Pre-Hospital Emergency Care Council

Governance Validation Framework

Site Assessment Report

Cara Ambulance Service Ltd

November 2019

“The Pre-Hospital Emergency Care Council protects the public by independently specifying, reviewing, maintaining and monitoring standards of excellence for the safe provision of quality pre-hospital emergency care.”

Pre-Hospital Emergency Care Council

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Executive Summary

The Pre-Hospital Emergency Care Council (PHECC) is the statutory agency responsible for setting standards in Ireland for the provision of pre-hospital emergency care. The PHECC primary role is to protect the public by independently specifying, reviewing, maintaining and monitoring standards of excellence for the safe provision of quality pre-hospital emergency care.

The Governance Validation Framework (GVF) has been developed by Council as an evidence-based methodology designed to improve quality and safety in pre-hospital emergency care services. Setting and implementing standards and monitoring of compliance are important levers for driving service improvements. The framework combines a system of self-assessment, on-site review and validation of evidence presented, and staff and management engagement in addition to quality improvement planning and support during the licensing cycle. Documentation submitted by Cara Ambulance Service Ltd prior to the assessment and any evidence provided on assessment day(s) is reviewed and considered by the assessment team for assessment purposes.

GVF concentrates on a series of Standards related to specific themes and identifies the supporting components that service providers should have in place to ensure the formation of a quantifiable quality improvement plan. The framework incorporates 6 Themes and encompasses 43 Standards, that service providers must comply with, and provide evidence on, to the external assessment team. Council published the GVF in July 2017.

The Licensed CPG Provider that is the subject of this report is Cara Ambulance Service Ltd, a private provider of pre-hospital emergency care services in Cork. The on-site GVF assessment visits for this report were conducted during October and November 2019 by an assessment team drawn from a panel of subject matter experts selected and trained by PHECC to conduct the on-site assessments.

It is important to note that the provision of pre-hospital emergency care is constantly evolving, and quality improvement within service providers is a continuous process. Therefore, this report documents the external assessment team's observations related to the time when the assessment was undertaken, and the material supplied by the Provider for the assessment. Documentation and/or evidence submitted by the Provider post assessment cannot be considered by the assessment team to amend assessment outcome(s). The report is intended to support the ongoing quality improvement process within Cara Ambulance Service Ltd's organisation.

The framework combines six Themes which are — Person Centred Care and Support, Effective Care and Support, Safe Care and Support, Leadership Governance and Management, Workforce and Use of Information. The specific findings and comments of the assessment team are outlined for each of the six Themes, and the individual Standards, under the three headings of Assessment Panel Findings, Areas of Best Practice and Areas for Improvement.

Cara Ambulance Service Ltd's Governance Validation Framework assessment report concludes with a Report Summary, which includes a tabular format that provides an overview to Cara Ambulance Service Ltd's Governance Validation Framework assessment status. This section outlines any required action from a licensing perspective and all Providers will be required to update their quality improvement plan based on the content of the report.

Overview of Licensed CPG Provider

Cara Ambulance Service Ltd (CAS) is based in Cork and responds to requests to complete patient transfers from university hospitals and also provides patient transport services for a private health insurer. CAS offers a pre-booking service for routine transfers and provides event medical cover at a variety of events.

Information used to create this overview was supplied by the Provider.
For more information visit: www.caraambulanceservice.ie

Overview of Licensed CPG Provider

Assessment Details:

Licensed CPG Provider	Cara Ambulance Service Ltd
Type of Visit	Full GVF Assessment - GVFREP CAS 001_1119
Licensed CPG Provider Lead	GVFA5966
Date of Review	Practitioner Engagement - 09/10/2019 Site Assessment - 14/11/2019
Assessment Team	GVFA5966 - Team Lead GVFA1637 - Site Assessor GVFA4352 - Practitioner Engagement
Circumstances of this Site Assessment	Establishment of GVF programme - Transition to 3-year licensing cycle.
Relevant Recent Visits	Practitioner Engagement and On-site Assessment conducted October and November 2019.

Assessment Details (continued):

Licensed CPG Provider Participants

Chief Ambulance Officer
Administrator
Medical Officer (Medical Council Reg No 228767)

Onsite Feedback

Verbal feedback related to the Assessment Team's initial findings was provided to the Management Team of Cara Ambulance Service Ltd by the PHECC GVF Assessment Team Lead at the closing meeting. A number of items were identified as areas of potential improvement. There was agreement by all in attendance regarding the relevance and substance of the GVF Assessment Team's comments and indicative findings.

Judgement Framework

Level & Scoring	Descriptor
Not Applicable	• The standard is not applicable to this organisation/base location
Not Met	• Does not meet expectations • No evidence of compliance anywhere in the organisation with the requirements set by the statement/standard
Minimally Met	• Evidence of a low degree of organisation-wide compliance with the requirements set by the statement/standard • Demonstrable evidence that a start has been made towards compliance in some or all parts of the organisation
Moderately Met	• Evidence of a moderate degree of organisation-wide compliance with the requirements set by the statement/standard • Demonstrable evidence that work is ongoing across most parts of the organisation to achieve compliance • Confident in management's ability to deliver full compliance within a reasonable timeframe
Substantively Met	• Substantive evidence of organisation-wide compliance with the requirements set by the statement/standard • Demonstrable evidence that most parts of the organisation are meeting most of the requirements set by the statement/standard • Only minor non-compliance issues requiring, in the main, minor action(s) • Confident in management's ability to deliver full compliance within a reasonable timeframe
Fully Met	• Meets or exceeds expectations • Evidence of full compliance across the organisation with the requirements set by the statement/standard

Theme 1

Person Centred
Care and Support

Standard 1.1 Patients have equitable access to healthcare services based on their assessed needs.

PHECC Statement	The Licensed CPG Provider has appropriate arrangements in place to ensure patients have equitable access to services based on assessed needs.
PHECC Requirements	1.1.1 The Licensed CPG Provider has systems, processes and procedures for the timely and clinically appropriate response to provide safe care and treatment to patient population they serve.

PHECC Statement	The Licensed CPG Provider has appropriate arrangements in place to ensure screening and prioritisation of calls.
PHECC Requirements	1.1.2 The Licensed CPG Provider has systems, processes and procedures in place for taking calls, verifying addresses and dispatch to call.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 1.1 Patients have equitable access to healthcare services based on their assessed needs.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.1.1 The Provider states it has a high staff turnover, however, this appears not to cause service delivery issues as there is a pool of part time staff that can be utilised at short notice to fill vacancies.

The GVF assessment team observed information technology solution to monitor dispatch and response times. This technology solution also allows monitoring aspects of driver performance. A policy exists to document the dispatch process.

Core workload is non-emergency in nature, however, some event cover is also part of the business model. Evidence exists that the most appropriate personnel are dispatched to the patient. Crews of two EMTs are dispatched to inter-hospital and non-emergency transfers. Paramedic/EMT crew are available for event cover.

The Provider does not participate in major incident response training (not appropriate to their operational profile).

1.1.2 The Provider receives call requests directly to its business phone, operated by the administration team, from hospital and healthcare facilities. This information is documented in an electronic call log and call diary. A verbal agreement of expected response time is decided on receipt of call. The dispatch information is accurate and relevant and includes patient name, date of birth, pick up location and final destination.
This information is then passed on to the Operations Supervisor's phone by text message in the ambulance. If there is no Operations Supervisor phone on the ambulance, this information is sometimes sent by text to the crew's personal mobile phones.

Dedicated telematics information technology exists to monitor and review ambulance condition and driver performance. Evidence was provided of monitoring of this information, and an example of audit where this information was used to improve service delivery.

No specific training exists for call handling.

No evidence was found for translation services.

Standard 1.1 Patients have equitable access to healthcare services based on their assessed needs.

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.1.1 A documented process for access to care that outlines the procedure for call taking and dispatch.

1.1.2 Good use of technology solutions to monitor ambulance conditions and driver data.

Areas for Improvement

1.1.1 The Provider should consider a regular audit of telematics data and generate reports accessible to staff.

1.1.2 The Provider shall secure patient dispatch information by reviewing its dispatch procedure and review alternative technologies to assure patient data protection. There is a risk of patient information breach using personal mobile phones and text message technology.

Standard 1.2 Patients' informed consent to care and treatment is obtained in accordance with legislation and best available evidence.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider has systems, policies and procedures in place that respect the values, preferences and wishes of patients.
PHECC Requirements	1.2.1 The Licensed CPG Provider has systems, processes and procedures, developed in line with best practice for patient consent and/or patient identification (which includes guidance for Practitioners) in line with the PHECC Code of Professional Conduct & Ethics.
PHECC Requirements	1.2.2 The Licensed CPG Provider has a policy/procedure in place in relation to the refusal of treatment and/or transport.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 1.2 Patients' informed consent to care and treatment is obtained in accordance with legislation and best available evidence.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.2.1 The Provider has a patient consent policy and consent is also addressed in the Provider's medication policy. During Practitioner Engagement, patient consent was observed at all patient encounters. This was applied in a professional and courteous manner.

1.2.2 During Practitioner Engagement and onsite assessment interviews, evidence exists of staff being aware of patient consent and refusal policy and procedures.

Standard 1.2 Patients' informed consent to care and treatment is obtained in accordance with legislation and best available evidence.

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.2.1 A comprehensive patient consent policy exists that makes reference to refusal of patient care and is in line with the PHECC code of professional conduct and ethics.

1.2.2 During Practitioner Engagement, staff showed awareness of the process of dealing with a patient's refusal of treatment and/or transport. They stated that they had never encountered this, however, were able to describe the process to follow in such an occurrence.

Areas for Improvement

1.2.2 The Provider should demonstrate evidence of staff training in policies and procedures regarding consent.

Standard 1.3 Patients' dignity, privacy and autonomy are respected and promoted.

PHECC Statement	The Licensed CPG Provider has systems, policies and procedures in place that respect the values, preferences and wishes of patients.
PHECC Requirements	1.3.1 The Licensed CPG Provider has arrangements in place to promote patients' privacy, dignity and autonomy.
PHECC Requirements	1.3.2 The Licensed CPG Provider demonstrates a commitment to develop a culture where volunteers, contractors and/or employees involve and treat people with compassion, kindness, dignity and respect.

Standard 1.3 Patients' dignity, privacy and autonomy are respected and promoted.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.3.1 A staff code of conduct is in place, and during the onsite assessment a documented example was given of the process of dealing with a staff member who was not meeting required driving standards. Practitioners demonstrated an awareness of the requirements of patient confidentiality and policies exists on clinical records management and the protection of patients from abuse.

1.3.2 During Practitioner Engagement, staff were observed to conduct themselves in a professional and courteous manner to patients.

Standard 1.3 Patients' dignity, privacy and autonomy are respected and promoted.

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.3.1 Practitioners standard of professionalism and behaviour towards patients was observed to be of a very high standard.

Areas for Improvement

1.3.2 The Provider should provide evidence of specific training or familiarisation on 'Code of Conduct' policy.

Standard 1.4 Licensed CPG Providers promote a culture of kindness, consideration and respect.

PHECC Statement	The Licensed CPG Provider has systems in place to promote and measure positive patient experience.
PHECC Requirements	1.4.1 The Licensed CPG Provider undertakes Patient Satisfaction and/or Patient Experience Surveys to help shape and improve services and culture.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 1.4 Licensed CPG Providers promote a culture of kindness, consideration and respect.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.4.1 Documentary evidence of a patient feedback report was provided during onsite assessment. The Provider does not conduct regular patient feedback/experience surveys. Patient surveys are conducted through a follow-up phone call by administration staff and documented accordingly. An example was given of a regular service user being chosen for survey.
The Provider's annual report 2018 references 40 compliments received (mainly verbal) of patient surveys but no documentary evidence was provided to support this. The Provider demonstrated a willingness to develop the patient satisfaction survey process further.

At Practitioner Engagement, staff stated they do receive feedback from the Provider on patient experience in a face-to-face or telephone conversation.

There were no records of patient or service user complaints.

Standard 1.4 Licensed CPG Providers promote a culture of kindness, consideration and respect.

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.4.1 The Provider demonstrated a desire to gain feedback from a regular service user.

Areas for Improvement

1.4.1 The Provider should consider regular random and targeted audits of service users in satisfaction surveys to gain a balanced spectrum of opinion to help shape and improve services. This information should be shared with staff regularly to celebrate good staff practice and culture.

Standard 1.5 Patients' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider has an internal complaints/concern handling process.
PHECC Requirements	1.5.1 Patients' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.
PHECC Requirements	1.5.2 The Licensed CPG Provider provides training to all front-line volunteers, contractors and/or employees in handling a patient or family member's complaint or concern.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 1.5 Patients' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.5.1 The Provider has a documented complaints policy (policy number 20), which contains discrepancies. The policy states that all complaints will be dealt with by a legal team that leads the management of complaints. The policy then goes on to mention a different legal company that deal with claims. Within the policy it also suggests that the Provider investigates elements of the complaint. This policy suggest that even complaints of a minor low risk category are always dealt with by a legal team.

The complaints policy, which is effective from June 2017, also states a reviewed date every year. This is then contradicted by stating a review in June 2020.

A sample of the complaint form and patient satisfaction survey form were submitted at the end of the assessment.

The Provider stated it received no patient complaints but did provide documentary evidence of an internal staff performance complaint, which was investigated and acted on.

1.5.2 Practitioner interview at onsite assessment identified that staff were able to state the process of handling a patient complaint both verbally with the patient or service user and the documentation and reporting process. Complaints are reported immediately to administration/managers and a log of the complaint is kept in the ambulance vehicle incident logbook.

Training records were verified for staff attending policy training, however, no specific record of complaints policy training was provided.

Standard 1.5 Patients' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.5.2 The staff interviewed displayed a good working knowledge of how to deal with and record a patient complaint, including issuing an apology, if necessary, to the patient at the time of the incident.

Areas for Improvement

1.5.1 The Provider should clarify the complaints investigation procedure and those individuals or companies responsible for each element of the investigation process. The Provider should rectify inaccuracies within their complaints policy in order to provide clear guidance to service users, legal team and staff.

1.5.2 The Provider should document training and/or familiarisation provided for specific policies.

Theme 2

Effective Care and Support

Standard 2.1 Healthcare reflects national and international evidence of what is known to achieve best outcomes for patients.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider must ensure that privileged Responders/ Practitioners administer specific medications and perform specific clinical interventions in keeping with their CPG status.
PHECC Requirements	2.1.1 The Licensed CPG Provider has systems, processes and procedures in place to ensure Responders/Practitioners utilise the evidence-based CPG appropriate to their status to deliver and ensure safe and appropriate care.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 2.1 Healthcare reflects national and international evidence of what is known to achieve best outcomes for patients.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.1.1 During onsite assessment a local register of Practitioners employed by the Provider was verified. This included Practitioners' PHECC PIN numbers and CPG upskill status. A random sample of records were reviewed and found that not all upskilling records were complete as the Provider was awaiting certificates from a third party.

The Provider does not have a clear database, system or training record that ensures the surveillance of ongoing upskilling or competency.

During onsite assessment interviews, staff could not describe a clear process where updates in policies and procedures are relayed to them. It was unclear how the staff can access the Provider's policies.

The onsite assessment team observed a sign-in sheet for recent training, which included familiarisation with policies; however, there was no specific description of what this training involved such as specific policies, lesson plans, or learning outcomes.

During onsite assessment interview with senior management, some evidence exists of ongoing clinical observation shifts by the Chief Ambulance Officer. This was also verified through interview with staff. No documentary evidence was verified for this activity and it appeared to occur on an ad hoc basis.

Standard 2.1 Healthcare reflects national and international evidence of what is known to achieve best outcomes for patients.

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.1.1. The Provider has made efforts to ensure its staff have been upskilled and can provide some evidence of this for some, but not all staff. Occasional clinical observation shifts are also conducted by the Chief Ambulance Officer.

Areas for Improvement

2.1.1 The Provider should develop a process of dissemination of new policies and procedures to staff within the organisation.

2.1.1 The Provider should demonstrate evidence of the conduction of staff training or familiarisation with specific policies and procedures.

2.1.1 The Provider should develop processes that ensure staff are practicing using appropriate CPGs. An example of this may be to conduct regular clinical observation shifts with Practitioners that may identify learning needs and/or reinforce existing good clinical practice.

Standard 2.2 Patients receive integrated care, which is coordinated effectively within and between services.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider promotes a structured but flexible handover process that optimises patient safety and quality of care.
PHECC Requirements	2.2.1 The Licensed CPG Provider has a standardised handover process in place to ensure the safe, timely, and structured exchange of information during handover of patients.

Not Applicable | Not Met | Minimally Met | Moderately Met | Substantively Met | Fully Met

Standard 2.2 Patients receive integrated care, which is coordinated effectively within and between services.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.2.1 The Provider has submitted a communications policy that does not address patient handover processes. The Patient Handover Policy was submitted and reviewed. The policy does not include a recognised handover tool that incorporates specific key information that must be relayed to receiving staff.

During Practitioner Engagement good communication was observed but not all information given to Practitioners by healthcare staff was documented on the PCR. Handover technique was observed but this lacked structure both in giving and receiving handovers.

Standard 2.2 Patients receive integrated care, which is coordinated effectively within and between services.

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.2.1 During Practitioner Engagement observation there was evidence of effective engagement and communication between Practitioners, patients and healthcare staff.

Areas for Improvement

2.2.1 The Provider should ensure training and use of a safe patient handover tool to help ensure a safe patient transfer process. A common example of clinical handover tool is 'IMIST AMBO'.

Standard 2.3 Healthcare is provided in a physical environment, which supports the delivery of high-quality, safe, reliable care and protects the health and welfare of patients.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider must ensure that ambulances are fit for purpose.
PHECC Requirements	2.3.1 The Licensed CPG Provider has processes, systems and procedures in place to ensure the road-worthiness of their patient transport vehicles in line with legislation.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 2.3 Healthcare is provided in a physical environment, which supports the delivery of high-quality, safe, reliable care and protects the health and welfare of patients.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.3.1 During Practitioner Engagement and the onsite assessment, the Provider produced two ambulance vehicles. Both vehicles were CVRT compliant and documentary evidence was provided of maintenance and repair records.

Vehicle registrations: 10 G 4*** and 152 C 7***

Standard 2.3 Healthcare is provided in a physical environment, which supports the delivery of high-quality, safe, reliable care and protects the health and welfare of patients.

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.3.1 Clear records of vehicle purchase, maintenance and recent repair were provided.

Areas for Improvement

No specific observation noted by the GVF Assessment Team.

Standard 2.4 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider provides an annual CPG report to the PHECC, which includes all the core components outlined in PHECC Council Rules POL003 (Section 23.1-23.10).
PHECC Requirements	2.4.1 The Licensed CPG Provider submits an Annual Medical Director report annually,* which informs the PHECC of clinical activities in the organisation and includes a CPG report (*Calendar year).

PHECC Statement	The Licensed CPG Provider undertakes an ongoing programme of clinical audit, as appropriate, which involves an appropriate combination of structure, process and outcome audits and implements the full audit cycle to support the quality improvement.
PHECC Requirements	2.4.2 The Licensed CPG Provider has a systematic programme of clinical audit in line with PHECC standards (STN019), which is used to monitor quality and outcomes and promote learning.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 2.4 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.4.1 The Provider submitted its 2018 annual Medical Director's report in the submission process, however, this contains no substantive information regarding annual clinical activities.

During onsite assessment interview with the Medical Director, some evidence was provided of PCR review on an occasional basis by the Medical Director. There was no evidence of the Medical Director taking part in regular audit activity.

2.4.2 During Practitioner Engagement and onsite Practitioner interviews the Provider produced verbal and documentary evidence of regular ongoing clinical audit using PCRs where they are reviewed, and staff are provided with verbal feedback. An example was given of quality improvement and outcomes as a result of PCR audit.

The Provider has a Clinical Audit Policy, which does not make reference to publication or dissemination of audit results to its staff. The clinical audit policy is effective from June 2017 and is to be reviewed in January 2020. This mirrors similar discrepancies to other polices.

The Provider has submitted an audit of a report of an audit concerning infection control in 2017 and was due for re-audit in 2018. The results of the audit are unclear and during the onsite assessment it was established that the re-audit did not occur.

References are made to various audits within the Provider's policies, but other than PCRs no evidence exists of ongoing regular clinical audits.

No evidence was found during Practitioner interviews of staff being aware of any other clinical audits other than PCR audit.

Standard 2.4 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.4.2 Regular audits occur of PCRs and an example was given of learning and improvement as a result.

Areas for Improvement

2.4.1 The Provider should engage with the Medical Director to promote regular clinical audit activity.

2.4.2 The Provider should provide documentary evidence of clinical and PCR audits to monitor quality outcomes and promote learning among staff. This may be in the form of regular staff bulletins.

Theme 3

Safe Care and Support

Standard 3.1 Licensed CPG Providers protect patients from the risk of harm associated with the design and delivery of healthcare services.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider identifies aspects of the delivery of care associated with possible increased risk of harm to service users and has structured arrangements to minimise these risks.
PHECC Requirements	3.1.1 The Licensed CPG Provider has a reliable system in place to prevent and protect patients and staff from healthcare associated infections.
PHECC Statement	The Licensed CPG Provider ensures that there are systems in place to ensure the effective, efficient and safe use of medicines for the administration of pre-hospital emergency care.
PHECC Requirements	3.1.2 The Licensed CPG Provider ensures that there are systems, processes and procedures in place to ensure medicines availability, storage, stocking and disposal processes for the administration of pre-hospital emergency care.
PHECC Statement	The Licensed CPG Provider ensures that there is systems place to ensure the effective, efficient and safe use of medical devices and equipment for the administration of pre-hospital emergency care.
PHECC Requirements	3.1.3 The Licensed CPG Provider ensures that there are systems, processes and procedures in place to ensure the equipment/medical device availability, storage, stocking and disposal for the administration of pre-hospital emergency care.

Not Applicable | Not Met | Minimally Met | Moderately Met | Substantively Met | Fully Met

Standard 3.1 Licensed CPG Providers protect patients from the risk of harm associated with the design and delivery of healthcare services.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

3.1.1 During Practitioner Engagement it was verified that Practitioners were afforded time to check, clean and prepare the ambulance. During various patient contacts the ambulance stretcher was cleaned before and after each patient but not all areas where the patient had contact inside the ambulance were cleaned.

The Provider does not have a formal arrangement with healthcare facilities/hospitals to dispose of clinical waste at their sites. The Provider states they have a contract for removal of clinical waste at only one of their own facilities – the owner's home. Documentary evidence was produced to verify a clinical waste removal contract. Staff sometimes convey clinical waste to this residence for disposal.

During the onsite assessment the Provider presented policy 'Infection Control and infection prevention policy and procedure'. This policy refers to all aspects of infection prevention and control measures of what should be done, however, specific guidance on the step-wise process of how to clean, which colour mops to use, and how to dispose of clinical waste correctly was not provided in this policy. Most of this procedural information was provided in a separate policy (Cleaning policy including vehicle BCA – 0619).

No evidence of cleaning audits was presented for verification.

Two ambulances were presented by the Provider for inspection during the onsite assessment (10 G 4*** and 152 C 7***). Both were visibly clean and free of dirt, and smelled clean. Both vehicles had alcohol gel, protective gloves and aprons, sharps bin, and clinical waste present. A minor but important note, vehicle 152 C 7*** did not have tissue paper for patient use.

3.1.2 The Provider has TWO medicines policies (COP-0819 & Policy No 14). During Practitioner Engagement all drugs required for PHECC paramedic and EMT use were present and stored securely. An observation was made that the pharmacy supplier has placed stickers on some of the medications, which obscured some of the expiry dates. This presents a risk to the patient.

There appears to be no process on how drugs should be checked or documented such as a medication checklist book, and the medicines policy does not include a specific step-wise process for this. The Practitioner Engagement verified this process taking place using a blank piece of paper.
Staff were aware of the process of reporting a medication error.
Medication policy COP-0819 makes reference to medications being stored overnight at the Provider's HQ. During onsite assessment, it was verified that this does not always occur.
During staff interviews it was stated that daily medication checks do not always occur. Staff also stated that if a seal is on the medication pack, they do not open it and check contents as is the requirement of policy CO-0819.
Confusion also lies in the fact that the Provider has TWO medicines policies (COP-0819 & Policy No 14).

Assessment Panel Findings Cont'd

3.1.3 The Provider has a policy titled Equipment – Inspection Testing and Maintenance. This policy states all staff will ensure equipment is fit for purpose before use. The policy states that the Operations Manager will ensure that all equipment in their area is appropriately maintained and calibrated. The policy also states that all equipment shall be tested and have a unique asset number, which corresponds to an entry on the Provider's equipment register. The policy states that annual equipment external testing will be completed on the spinal board, stretcher and portable/fixed oxygen supply. The policy states that internal testing will be completed on the pulse oximeter, defibrillator and suction unit. The policy states that internal checks on the equipment will be available in each ambulance and recorded on the Provider's ambulance equipment checklist.

During the onsite assessment the Provider offered evidence for the servicing, repair or replacement of various items of ambulance and gas supply equipment that had been highlighted as non-compliant during the Practitioner Engagement. The Provider presented an equipment register for each ambulance, however, asset numbers were not present on all pieces of equipment as the Equipment policy suggests. The report of recent assessment of medical gas cylinder pressure regulators by a third party are yet to take place.

Vehicle 10 G 4*** was inspected to follow up previous equipment issues identified during the Practitioner Engagement. A medical gas cylinder was observed stored on the floor in a blue carry bag underneath the attendant's seat. The bag was not fixed or secured and has the potential to become a projectile in the event of a collision.

Standard 3.1 Licensed CPG Providers protect patients from the risk of harm associated with the design and delivery of healthcare services.

Pre-Hospital Emergency Care Council

Areas of Best Practice

3.1.1 Deep cleaning of vehicles is conducted with a local provider and occurs on an as needed basis. This does not seem to interrupt service delivery.

Areas for Improvement

3.1.1 The Provider should review and update its infection control policy to reflect and meet the needs and activities of the service. Consideration should be given to reviewing and possibly amalgamating the following three policies – BCA 01 Infection Control and Prevention, BCA 07 Clinical and non-clinical waste & BCA 06 vehicle cleaning.
The Provider should make arrangements to avoid conveying clinical waste unnecessarily.
The Provider should provide arrangements of regular deep cleaning of vehicles and initiate log and audit of same.

3.1.2 The Provider shall review its medicines management policies to reflect the requirements for the organisation and clarify daily checking procedures of medications.

3.1.3 The Provider should update the equipment register to include recording of asset numbers.

3.1.3 The Provider should ensure items of medical gas equipment that require replacement are addressed.

3.1.3 The Provider shall ensure medical gas cylinder are stored securely inside a cupboard in the rear of the ambulance.

Standard 3.2 Licensed CPG Providers effectively identify, manage, respond to and report on patient-safety incidents.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider has a patient safety incident (which includes adverse events, near-misses and no-harm events) reporting system with an open disclosure and non-punitive reporting ethos.
PHECC Requirements	3.2.1 The Licensed CPG Provider has structured incident reporting and investigation mechanisms, which support and encourage volunteers, contractors and/or employees to report adverse events, near-misses and no-harm events.
PHECC Statement	The Licensed CPG Provider has arrangements in place to identify, assess and respond appropriately to patients' safety incidents and complaints.
PHECC Requirements	3.2.2 The Licensed CPG Provider has a process for the sharing of lessons learned from patient safety incidents (including adverse events, near-misses and no-harm events) and complaints, which have occurred locally, nationally or internationally with volunteers, contractors and/or employees.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 3.2 Licensed CPG Providers effectively identify, manage, respond to and report on patient-safety incidents.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

3.2.1 The Provider has an incident reporting policy, which states all staff have a responsibility to report safety incidents.

3.2.2 During the onsite assessment no documentary evidence was observed of staff receiving specific training in safety and incident reporting, however, during staff interviews it was observed that they were aware of the necessity of reporting. Staff stated they would do this through verbal reporting to their line manager and written reporting using the vehicle incident book. During staff interview, the assessment team could not establish a clear process by which a local, national, or international notice or communication regarding a patient safety incident would be communicated.

Standard 3.2 Licensed CPG Providers effectively identify, manage, respond to and report on patient-safety incidents.

Pre-Hospital Emergency Care Council

Areas of Best Practice

3.2.1 Staff showed awareness of necessity to report safety incidents.

Areas for Improvement

3.2.2 The Provider should demonstrate evidence of staff training in policies and procedures in safety incident and near-miss reporting.

3.2.2 The Provider should consider establishing its communication processes with staff of local, national and international safety related incidents.

Standard 3.3 Licensed CPG Providers ensure all reasonable measures are taken to protect patients from abuse.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider is committed to safeguarding vulnerable members of the community.
PHECC Requirements	3.3.1 The Licensed CPG Provider has policies/procedures in place to prevent harm or abuse occurring and take action where concerns arise.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 3.3 Licensed CPG Providers ensure all reasonable measures are taken to protect patients from abuse.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

The Provider has a safeguarding policy titled ‘Safeguarding Patients from Abuse’.

Standard 3.3 Licensed CPG Providers ensure all reasonable measures are taken to protect patients from abuse.

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

3.3.1 The Provider should demonstrate evidence of staff training in safeguarding policy and procedure.

Theme 4

Leadership, Governance and Management

Standard 4.1 Licensed CPG Providers have clear accountability arrangements to achieve the delivery of high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider has an established governance structure with clear accountability arrangements for clinical and corporate governance.
PHECC Requirements	4.1.1 The Licensed CPG Provider has an established reporting and accountability structure for clinical governance.

4.1.2 The Licensed CPG Provider has an identified Medical Director who is registered with the Medical Council and who is based in this jurisdiction and who oversees the service.

4.1.3 The CPG Provider is compliant with taxation laws.

4.1.4 The Licensed CPG Provider has documentary evidence of the required insurance policies.

Not Applicable | Not Met | Minimally Met | Moderately Met | Substantively Met | Fully Met

Standard 4.1 Licensed CPG Providers have clear accountability arrangements to achieve the delivery of high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.1.1, 4.1.2 The Provider identifies the Chief Ambulance officer as being responsible for clinical governance, but no clinical governance policy was submitted or reviewed during the onsite assessment. The Medical Director's job description identifies the Medical Director as providing clinical leadership and oversight. This was confirmed during interviews; however, this process appears to be on an as-required basis with no formal regular clinical governance meetings taking place.
During Practitioner Engagement interviews staff were aware of the Medical Director but stated they had no encounters with him other than collecting medication order paperwork when necessary.

4.1.3 Tax Clearance Access Number and Tax Ref Number were submitted with the Provider's GVF submission document.

4.1.4 The Provider has submitted a certificate of employer's liability insurance and medical malpractice insurance documents.
During onsite assessment valid insurance documents for the following vehicles were verified:
10 G 4*** and 152 C 7***.

Standard 4.1 Licensed CPG Providers have clear accountability arrangements to achieve the delivery of high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

Areas of Best Practice

4.1.1 During interview with the Medical Director it was evident that a good relationship exists between the Provider and Medical Director.

Areas for Improvement

4.1.2 The Provider should consider further development of its relationship with the Medical Director to reflect the Provider's Medical Director job description. Examples of this may be involving the Medical Director in policy drafting and review, regular clinical audit and governance, as well as participation in relevant CPD activities.

Standard 4.2 Licensed CPG Providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider has systems, processes and practices in place to utilise safety and quality information to highlight areas of improvement and improve the quality and safety of the service.
PHECC Requirements	4.2.1 The Licensed CPG Provider has systems, processes and practices in place to utilise safety and quality information to highlight areas of improvement and improve the quality and safety of the service.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Assessment Panel Findings

4.2.1 Evidence exists of organisational change as a result of incident reporting. Example given was of delays at healthcare facilities due to process of waiting for patient documentation. The Provider acted on the incident report and as a result procedure was changed regarding obtaining patient records thus minimising any delays to patient transport and service delivery.
The Provider has a risk management policy, which outlines its approach to risk management.

Standard 4.2 Licensed CPG Providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Pre-Hospital Emergency Care Council

Areas of Best Practice

4.2.1 The Provider has an incident logbook on each vehicle, which is reviewed regularly.

Areas for Improvement

No specific observation noted by the GVF Assessment Team.

Standard 4.3 The conduct and provision of healthcare services are compliant with relevant Irish and European legislation.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider is compliant with all relevant laws and regulations.
PHECC Requirements	4.3.1 The Licensed CPG Provider has systems, processes and procedures in place to ensure compliance with statutory legislation relating to the provision of safe and effective care.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 4.3 The conduct and provision of healthcare services are compliant with relevant Irish and European legislation.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.3.1 The Provider has a risk management policy in place. No specific risk assessment audits are documented; however, each vehicle incident logbook is monitored regularly, and evidence was provided of actions arising out of incident reporting. Examples given were of vehicle defects.
No corporate risk register was available for verification; however, a SWOT analysis exists in the company Operational Plan.

Standard 4.3 The conduct and provision of healthcare services are compliant with relevant Irish and European legislation.

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

4.3.1 The Provider should consider developing a proactive approach to risk management and mitigation by conducting regular risk assessments.

Standard 4.4 Licensed CPG Providers act on standards and alerts and take into account recommendation(s) and guidance, as formally issued by relevant regulatory bodies as they apply to their service.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider has systems in place to ensure actions are taken/ issues communicated on new recommendation(s) and guidance issued by the PHECC and other regulatory bodies.
PHECC Requirements	4.4.1 The Licensed CPG Provider has a process in place to ensure the appropriate communication and adoption of new recommendation(s) and guidance issued by the PHECC and other regulatory bodies.
PHECC Statement	The Licensed CPG Provider complies with the PHECC Governance Validation Framework.
PHECC Requirements	4.4.2 The Licensed CPG Provider is compliant with the PHECC Governance Validation Framework.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 4.4 Licensed CPG Providers act on standards and alerts and take into account recommendation(s) and guidance, as formally issued by relevant regulatory bodies as they apply to their service.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.4.1 The Provider has a Communications Policy in place that outlines how information is communicated to staff. During onsite assessment interviews with staff there was evidence of information and guidance issued by PHECC, however, this was inconsistent with the communication policy. This mentions staff bulletins being placed on noticeboards at each location where staff are based, however, at the Practitioner Engagement there was no traditional base facility to place a noticeboard.
During Practitioner Engagement and group interview there was no evidence provided of an audit trail ensuring staff have received updates and bulletins etc.

4.4.1 During onsite assessment interviews, senior management stated that any safety alerts are relayed to crews/staff. This was confirmed by staff at interview and the Communications Policy states that this happens on a quarterly and as needed basis.

4.4.2 The Provider has submitted documents to implement the GVF self-assessment process. Some documents and policies were not submitted in the original self-assessment submission but were immediately released for verification on request at the onsite assessment.

Areas of Best Practice

4.4.1 It is clear the Provider communicates with staff.

Areas for Improvement

4.4.1 The Provider should develop a documented procedure for dissemination for staff that aligns to current policy or an amended policy on communications.

Theme 5

Workforce

Standard 5.1 Licensed CPG Providers plan, organise and manage their workforce (volunteers, contractors and/or employees) to achieve the service objectives for high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider effectively manages its workforce (volunteers, contractors and/or employees) to meet the current and projected service needs.
PHECC Requirements	5.1.1 The Licensed CPG Provider undertakes workforce planning to align resources to current workload and projected needs.

Not Applicable Not Met Minimally Met Moderately Met Substantively Met Fully Met

Standard 5.1 Licensed CPG Providers plan, organise and manage their workforce (volunteers, contractors and/or employees) to achieve the service objectives for high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.1.1 The Provider has a staff recruitment, selection, appointment and termination of employment policy in place.
During onsite interview the Provider stated that it has a high turnover of staff that tend to exit the organisation for full time employment in other ambulance services. The Provider advised that although high staff turnover exists, this does not compromise service delivery due to a sufficient number of existing and new staff who demonstrate flexibility in providing capacity gaps at short notice.

5.1.1 No evidence was submitted for succession planning.

Standard 5.1 Licensed CPG Providers plan, organise and manage their workforce (volunteers, contractors and/or employees) to achieve the service objectives for high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

Areas of Best Practice

5.1.1 The Provider has a robust workforce planning policy in place.

5.1.1 The flexibility of existing staff in providing service delivery on occasion at short notice is to be commended.

Areas for Improvement

5.1.1 The Provider may wish to consider inclusion of a formal workforce planning and recruitment strategy in their policies.

Standard 5.2 Licensed CPG Providers recruit/engage with Practitioners with the required competencies to provide high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CGP Provider has in place robust processes to assure English language competency for all volunteers, contractors and/or employees whose first language is not English.
PHECC Requirements	5.2.1 The Licensed CPG Provider has a process in place to satisfy itself that the English language competence of its Responders and Practitioners, whose first language is not English, is appropriate to the clinical/professional activities to be carried out by that person i.e. Responder or Practitioner levels. 
PHECC Statement	The Licensed CPG Provider ensures all volunteers, contractors and/or employees providing care on behalf of the organisation are currently on the PHECC register.
PHECC Requirements	5.2.2 The Licensed CPG Provider has a process in place to check registration on appointment and on-going renewals of registration for volunteers, contractors and/or employees. 
PHECC Statement	The Licensed CPG Provider ensures that all volunteers, contractors and/or employees are subject to the appropriate pre-employment checks to ensure delivery of safe care.
PHECC Requirements	5.2.3 The Licensed CPG Provider conducts checks and confirms that all volunteers, contractors and/or employees have the appropriate qualifications and registrations. 
PHECC Statement	The Licensed CPG Provider has robust security clearance processes in place for volunteers, contractors and/or employees.
PHECC Requirements	5.2.4 The Licensed CPG Provider ensures that volunteers, contractors and/or employees are subject to Garda Vetting in line with the National Vetting Bureau (Children & Vulnerable Persons) Act 2012 prior to patient contact. 

Standard 5.2 Licensed CPG Providers recruit/engage with Practitioners with the required competencies to provide high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.2.1 The Provider has an English-Speaking Competency Policy in place that appears fit for purpose. The policy makes reference to a policy Staff Credentials and verification policy, which was not submitted.

5.2.2, 5.2.3 The Provider has a staff recruitment and selection policy that states new employees must demonstrate evidence of identity and current PHECC registration. The Provider also has a fitness to practice policy, which acknowledges the primacy of PHECC fitness to practice policy and the right to refer Practitioners where any areas of fitness to practice arise.

A random selection of employee records was sampled and current PHECC registration for all staff was verified. The employee records also contained records of staff training and certificates, although a copy of NQEMT certificate was only present for one staff member.

5.2.4 Garda vetting disclosure certificates were present in all employee records observed. No evidence was observed of ongoing monitoring or self-reporting procedure for staff, other than acknowledging the PHECC fitness to practice policy.

Standard 5.2 Licensed CPG Providers recruit/engage with Practitioners with the required competencies to provide high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

5.2.3 The Provider should retain copies of relevant educational awards such as NQEMT for PHECC Practitioners.

5.2.4 The Provider should develop its fitness to practice police to specifically include procedures for staff should they become under investigation for criminal activity or under investigation for fitness to practice.

Standard 5.3 Licensed CPG Providers ensure their workforce (volunteers, contractors and/or employees) have the competencies required to deliver high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider provides, or provides access to, on-going training to ensure that volunteers, contractors and/or employees' CPG skill levels are maintained commensurate with their current CPG privileged status.
PHECC Requirements	5.3.1 The Licensed CPG Provider has developed and implemented a comprehensive induction programme to ensure volunteers, contractors and/or employees understand their responsibilities in relation to the safety and quality of services.

5.3.2 The Licensed CPG Provider has a training and development programme in place to ensure volunteers, contractors and/or employees have the required competencies to undertake their duties in line with their registered status.

5.3.3 The Licensed CPG Provider has appropriate arrangement for the management, supervision and performance management of students (If applicable).

Not Applicable | Not Met | Minimally Met | Moderately Met | Substantively Met | Fully Met

Standard 5.3 Licensed CPG Providers ensure their workforce (volunteers, contractors and/or employees) have the competencies required to deliver high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.3.1 The Provider has a Staff Education, Training and Supervision policy in place. Attendance records for staff induction training were reviewed. Staff induction covered equipment training and policy review, however, it was unclear which policies were covered in staff induction training.
The Chief Ambulance Officer stated that as a qualified tutor he completes clinical observation shifts with new staff for guidance and support.

5.3.2 During Practitioner Engagement staff stated that induction training on specific equipment and basic and essential training such as moving and handling was delivered, and CFR-A training, annually. This was covered by a qualified tutor. Staff expressed that no additional CPD/CME training was delivered by the Provider and they arrange their own CPD. During onsite assessment this was confirmed. No evidence exists of additional staff refresher training on various clinical skills or equipment.

5.3.2 During Practitioner Engagement, staff were observed to be unfamiliar in the use of a piece of equipment.

5.3.3 Not applicable.

Standard 5.3 Licensed CPG Providers ensure their workforce (volunteers, contractors and/or employees) have the competencies required to deliver high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

Areas of Best Practice

5.3.1 The Provider demonstrated good practice of clinical observation of new staff in an induction/probationary period.

Areas for Improvement

5.3.2 The Provider should develop a regular programme of training that is suitable for the organisation's requirements and main patient population. Examples of this may be refresher training in basic clinical observations, patient cardiac monitoring, sepsis awareness, and equipment training for items less frequently used.
Consideration may be given to involving the Medical Director in delivery of elements of refresher training/CPD.

Standard 5.4 Licensed CPG Providers support their workforce (volunteers, contractors and/or employees) in delivering high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider supports volunteers, contractors and/or employees to exercise their personal, professional and collective responsibility for the provision of high quality, safe and reliable healthcare.
PHECC Requirements	5.4.1 The Licensed CPG Provider has a Critical Incident Stress Management process in place.

5.4.2 The Licensed CPG Provider has a Fitness to Practice Policy/Procedure, which makes reference to the PHECC Fitness to Practice processes.

5.4.3 The Licensed CPG Provider has processes for the identification of poor or variable staff performance.

5.4.4 The Licensed CPG Provider improves patient safety by encouraging and supporting volunteers, contractors and/or employees in the reporting and learning from patient safety incidents (including adverse events, near-misses and no-harm events).

PHECC Requirements	5.4.5 The Licensed CPG Provider creates opportunities for staff to feedback on the quality and safety of the service they work in.

Not Applicable | Not Met | Minimally Met | Moderately Met | Substantively Met | Fully Met

Standard 5.4 Licensed CPG Providers support their workforce (volunteers, contractors and/or employees) in delivering high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.4.1 During Practitioner Engagement crews showed some awareness of the process and policy regarding critical incident stress management (Dignity at Work and Post Incident Management Policy). Crews stated they would initially contact Chief Ambulance Officer but were unaware of other support mechanisms available to them.
At onsite assessment interviews, the crews were able to identify the external support mechanisms available for critical incident stress management delivered by third party agencies.

5.4.1 During onsite assessment interview with the Provider's Director, his description of managing the CISM procedure did not reflect the procedure described in the policy. The Director made reference to approaching an external agency for CISM support, however, no service level agreement is in place.

5.4.2 At onsite assessment, the Provider presented a Fitness to Practice policy, which made reference to the PHECC fitness to practice process.

5.4.3 The Provider makes reference to staff performance, appraisal and professional development within Staff Performance Appraisal and Professional Development Plan policy, which was reviewed during the onsite assessment. During Practitioner interviews staff indicated that an informal appraisal does take place although no documentary evidence of this was able to be verified.

5.4.3 A complaints process and procedure exists within the organisation and an example of complaint handling was presented for review at onsite assessment.

5.4.3 The company Director holds a tutor qualification and delivers upskilling training as required.

5.4.4 It was evidenced during interviews at the onsite assessment that staff were aware of the process of incident reporting and felt supported in reporting any such incidents.

5.4.4 The Provider has a whistleblowing policy in place.

5.4.5 Staff interviewed expressed a positive and supportive culture within the organisation and gave an example of where staff feedback on patient delays at healthcare facilities led to a service improvement, which led to benefits for service users and the organisation.

Standard 5.4 Licensed CPG Providers support their workforce (volunteers, contractors and/or employees) in delivering high-quality, safe and reliable healthcare.

Pre-Hospital Emergency Care Council

Areas of Best Practice

5.4.1 The Provider has created an environment where staff are confident in being supported by senior management if they required specific CISM support.

5.4.2 The Provider has a robust fitness to practice policy, which makes reference to the PHECC fitness to practice process.

5.4.5 The Provider demonstrates a caring and supportive working environment for its staff who are valued by the organisation.

Areas for Improvement

5.4.1 The Provider should improve the basis of CISM support services, which may involve reviewing the CISM policy and establishing formal service level agreement with external agency and determining the formal points of contact for staff members wishing to access the scheme.

5.4.3 The Provider should formalise staff appraisals and maintain documentary evidence of the process.

Theme 6

Use of Information

Standard 6.1 Licensed CPG Providers have effective arrangements in place for clinical information governance.

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider is compliant with Council Policy for implementation timeframes for clinical information standards and associated reports – V1. (POL043)
PHECC Requirements	6.1.1 The Licensed CPG Provider implements the PHECC clinical information standards and associated patient reports.

6.1.2 The Licensed CPG Provider has systems, processes and procedures in place to assure the data quality of healthcare records.

Not Applicable | Not Met | Minimally Met | Moderately Met | Substantively Met | Fully Met

Standard 6.1 Licensed CPG Providers have effective arrangements in place for clinical information governance.

Pre-Hospital Emergency Care Council

Assessment Panel Findings

The Provider has a Clinical Records Management policy (No13). The policy describes transport and secure storage of clinical records (PCRs).
During the Practitioner Engagement, staff demonstrated knowledge of clinical records management procedure. At the onsite assessment the administrator described a slightly differing process of where clinical records are collated and audited before secure storage.

The Provider's clinical records management policy states that records may be amended by the Medical Director. During onsite assessment interviews the Medical Director and Chief Ambulance Officer were unaware of this reference in the policy.

The Clinical Records Management Policy includes a consent form, which service users may wish to sign to agree involvement in audit and quality improvement.

No facility was verified whereby patients could access their clinical records.

Specific site security for patient records exists in that patient records are locked in a cabinet within a locked office. The office sits within a shared building and security cameras are mounted outside in the street. The cameras are not under the control of the organisation. Consideration should be given to improve security of patient records storage and medications stored within company HQ.

6.1.2 The Provider demonstrated evidence of PCR audit feedback through existing records and Practitioner Engagement interviews. The results of PCR audit indicated satisfactory completion rates among staff.

6.1.2 A sample of recent PCRs were reviewed and found to be complete and legible.

Standard 6.1 Licensed CPG Providers have effective arrangements in place for clinical information governance.

Pre-Hospital Emergency Care Council

Areas of Best Practice

6.1.2 During Practitioner Engagement the PCR records were legible and contained appropriate information.

6.1.2 The Provider demonstrated evidence of PCR data regular audits, which resulted in improved PCR completion rates. This regular audit and feedback were viewed as a positive experience by staff.

Areas for Improvement

6.1.1 The Provider shall amend its existing Clinical Records Management Policy to reflect the PHECC standards, and explicitly remove any reference to any clinician being able to amend completed PCRs.

6.1.1 The Provider should review its clinical records management policy and align practice to policy regarding transport and storage of patient clinical records. This should avoid unnecessary storage of clinical records outside company headquarters.

6.1.1 The Provider should improve security measures for patient records and medications held at its offices.

Report Summary

The PHECC Governance Validation Framework cconsists of six (6) Themes that encompasses forty-three (43) Standards, which have been assessed by the external team of PHECC GVF Assessors during this assessment. The overall PHECC standards compliance ratings for Cara Ambulance Service Ltd are as follows:

Judgement Framework Level	External Assessment Assigned Level	Percentage
Not Applicable	1	2.33%
Not Met	0	0%
Minimally Met	1	2.33%
Moderately Met	11	25.58%
Substantively Met	14	32.56%
Fully Met	16	37.20%

GVF Site Assessment Summary - Cara Ambulance Service Ltd

	PHECC Requirement	Compliance level
Theme 1: Person-Centred Care and Support	**Standard 1.1 Patients have equitable access to healthcare services based on their assessed needs.**	
	1.1.1 The Licensed CPG Provider has systems, processes and procedures for the timely and clinically appropriate response to provide safe care and treatment to patient population they serve.	**Fully Met**
	1.1.2 The Licensed CPG Provider has systems, processes and procedures in place for taking calls, verifying addresses and dispatch to call.	**Moderate**
	Standard 1.2 Patients' informed consent to care and treatment is obtained in accordance with legislation and best available evidence.	
	1.2.1 The Licensed CPG Provider has systems, processes and procedures, developed in line with best practice for patient consent and/or patient identification (which includes guidance for practitioners) in line with the PHECC Code of Professional Conduct & Ethics.	**Fully Met**
	1.2.2 The Licensed CPG Provider has a policy/procedure in place in relation to the refusal of treatment and/or transport.	**Fully Met**
	Standard 1.3 Patients' dignity, privacy and autonomy are respected and promoted.	
	1.3.1 The Licensed CPG Provider has arrangements in place to promote patients' privacy, dignity and autonomy.	**Fully Met**
	1.3.2 The Licensed CPG Provider demonstrates a commitment to develop a culture where volunteers, contractors and/or employees involve and treat people with compassion, kindness, dignity and respect.	**Substantive**
	Standard 1.4 Licensed CPG Providers promote a culture of kindness, consideration and respect.	
	1.4.1 The Licensed CPG Provider undertakes Patient Satisfaction and/or Patient Experience Surveys to help shape and improve services and culture.	**Substantive**
	Standard 1.5 Patients' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	
	1.5.1 Patients' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	**Substantive**
	1.5.2 The Licensed CPG Provider provides training to all front-line volunteers, contractors and/or employees in handling a patient or family member's complaint or concern.	**Substantive**
Theme 2: Effective Care and Support	**Standard 2.1 Healthcare reflects national and international evidence of what is known to achieve best outcomes for patients.**	
	2.1.1 The Licensed CPG Provider has systems, processes and procedures in place to ensure Responders/Practitioners utilise the evidence-based CPG appropriate to their privledged status to deliver and ensure safe and appropriate care.	**Moderate**
	Standard 2.2 Patients receive integrated care, which is coordinated effectively within and between services.	
	2.2.1 The Licensed CPG Provider has a standardised handover process in place to ensure the safe, timely, and structured exchange of information during handover of patients.	**Moderate**
	Standard 2.3 Healthcare is provided in a physical environment, which supports the delivery of high-quality, safe, reliable care and protects the health and welfare of patients.	
	2.3.1 The Licensed CPG Provider has process, systems and procedures in place to ensure the road-worthiness of their patient transport vehicles in line with legislation.	**Fully Met**
	Standard 2.4 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	
	2.4.1 The Licensed CPG Provider submits an Annual Medical Director Report annually,* which informs the PHECC of clinical activities in the organisation and includes a CPG report (*Calendar year).	**Minimal**
	2.4.2 The Licensed CPG Provider has a systematic programme of clinical audit in line with the PHECC standards (STN019), which is used to monitor quality and outcomes and promote learning.	**Moderate**

Theme 3: Safe Care and Support	**Standard 3.1 Licensed CPG Providers protect patients from the risk of harm associated with the design and delivery of healthcare services.**	
	3.1.1 The Licensed CPG Provider has a reliable system in place to prevent and protect patients and staff from healthcare associated infections.	**Moderate**
	3.1.2 The Licensed CPG Provider ensures that there are systems, processes and procedures in place to ensure medicines availability, storage, stocking and disposal processes for the administration of pre-hospital emergency care.	**Moderate**
	3.1.3 The Licensed CPG Provider ensures that there are systems, processes and procedures in place to ensure equipment/medical device availability, storage, stocking and disposal for the administration of pre-hospital emergency care.	**Moderate**
	Standard 3.2 Licensed CPG Providers effectively identify, manage, respond to and report on patient-safety incidents.	
	3.2.1 The Licensed CPG Provider has structured incident reporting and investigation mechanisms, which support and encourage volunteers, contractors and/or employees to report adverse events, near-misses and no-harm events.	**Fully Met**
	3.2.2 The Licensed CPG Provider has a process for the sharing of lessons learned from patient safety incidents (including adverse events, near misses and no-harm events) and complaints, which have occurred locally, nationally or internationally with employees, contractors and/or volunteers.	**Substantive**
	Standard 3.3 Licensed CPG Providers ensure all reasonable measures are taken to protect patients from abuse.	
	3.3.1 The Licensed CPG Provider has policies/procedures in place to prevent harm or abuse occurring and take action where concerns arise.	**Substantive**
Theme 4: Leadership, Governance and Management	**Standard 4.1 Licensed CPG Providers have clear accountability arrangements to achieve the delivery of high-quality, safe and reliable healthcare.**	
	4.1.1 The Licensed CPG Provider has an established reporting and accountability structure for clinical governance.	**Substantive**
	4.1.2 The Licensed CPG Provider has an identified Medical Director who is registered with the Medical Council and who is based in this jurisdiction and who oversees the service.	**Substantive**
	4.1.3 The Licensed CPG Provider is compliant with tax laws.	**Fully Met**
	4.1.4 The Licensed CPG Provider has documentary evidence of the required insurance policies.	**Fully Met**
	Standard 4.2 Licensed CPG Providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	
	4.2.1 The Licensed CPG Provider has systems, process and practices in place to utilise safety and quality information to highlight areas of improvement and improve the quality and safety of the service.	**Fully Met**
	Standard 4.3 The conduct and provision of healthcare services are compliant with relevant Irish and European legislation.	
	4.3.1 The Licensed CPG Provider has systems, processes and procedures in place to ensure compliance with statutory legislation relating to the provision of safe and effective care.	**Moderate**
	Standard 4.4 Licensed CPG Providers act on standards and alerts and take into account recommendation(s) and guidance, as formally issued by relevant regulatory bodies as they apply to their service.	
	4.4.1 The Licensed CPG Provider has a process in place to ensure the appropriate communication and adoption of new recommendation(s) and guidance issued by the PHECC and other regulatory bodies.	**Substantive**
	4.4.2 The Licensed CPG Provider is compliant with the PHECC Governance Validation framework.	**Substantive**

Theme 5: Workforce	**Standard 5.1 Licensed CPG Providers plan, organise and manage their workforce (volunteers, contractors and/or employees) to achieve the service objectives for high-quality, safe and reliable healthcare.**	
	5.1.1 The Licensed CPG Provider undertakes workforce planning to align resources to current workload and projected needs.	**Substantive**
	Standard 5.2 Licensed CPG Providers recruit/engage with practitioners with the required competencies to provide high-quality, safe and reliable healthcare.	
	5.2.1 The Licensed CPG Provider has a process in place to satisfy itself that the English language competence of its Responders and Practitioners, whose first language is not English, is appropriate to the clinical/ professional activities to be carried out by that person i.e. Responder or Practitioner levels.	**Fully Met**
	5.2.2 The Licensed CPG Provider has a process in place to check registration on appointment and on-going renewals of registration for volunteers, contractors and/or employees.	**Fully Met**
	5.2.3 The Licensed CPG Provider conducts checks to confirm that all employees, contractors and/or volunteers have the appropriate qualifications and registrations.	**Substantive**
	5.2.4 The Licensed CPG Provider ensures that employees, contractors and/or volunteers are subject to Garda Vetting in line with the National Vetting Bureau (Children & Vulnerable Persons) Act 2012 prior to patient contact.	**Fully Met**
	Standard 5.3 Licensed CPG Providers ensure their workforce (volunteers, contractors and/or employees) have the competencies required to deliver high-quality, safe and reliable healthcare.	
	5.3.1 The Licensed CPG Provider has developed and implemented a comprehensive induction programme to ensure volunteers, contractors and/or employees understand their responsibilities in relation to the safety and quality of services.	**Substantive**
	5.3.2 The Licensed CPG Provider has a training and development programme in place to ensure volunteers, contractors and/or employees have the required competencies to undertake their duties in line with their registered status.	**Moderate**
	5.3.3 The Licensed CPG Provider has appropriate arrangement for the management, supervision and performance management of students (if applicable).	**Not Applicable**
	Standard 5.4 Licensed CPG Providers support their workforce (volunteers, contractors and/or employees) in delivering high-quality, safe and reliable healthcare.	
	5.4.1 The Licensed CPG Provider has a Critical Incident Stress Management process in place.	**Moderate**
	5.4.2 The Licensed CPG Provider has a Fitness to Practice Policy/Procedure, which makes reference to the PHECC Fitness to Practice processes.	**Fully Met**
	5.4.3 The Licensed CPG Provider has processes for the identification of poor or variable staff performance.	**Substantive**
	5.4.4 The Licensed CPG Provider improves patient safety by encouraging and supporting employees, contractors and/or volunteers in the reporting and learning from patient safety incidents (including adverse incidents, near misses and no-harm events).	**Fully Met**
	5.4.5 The Licensed CPG Provider creates opportunities for staff to feedback on the quality and safety of the service they work in.	**Fully Met**
Theme 6: Use of Information	**Standard 6.1 Licensed CPG Providers have effective arrangements in place for clinical information governance.**	
	6.1.1 The Licensed CPG Provider implements the PHECC clinical information standards and associated patient reports.	**Moderate**
	6.1.2 The Licensed CPG Provider has systems, processes and procedures in place to assure the data quality of healthcare records.	**Fully Met**

Report Summary

Report Status

In accordance with the Council rules this GVF site-assessment does trigger a requirement for PHECC to issue an improvement notice regarding the Provider's service.

Council Rules for pre-hospital emergency care service providers who apply for recognition to implement Clinical Practice Guidelines (POL003 V6) outlines that, where appropriate, full recognition to implement CPGs will be awarded for a three (3) year period. This approval will apply from the last approval date.

Quality Improvement Plan

Cara Ambulance Service Ltd are required to adjust and re-submit their quality improvement plan to PHECC.
This adjustment of the quality improvement plan will encompass the findings outlined in this report and any other planned quality improvement or organisational development initiatives to be undertaken in the upcoming licensing period.

Report Summary

Improvement Notice

This section highlights specific actions to be taken by Cara Ambulance Service Ltd with immediate effect. Be advised that all other recommendations, made in the body of the report, should also be observed and actioned in the follow up quality improvement plan.

Cara Ambulance Service shall:
(1.1.2)
improve its systems, processes and procedures in place for taking calls, verifying addresses and dispatching resources to each call;

(2.4.1 – 2.4.2)
take the appropriate steps to improve its engagement with the Medical Director to promote regular clinical audit activity and the quality of the content of the Annual Medical Director's Report, which is a co-created document;

(2.1.1 – 2.2.1)
improve its process of dissemination of new policies and recording of training activity within the organisation; this should coincide with an improvement in its monitoring of clinical activities;

(3.1.1 – 3.1.2 ¬ 3.1.3)
review and update its infection prevention and control policies to reflect and meet the needs and activities of the service to include the management of clinical and non-clinical waste, and the provision for adequate vehicle and equipment cleaning and maintenance to include provision for regular and deep cleaning;

review the medicines management policies, procedures and guidelines regarding the daily checking of medications and correct response to medication shortages, etc.;

update the equipment register to include recording of asset numbers and ensure all medical gas cylinders are stored securely in the rear of the ambulance;

(4.3.1)
develop a proactive approach to documenting risk management activities;

(5.3.2)
should develop a programme of training and updating of necessary clinical skills;

(5.4.1)
review the CISM policy and establish formal arrangements to provide access to CISM;

(6.1.1)
review and adjust its clinical records management policy to reflect PHECC standards; this review shall also seek to improve security measures and storage arrangements.

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