Pre-Hospital Emergency Care Council

Governance Validation Framework

Assessment Report

Dublin Airport Authority

September 2023

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 (CPGs) 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.

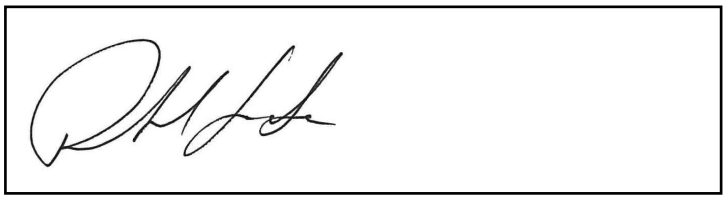
The GVF and the QRF relate to specific standards and identify the supporting components that PHECC recognised CPG service providers and approved organisations should have in place to ensure good governance and quality in delivery of education, pre-training, and operational hospital emergency care with 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 Airport Authority, a PHECC Recognised CPG Service Provider, licensed to deliver pre-hospital emergency care services in Ireland since 2009. Dublin Airport Authority are 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 Fire Station, Dublin International Airport. ☑ Practitioner Engagement Fire Station, Dublin International Airport.
Outcome Rating **Technical Weighting Applied** **Yes** ☐ **No** ☑	No of criterion assessed: 45 Maximum score available: 180 63% of Max = 113 **Assessment Results** Total score achieved: 140 Total score as percentage: 78% **Assessment Outcome Rating: Moderately Acceptable**
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**	 15/01/2024

3. Assessment Participants

Organisation	PHECC Assessment Team
Medical Services Manager Medical Director (Medical Council Reg No 409301)	Team Lead
EMS Support Officer	Onsite Assessor
Advanced Paramedic x 1	Practitioner Engagement Assessor
Paramedic x 1	

4. Initial Feedback Given

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

The following areas were identified as areas requiring improvement, or further potential for improvement areas: audit programme, training and development plan, clinical governance, ambulance policy manual, clinical waste management, and administrative support.

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 has adequate clinical response levels for anticipated workload within the international airport grounds. Emergency Medical Technician, Paramedic and Advanced Paramedic cover can be provided. Practitioners are primarily employed as firefighters and can then choose to train to various PHECC recognised practitioner clinical levels. Ambulance cover is provided with varying clinical levels of practitioners on board, and practitioners can transport patients to appropriate emergency departments where relations with the local receiving hospital appear strong.

Fire crew appliances take priority within the service activities of the Provider with crews withdrawn from the ambulance to cover the fire appliances if there are staffing shortages on any given shift. These practitioners can continue to provide pre-hospital care while responding in a fire appliance and a car with practitioners can be made available to attend incidents should the ambulance not have sufficient crew.

Area(s) of Good Practice

The Provider was noted to have the appropriate skill level to match the service they provide with ongoing training to practitioner level for their firefighter crews.

Area(s) for Improvement

The Provider should review required staffing levels to improve public safety by avoiding the withdrawal of the ambulance service should the fire fighter team be short staffed.

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

Practitioners were observed to be polite, communicative, and professional with service users and patients including those whose first language was not English. Prehospital care was delivered in a professional and empathetic manner to patients from other countries, which is commonplace given the population they serve in the international airport setting in Dublin.
The assessment team were unable to verify that translation services were available when required.

Practitioners discussed the importance of patient dignity and advised the assessment team that they had received training in patient dignity and non-discriminatory practice within the Provider's induction programme.

Area(s) of Good Practice

Observations during Practitioner Engagement, and at the onsite assessment, indicate a non-discriminatory approach by the Provider.

Area(s) for Improvement

No specific observations 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

Call activation is via a loudspeaker and radio dispatch system with details passed to the crew via a Watch Officer within the Fire Station control tower. This process was observed by the Assessment Team.
Call details originate from various sources within the airport and as such details of patients can be unreliable as they often pass from one source to another before arriving at the Fire Station. The Watch Officer has a proforma available to them to assist with the gathering of information and has received training on call taking.

There is a standardised system of collecting basic patient/incident data such as chief complaint and location. The information is recorded in a logbook and passed on to responding practitioners via loudspeaker or ambulance radio. The crew recently visited the control room to determine potential improvements for their service.

Incidents on in-flight services may lead to a call for assistance to be available upon landing and this may come in well in advance of landing. Due to the limitations surrounding there being only one ambulance on site, these calls may be transferred to one of the statutory services, to ensure the ambulance and crew remain available to other incidents within the airport complex.

Area(s) of Good Practice

The Provider has training for call takers and procedures were observed to be adequate, with recognition of the difficulties in gleaning information from third parties and proactive attempts from the Provider to improve this.

Area(s) for Improvement

The Provider should continue to review call taking procedures and make improvements on the accuracy of information conveyed as appropriate.

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

Observations on the engagement and review of the Provider's policy document indicates robust practices for patient identification. Many patients requiring care are travelling so have their passport with them, assisting this process.

Area(s) of Good Practice

The Assessment Team found the identification of patients to be satisfactory.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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

There is a comprehensive policy relating to consent within the Ambulance Policy Manual.

The Assessment Team verified good practice in obtaining informed consent as observed during Practitioner Engagement.

Area(s) of Good Practice

Practitioners are aware of and complete informed consent with all patients as per the Provider's informed consent policy.

Area(s) for Improvement

The Provider would benefit from refining their informed consent policy into a more operational document for ease of reference among practitioners, alongside the definitions and detail regarding informed consent.

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 includes detail on refusal to treat or transport within its informed consent policy.

Observations during Practitioner Engagement in relation to refusal to treat or transport identified practitioners able to describe and demonstrate with patient contact the process regarding refusal of transport. This is a common issue given the nature of the patients treated and practitioners were adept at making thorough notes regarding this area.

Area(s) of Good Practice

Knowledgeable staff who were aware of and implemented refusal to treat or transport procedures with a high degree of skill.

Area(s) for Improvement

The Provider's practitioners would benefit from having a refined operational document relating to refusal to treat, or transport.

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

During the Practitioner Engagement, practitioners were observed dealing with patients in an empathetic, respectful, and professional manner under often stressful circumstances. The professional communication and working relationships between practitioners and other airport staff was also observed.

This theme continued at the onsite assessment where the management team were also found to consider this area a priority. At staff induction, there is a section whereby all staff are expected to maintain standards in this area, across all customer service.

Area(s) of Good Practice

Observed practices indicate a high level of importance placed on the area of compassion, respect, and dignity throughout the Provider's organisation.

Area(s) for Improvement

No specific observations 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 Assessment Team verified that feedback mechanisms for patients were available within the ambulance. Signage is displayed on the ambulance interior and feedback links on the airport website are available.

Examples of service user positive feedback were provided to the Assessment Team. The Provider stated they have not received any service user complaints and considered potential barriers to this to include brief patient contacts and language barriers.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

The Provider may wish to provide ambulance service specific feedback links on the main airport website. This may be helpful in shaping future audits and training needs. The Provider should also ensure practitioners are trained in actively seeking 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 comprehensive complaints management policy, including a designated person, investigation procedure and timeframes for responses.

The senior management team were able to describe one historic complaint about non availability of an ambulance due to capacity issues, other than this, there were no other recorded complaints and practitioners were not aware of any complaints.

Practitioners are trained on the complaints policy.

Area(s) of Good Practice

A complaints policy is in place.

Area(s) for Improvement

Ongoing training of staff regarding the handling of complaints is necessary alongside a more user-friendly compact complaints policy that practitioners could easily follow, for example as an algorithm or flow-chart.

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

Practitioners demonstrated good knowledge of current PHECC guidelines and were observed practising using the appropriate guidelines during patient contact.
Practitioners showed a willingness to develop knowledge and skills and partake in training opportunities when offered.

The newly appointed Medical Director has a good knowledge of the requirements of the role in relation to development of governance, audit, and ongoing education.

Practitioners have had little interaction with the Medical Director to date, however, there have been informal education and training sessions with emergency care doctors in the recent past.

Area(s) of Good Practice

Observed practitioners were deemed to be providing a high level of patient care and in line with PHECC CPG.

Area(s) for Improvement

See comments in Standard 5 in relation to a current deficit in practitioner CPG upskilling and the need for a structured training and development plan in conjunction with the newly appointed Medical Director.

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 Assessment Team verified use of appropriate handover tools for patients. Further evidence exists that patient handover processes have evolved over the years, and are , according to the newly appointed Medical Director who has experience in the A&E setting of the receiving hospital, of excellent standard, with good communication between the Provider's practitioners and Emergency Department staff.

Area(s) of Good Practice

The handover process is of a high standard.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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 Provider uses its own vehicle maintenance facilities to service and maintain ambulances. This appears to be an appropriate and efficient arrangement. Vehicle service records were viewed and verified by the Assessment Team.

The Provider has one active ambulance and one fully kitted spare ambulance if required. Ambulance vehicles were CVRT certified and have a standard layout. The operational ambulance on duty appeared to be fully stocked, clean and fully serviceable.

Vehicle checks are undertaken prior to commencement of each shift, on a pre-populated proforma on a tablet device. A vehicle wash bay and cleaning cupboard was readily available for external and internal vehicle cleaning. The Assessment Team verified suitable cleaning and disinfectant contents of the ambulance cleaning cupboard in station.

Area(s) of Good Practice

The Assessment Team found the two ambulances on site to be compliant with legislation and in serviceable condition.

Area(s) for Improvement

No specific observations 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 access to four Road Safety Authority qualified driving instructors employed to deliver emergency driver training to practitioners when required. All practitioners are also trained to drive the fire appliances.

Area(s) of Good Practice

The Provider ensures appropriate training for safe transport for patients.

Area(s) for Improvement

No specific observations 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

Practitioners confirmed that they were trained in emergency response driving. There are documented procedures for driving in emergency conditions in the Provider's policy document.

Area(s) of Good Practice

Appropriate policies and training are in place for the use of emergency lights and sirens.

Area(s) for Improvement

No specific observations 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 Assessment Team were able to verify a site-specific fire safety plan and procedure for employees and visitors to the Fire Station.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

No specific observations 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

There appears to be strong links between the Provider's CPG service delivery department and senior management with frequent communication at managerial level. It is clear that the management maintain responsibility for maintaining the division's budget, and decision-making in relation to the business continuity of the ambulance service.

The Provider displays resilience in the provision of continuous cover despite limitations on staffing. With the priority being the provision of the fire service, crews can be diverted from the ambulance to the fire appliance when staff shortages occur, however, these practitioners will continue to provide medical care when appropriate and a car can be used to allow medical practitioners attend medical incidents should the ambulance not be fully crewed, ensuring a high level of service is provided, despite their limitations.

Area(s) of Good Practice

The provider has shown initiative and commitment to the provision of pre-hospital care.

Area(s) for Improvement

The Provider shall ensure that CPG service provision is appropriately funded and resourced, in the interests of continuing the high level of care they are currently providing with limited resources.

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

In line with the potential risks associated with an airport site, regular training takes place in relation to major incident planning. A multi-agency approach is taken, and a practical training session, in which the Provider will play a pivitol role, was scheduled to take place soon after the assessment date.

Area(s) of Good Practice

As expected, given the nature of the site serviced by the Provider, major incident planning is a priority, and this was evidenced.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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 recognises that attention to audit has been poorly constructed in recent years. Audits have been infrequent and ad hoc to date, with the only notable audit being that of Patient Care Records (PCR).
During assessment, discussions with management centered around the commencement of a new Medical Director, who was also in attendance, and will be tasked with development of an audit programme. Knowledge of the importance of audit and the need for both clinical and environmental audits, dictated by the needs of the organisation were evident within the management team and by the Medical Director.

Resources within the organisation were highlighted as a potential limiting factor, with thoughts around designating audits to practitioners to assist with the workload.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider shall initiate a cyclical audit programme involving the newly appointed Medical Director and utilise a clinical governance system to ensure continuity of good practice and identification of risk.
The Provider will need to consider the time required to conduct audits and disseminate their findings, alongside training and development and clinical governance. With a small managerial team, thought should be given to allocating time and a designated role to ensure audit, training and development, and governance are given adequate resources to succeed. See Standard 4 and 5 for further comment.

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 was unable to provide a completed Annual Medical Director's Report for 2022. Acknowledgment is made of the transition period between Medical Directors and the somewhat lengthy process of securing a new Medical Director, which has led to this omission. The new Medical Director has committed to providing the new format Annual Report going forward.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

The Provider shall ensure to submit an Annual Report in line with PHECC requirements every calendar year.

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 Provider has an extensive infection prevention control (IPC) policy and procedures document within the Ambulance Policy Manual, which appears to be relatively new (August 2023). The IPC policy is quite extensive and not user-friendly, despite being comprehensive.

Observations during Practitioner Engagement were positive, with good hand hygiene witnessed along with availability of cleaning and IPC equipment. Ambulances are cleaned before every shift and in between as necessary.
There was no evidence available regarding IPC audits within the organisation.

Area(s) of Good Practice

The Assessment Team observed good IPC in practice, supported by a comprehensive policy document.

Area(s) for Improvement

The Provider should refine the IPC policy and procedure document. While the educational components are important, they are not easy to navigate during busy shifts. Dividing the document into an educational component alongside a user-friendly operational document would be of help, utilising stepwise flow-charts and algorithms for ease of reference on the ambulance.

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

The Assessment Team, both at Practitioner Engagement and at the onsite assessment, verified waste segregation occurs within the organisation, however there are IPC segregation and storage systems that are non-standard and non-compliant with the Provider's IPC section in the Ambulance Policy Manual. Senior managers were advised of these incidences as being a risk and non-compliant with clinical waste management and the Ambulance Policy Manual.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

The Provider shall put in place measures to ensure appropriate clinical waste disposal and traceability of waste.
The Provider shall initiate an education and information programme for practitioners on appropriate waste disposal procedures, which is in line with current healthcare practice and the Ambulance Policy Manual.

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 has safe systems of operation that ensures registered practitioners can administer medicines within their scope of practice. Practitioners within the organisation were observed to be aware of their individual scope of practice regarding medication administration.
Garda certificates in relation to safes for controlled medications were reviewed by the Assessment Team, as was a recently renewed HPRA certificate.

Area(s) of Good Practice

The Provider and its practitioners engage in good practices ensuring medications are administered in accordance with laws and regulations.

Area(s) for Improvement

No specific observations 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

A controlled medication policy was evidenced and the Assessment Team verified appropriate medication storage, transport and security measures within the Fire Station and ambulance. Daily checks of medication bags occur using a proforma on the tablet at the start of every shift, ensuring adequate supplies and in-date medication.

The Provider appears to have robust security for medications management, which includes a camera monitoring system, swipe card access to the medications room, medicines logbooks, restricted access to safe containing Advanced Paramedic medications.

Advanced Paramedics oversee stock control and order appropriately. Arrangements are in place with their local pharmacy in relation to disposal of medications.

Medicines recall alerts and other relevant information are disseminated to practitioners on a daily basis verbally via the daily shift briefing system, alongside email and a noticeboard.

Area(s) of Good Practice

The Provider has robust measures in place for medication management across all aspects of medication medicine and are commended on the security systems around medication storage.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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 Provider has adequate storage facilities within the Fire Station for ambulance consumables and a contracted medical provision supplier for consumable items and medical equipment. Equipment checks are undertaken alongside vehicle and medication checks at commencement of each shift and these records were evidenced by the Assessment Team.
Identification of faults or missing equipment is reported to the line manager at each shift who will replace equipment and consumables from storage supplies. The Provider also has the advantage of having a back-up ambulance on site and on occasion may temporarily use a piece of equipment from this ambulance while waiting on repair or replacement of a faulty item.

Area(s) of Good Practice

The Provider has robust systems in place for ensuring checking and availability of medical devices and consumables, with the back-up ambulance ensuring immediate availability of spare vehicles and equipment if required.

Area(s) for Improvement

No specific observations 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 introduction of new equipment is due to be overseen by the newly appointed Medical Director, who stated they will be involved in investigating what new equipment may be necessary, how it should be used and ensuring adequate training, with involvement of Advanced Paramedics in training where appropriate.

The Provider advised that training records for all new equipment will be kept. There was no evidence available for how training occurred to date, however the management team and practitioners were satisfied that, although informal, there were measures in place to ensure practitioners were trained appropriately on new equipment.

Area(s) of Good Practice

The Provider is commended for ensuring this role now sits under the Medical Director and appear to have a concise plan in place to ensure ongoing education and training.

Area(s) for Improvement

The Provider shall put in place plans for formal training and recording on the safe use of new equipment.

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.

During Practitioner Engagement, practitioners confirmed they have been TUSLA trained, and in discussion appeared to be knowledgeable on good safeguarding practice for adults and children.

TUSLA training certificates and Garda Vetting certificates were made available to the Assessment Team for inspection, and were evidenced as being up to date.

Area(s) of Good Practice

The Provider has adequate policies in place.

Area(s) for Improvement

No specific observations 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

There is a comprehensive clinical adverse incident policy within the Ambulance Policy Manual.

The Assessment Team discussed processes regarding incident/near miss reporting procedures and concede this has been ad hoc in recent times. It appears there is good communication between practitioners and line managers with exchange of information occurring regularly, however, there does not appear to be any formal method of monitoring findings or disseminating outcomes.

There does not appear to be a robust system in place for audit cycles and follow up action plans. The management team along with the newly appointed Medical Director outlined the process going forward, where investigation and management of adverse incidents/near misses would be formalised and documented, with these outcomes feeding into audit topics and additions to the risk register where appropriate.

Area(s) of Good Practice

Good communication exists between team members.

Area(s) for Improvement

The Provider shall formalise the process for training and investigation of adverse incidents or near misses, ensuring these findings feed into the audit cycle and outcomes are disseminated to all practitioners.

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 Assessment Team evidenced clear structures within the Provider's organisation, with the ambulance service sitting within the fire service, ensuring clear lines of accountability.

The Provider has a rank structure within the service with the Chief Fire Officer assuming overall management. The Chief Fire Officer liaises on a regular basis with senior managers including the Medical Services Manager and EMS Support Officer.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

No specific observations 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

Discussions with the management team in the area of clinical governance leaned towards their plans going forward following the recent appointment of their new Medical Director. Recognition was made that prior to this, their clinical governance was less than optimal with limited involvement from their Medical Director.

The Provider now has a structured accountability process within the organisation with responsibility for overall clinical governance assumed by the Medical Director and supported by the Medical Services Manager and EMS Support Officer.

Plans for quarterly meetings of the clinical governance team were discussed with a recognition that this is a time of change with numerous items to be addressed on their agenda in the immediate future.

Area(s) of Good Practice

The Assessment Team recognises that this is a time of change within the organisation and commend the team for putting in place a new clinical governance structure with the commencement of the new Medical Director.

Area(s) for Improvement

The Provider shall develop clinical governance procedures, hold quarterly meetings to develop and implement an agenda of items to be addressed. Where necessary new policies to establish a clinical governance structure and systems within the organisation should be developed as a matter of priority.

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 has recently appointed a Medical Director with suitable experience and qualifications, working in an Emergency Department and with an historical link to the Provider. The Medical Director has already been involved in training projects with the Provider following identification of needs, based on their experience with the Provider.

The Medical Director's role and responsibilities are described within the Ambulance Manual Policy.

Area(s) of Good Practice

The Provider has recently employed a Medical Director who has the adequate skill set to fulfil the role and demonstrates enthusiasm and knowledge of how to develop clinical governance and ongoing education within the organisation.

Area(s) for Improvement

The Provider should review the PHECC standard for the Medical Director (STN032) and align the roles and responsibilities of the Medical Director laid down within the Ambulance Policy Manual with the standard.

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 Assessment Team reviewed the Provider's Ambulance Policy Manual, which contains most of the organisation's policies and procedures.

Individually these policies are comprehensive with adequate level of detail. However, the document can be difficult to follow as it relies on the index, and it can be time consuming to find the document you are searching for. For certain policies, the operational aspect is absorbed into the educational component, making it difficult to follow for practitioners on the ground.

Area(s) of Good Practice

The Provider has a comprehensive Ambulance Policy Manual where relevant policies and procedures are stored.

Area(s) for Improvement

The Provider should consider separating policies out into stand-alone documents for ease of reference. For some policies, already highlighted in this review, separating the educational component from the operational component would make these policies more user-friendly and impactful.

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 were advised by practitioners and the management team that alerts and updates were generally provided verbally in the daily briefing that occurs at the start of each shift with updates being repeated for one week to ensure everyone is reached. Email is also used along with a notice board. There appears to be no common practice of confirming information receipt.

Area(s) of Good Practice

The daily briefings appear to provide a regular opportunity for verbal dissemination of updates and alerts from regulatory bodies.

Area(s) for Improvement

The Provider should ensure email is used in addition to verbal announcements and that read receipts on emails are utilised.

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

A Risk Management Policy was reviewed by the Assessment Team and an informative conversation took place with the Medical Director. The Medical Director was knowledgeable in this area with plans for development of the Risk Register, which will be a dynamic document whereby updates can be added, processed, reviewed and progress tracked. This will include inclusion on the register of any serious adverse incidents or near misses based on real life scenarios.

Area(s) of Good Practice

The Provider has a policy for risk management within the organisation.

Area(s) for Improvement

The Provider shall develop and maintain a risk register

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

All PHECC registered practitioners within the organisation are employed by the Provider as Firefighters in the first instance. Firefighters may then apply for Paramedic and Advanced Paramedic training courses when the opportunity arises. There appears to be a fair system in place for identifying and selecting those suitable for training, with career progression pathways available.
The Provider has undertaken two recruitment drives in the last two years as a means of succession planning and they report high retention rates among practitioners.

The Provider reports practitioners are enthusiastic about career progression to more advanced practitioner level. As discussed under Standard 2.1, there are occurrences when the ambulance cannot be fully staffed with the fire service being the priority.

Area(s) of Good Practice

The Provider has a solid staffing structure with recent recruitment drives and career progression opportunities.

Area(s) for Improvement

Given the situation that may arise whereby practitioners are removed from the ambulance to prioritise the firefighting service, the Provider should ensure the numbers of staff and skillset of staff required for the ambulance service is not scaled down when there are staff shortages. It is apparent that there is a willingness among staff to partake in practitioner training if more opportunities were available.

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 viewed staff records pertaining to PHECC registration. Discussions with the Medical Director confirmed he would be performing the duty of signing privileging letters to all practitioners this year.

Of note, a number of practitioners are awaiting upskilling to 2021 PHECC CPG. The management team explained a difficulty had arisen with the arrangement with their usual provider of upskilling training and advised they had moved to another provider in order to complete upskilling. The remaining practitioner upskilling should be complete by year end.
The Provider also advised they would be reviewing the current arrangement in place with these training partners.

Area(s) of Good Practice

The Provider maintains records of PHECC registration and privileging status of all practitioners.

Area(s) for Improvement

The Provider shall complete upskilling of their practitioners as a priority. They must also formalise arrangements going forward for subsequent upskilling arrangements.

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 Policy in place and a system of verification in place during the recruitment phase.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

No specific observations 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

Staff induction is conducted by the Provider. The Provider's induction involves HR involvement from the corporate perspective as a service provider with a Provider Staff Handbook. There is a bespoke induction programme for the ambulance service and includes a shadowing process and introduction to the Ambulance Policy Manual. Practitioners within the organisation appeared to have an excellent understanding of their role and responsibilities.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

No specific observations 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 management team acknowledges that training and development has been undertaken in an ad hoc capacity without being appropriately linked to identified training needs. Earlier in this report, the outstanding issue of CPG upskilling of practitioners, and the need to develop an audit programme, has been identified. The Provider did however give examples of continuous training linked to another CPG Service Provider, whereby paramedics receive training and attend placements for learning opportunities. Training records were also viewed for practitioners with clear records of any training courses undertaken by that practitioner.

Training has also been provided in the recent past by the Medical Director, before being in the Medical Director role, through links with the Emergency Department at the receiving hospital. Many of these opportunities were identified based on needs, and have included handover processes, and stroke care.
The management team, alongside the Medical Director, have plans for a coordinated training and development programme based on identified needs, case based, and CPG. There are plans for external teachers provided by the receiving hospital and strengthening links to their external training partner.

Area(s) of Good Practice

The Provider has successfully utilised training and development opportunities where possible by using external resources.

Area(s) for Improvement

The Provider must continue with plans, under the direction of the Medical Director, to formalise training and development for all practitioners based on identified training needs.

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

The Provider facilitates students on ambulance placements and have a documented Ambulance Observer policy.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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

This Provider have a comprehensive staff Health and Safety statement and policy. The Assessment Team viewed relevant hazard and reporting forms.
The Provider has an Occupational Health Department with staff well-being initiatives being driven by Human Resources. An Employee Assistance programme is available.

A Critical Incident Stress Management (CISM) policy exists and is shared with practitioners trained and designated to this programme, with signage displayed on how to access CISM if required. Practitioners report a positive engagement with this service and management report debriefs occur on a regular basis.

Practitioners within the organisation are encouraged to report variation in poor practice, adverse incidents and near misses. The Assessment Team were advised that feedback on outcomes of such reporting was provided verbally.
The Provider felt overall that they have a compassionate staff, astute to practitioner's feelings and needs.

Area(s) of Good Practice

A comprehensive staff support system is in place.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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 has a documented policy on Fitness to Practice and evidence exists that middle and senior managers are appropriately trained to investigate complaints and queries. Management reports an open-door policy with most issues being dealt with in-house in a supportive environment. They did however speak about escalation to the Medical Director and the Regulator where necessary for clinical concerns.

Operational aspects are escalated to the Chief Fire Officer and the Provider's HR partner if necessary.
There were no examples of fitness to practice cases available for the Assessment Team to review.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

Whilst it appears that there is a verbal review of any incidents, the Provider should ensure adequate recording of any performance management issue going forward to support the verbal discussions and for clarity for all involved.

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

The Provider has adopted a no blame culture within the organisation and documentation to support this was evidenced by the Assessment Team. Practitioners report they feel comfortable to express concerns or suggestions to managers anytime, confirming the positive open-door culture within the organisation.

The Assessment Team reviewed quarterly staff feedback questionnaires, on which a practitioner can remain anonymous if they wish. There are several key questions and then a comments box. Of the forms reviewed, the most common comment was of practitioners asking for more training opportunities.

Area(s) of Good Practice

The Provider has generated an open-door policy, which is evident throughout the organisation.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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 Practitioners within the organisation use standard PHECC hard copy Patient Care Reports (PCR). The Assessment Team verified appropriate use of PCR on a patient interaction and subsequent refusal to travel.

The Provider may look towards digital options for completion of PCR as more CPG Service Providers move away from paper-based records.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

No specific observations 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

PCR were verified as being kept in a cupboard within the ambulance before being placed in a locked box at the end of shift. All PCR are then compiled, and serial numbers recorded on a database before further long-term storage in a locked metal cupboard in a designated office.

Senior Managers are aware of time limits on PCR storage and advised that so far, no PCR are at the maximum storage time limit.

The Provider gave examples of requests for PCR records, which are generally legal or insurance related requests. These requests are handled via the Provider's Data Protection Officer, trained in confidentiality and the specifics regarding handling patient data.

Area(s) of Good Practice

The Provider utilises expertise available to them through their Data Protection Officer.

Area(s) for Improvement

No specific observations 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

PCR audits are conducted infrequently and feedback to practitioners is verbal in nature. There appears to be no cyclical PCR or record keeping audit practice. There is a risk within the organisation that poor clinical practice may not be identified.

The necessity and importance of patient care record audit and feedback was discussed by the Assessment Team, senior managers and the Medical Director. Both the Medical Director and senior managers are aware of the current lack of audit and feedback process and are keen to establish a robust system. Within the organisation, there appears to be minimal time or resources available to managers to adequately conduct a robust PCR audit system. The Assessment Team agreed with the management team that additional resources would assist in establishing robust audit and governance systems that highlight existing or emerging clinical and operational risks to patients, service users and the organisation.

As noted above, audit, governance, and training and development require adequate resources to support the clinical practitioners within this organisation.

Area(s) of Good Practice

No specific observations noted by the Assessment Team.

Area(s) for Improvement

The Provider shall establish a system of clinical audit and feedback for PCR generated by practitioners that is appropriate for the case mix encountered by them.

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
32	29	24	16	30	9	140

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	45
Maximum score available	180
63% of Max =	113
Assessment Results	
Total score achieved	140
Total score as percentage	78%
Assessment Outcome Rating	**Moderately 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 Airport Authority in accordance with Council Policy for Recognition to Implement Clinical Practice Guidelines (POL003) is unaffected.

Dublin Airport Authority 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 Airport Authority in the upcoming licensing period.

Dublin Airport Authority

Assessment Outcome Rating

Moderately 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.	3
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.	3
1.4	The Provider develops and implements a process to ensure best practice for patient identification.	4
1.5	The Provider has a policy for informed consent.	4
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.	3
1.9	Patients' complaints and concerns are responded to within an agreed timeframe and openly with clear support provided throughout this process.	3

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.	2
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.	4
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.	2
2.8	The Provider ensures plans are in place to deal with major incidents.	4
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).	0

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.	3
3.2	The Provider segregates and manages waste according to hazard level and disposes of same, according to best practice.	2
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.	2
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.	1
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.	1
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.	3
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.	3
4.6	The Provider develops a risk management plan that includes a reporting system and a process for identifying potential risks.	2

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.	3
5.2	The Provider ensures that Practitioners are Licensed by PHECC, Credentialed, and Privileged prior to delivering pre-hospital care.	2
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.	2
5.6	The Provider has appropriate arrangements for the management and supervision of students (if applicable).	4
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.	3
5.9	The Provider creates opportunities for employees, volunteers and/or contractors to feedback on all aspects of the service.	4
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.	1

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