this information include complaints, compliments, and patient feedback surveys. The feedback system needs to be transparent, and the information should be used to make improvements. Patients should be provided with instructions that are clear and relevant to their special needs and ethnicity.

	Criteria	Rating Score
1.1	Patients have access to pre-hospital emergency care based on their identified needs and the Provider's scope of services.	4
1.2	Access to pre-hospital emergency care is not affected by discrimination.	4
1.3	The Provider ensures information from calls / activation is recorded accurately and dispatched according to priority.	4
1.4	The Provider develops and implements a process to ensure best practice for patient identification.	3
1.5	The Provider has a policy for informed consent.	3
1.6	The Provider has a policy in place in relation to the patient's refusal of treatment and/or transport.	4
1.7	The Provider ensures all patients are treated with compassion, respect, and dignity.	4
1.8	The Provider seeks feedback from patients and carers to improve services.	1
1.9	Patients' complaints and concerns are responded to within an agreed timeframe and openly with clear support provided throughout this process.	4

Standard 2: Effective Integrated Care and Safe Environment

Statement – The intent here is to evaluate if the Provider's environment supports safe services. Fire safety, security, and planned preventative maintenance programmes are some of the topics covered. Safe clinical care is evaluated including identifying high risk patients. Pre-hospital emergency care Providers have a crucial part to play in major incident planning and testing.

	Criteria	Rating Score
2.1	The Provider has systems in place to ensure Practitioners utilise the PHECC CPG (Clinical Practice Guidelines) appropriate to their scope of practice.	4
2.2	The Provider has a standardised handover process in place to ensure the safe, timely, and structured exchange of information during handover of patients.	2
2.3	The Provider has a system in place to ensure the safety of their vehicles in line with legislation.	4
2.4	Training is provided for staff to transport patients safely, including during emergency situations.	4
2.5	The Provider has a policy on the use of emergency lights and sirens.	4
2.6	The Provider has a fire safety plan for any physical environments owned or used by their organisation.	4
2.7	The Provider ensures there is a business continuity plan for their organisation.	4
2.8	The Provider ensures plans are in place to deal with major incidents.	3
2.9	The Provider has a 3-year programme of clinical and environmental audits in line with the services provided.	1
2.10	The Provider submits a CPG Service Provider Annual Report,* which informs PHECC of clinical and other activities in their organisation. (*Calendar year).	4

Standard 3: Safe Care and Support		
Statement – The intent here is to evaluate risk management and reporting systems. Other safety issues are measured: Infection prevention and control (IPC), waste management, safeguarding, and medication management are patient safety issues that require specific attention in this standard. The sudden outbreak of transmissible diseases means practices have to rapidly adapt existing emergency plans to manage services and reduce the transmission of infection. Utilising PHECC CPGs provide important sources of best practice.		
Criteria		**Rating Score**
3.1	The Provider describes in a plan or policy the content of the infection prevention and control programme.	4
3.2	The Provider segregates and manages waste according to hazard level and disposes of same, according to best practice.	4
3.3	The Provider ensures that medications are administered in accordance with the relevant laws and regulation.	4
3.4	The Provider has systems and processes to ensure safe medication practices including, but not limited to, availability, storage, administration, expiration, disposal and recall alert.	4
3.5	The Provider ensures that there are systems in place to ensure the availability of medical devices and consumables.	4
3.6	Employees, volunteers and/or contractors with the relevant competencies receive training on the safe use of the Provider's diagnostic and therapeutic equipment.	4
3.7	The Provider has a safeguarding policy to deal with children and vulnerable adults.	4
3.8	The Provider can demonstrate follow-up and actions taken as a result of audit and monitoring findings.	3
Standard 4: Leadership and Governance		
Statement – The Provider is responsibly governed to its defined purpose. A clear understanding of responsibilities and accountabilities lead to role clarity and will support the implementation of appropriate policies. Clinical and corporate governance are distinguished and the leaderships commitment to patient safety is evaluated. Risk management is included as it is a significant part of any governance framework and should include a reporting system. A robust communication policy can mitigate a number of adverse events and both internal and external systems should be in place.		
Criteria		**Rating Score**
4.1	The Provider has a documented structure and accountability for corporate governance.	4
4.2	The Provider has a documented structure and accountability for clinical governance.	4
4.3	The Provider has a Medical Director, who is registered with the Medical Council, with general or specialist registration who provides oversight and support for Clinical Governance.	4
4.4	Written documents, including policies and procedures are managed in a consistent and uniform way.	3
4.5	The Provider has a system for monitoring and circulating new recommendations issued by PHECC, other regulatory bodies, and public health alerts.	4
4.6	The Provider develops a risk management plan that includes a reporting system and a process for identifying potential risks.	3

Standard 5: Workforce Planning		
Statement – The intent here is to ensure staff are registered and trained to provide care appropriate to their role. Staff need to be trained on safety issues at the onset of employment and at regular intervals during their employment. Orientation, both organisational and role specific, should be provided to all new staff. Staff learning and professional development needs, specific to pre-hospital emergency care should be identified, documented, and addressed. A health and safety programme is concerned with protecting the wellbeing, health, and safety of people employed by the Provider.		
Criteria		**Rating Score**
5.1	There is a staffing structure developed for the Provider that identifies the number, types, and required qualifications of staff required to provide the service.	4
5.2	The Provider ensures that Practitioners are Licensed by PHECC, Credentialed, and Privileged prior to delivering pre-hospital care.	4
5.3	The Provider has a process in place to satisfy itself of the Practitioner's English language competency where English is not the Practitioner's first language.	4
5.4	The Provider ensures employees volunteers, and/or contractors understand their responsibilities in relation to the safety and quality of services.	4
5.5	The Provider has an ongoing training and development programme in place to ensure employees, volunteers, and/or contractors have the required competencies to undertake their duties in line with their scope of practice.	4
5.6	The Provider has appropriate arrangements for the management and supervision of students (if applicable).	N/A
5.7	The Provider has systems in place to promote and protect the wellbeing, health, and safety of employees, volunteers and/or contractors.	4
5.8	The Provider has processes for the performance management of employees, volunteers, and/or contractors.	2
5.9	The Provider creates opportunities for employees, volunteers and/or contractors to feedback on all aspects of the service.	2
Standard 6: Use of Information		
Statement – The intent here is to ensure that there are information management policies in place to support the Provider providing best practice patient care. All episodes of patient care should be documented, and these records audited to measure compliance.		
Criteria		**Rating Score**
6.1	The Provider ensures appropriate documentation is maintained for all patient care in accordance with the current PHECC Clinical Information Standards.	4
6.2	The Provider ensures confidentiality and security of data is protected.	4
6.3	The Provider has systems in place to measure the quality of healthcare records.	4

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