Pre-Hospital Emergency Care Council

Governance Validation Framework

Site Assessment Report

Defence Forces Medical Corps

June 2021

“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. PHECC's 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 the Defence Forces Medical Corps 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 the Defence Forces Medical Corps is an auxiliary provider of pre-hospital emergency care services in Ireland The on-site GVF assessment visits for this report were conducted during June 2021 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). This report is intended to support the ongoing quality improvement process within the Defence Forces Medical Corps' 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.

Defence Forces Medical Corps' Governance Validation Framework assessment report concludes with a Report Summary, which includes a tabular format that provides an overview to Defence Forces Medical Corps' 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

The Defence Forces Medical Corps provide:

- 24hrs medic and/or ambulance crew duty in Defence Forces installations.
- Emergency medical cover at military exercises and training.
- Medical cover on overseas deployments.
- Medical cover aboard Irish Naval Service vessels.
- Medical cover aboard Air Corps Aircraft.
- Assistance to the National Ambulance Service with Emergency Ambulance in Aid to the Civil Authority operations.

Information used to create this overview was supplied by the Provider.
For more information visit: https://www.military.ie/en/who-we-are/army/army-corps/medical-corps/

Overview of Licensed CPG Provider

Assessment Details:

Licensed CPG Provider	Defence Forces Medical Corps
Type of Visit	Full GVF Assessment - GVFREP DFMC 001_0621
Licensed CPG Provider Lead	GVFA4532
Date of Review	Practitioner Engagement - 10/06/2021 Site Assessment - 25/06/2021
Assessment Team	GVFA4532 - Team Lead GVFA5966 - Site Assessor GVFA6815 - 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 June 2021.

Assessment Details (continued):

Licensed CPG Provider Participants

Director Medical Branch (who is also Provider's Medical Director - Medical Council No 012595)
Deputy Director Medical Branch (Doctor)
Sergeant Major, Curragh Camp (Advanced Paramedic)
Company Sergeant, St Bricin's Military Hospital
Sergeant, Reserve Defence Forces - recent advisor
Corporal, Reserve Defence Forces - support staff

Onsite Feedback

Verbal feedback related to the Assessment Team's initial findings was provided to the Senior Management Team of Defence Forces Medical Corps 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 Assessment Team's comments and indicative findings.

Overall, the Provider's organisation requires improvement in governance processes. The Assessment Team recommends that policies are developed to reflect actual practice and that senior staff with responsibility to enact the policies significantly contribute to their formulation.
The Provider would benefit from developing metrics/key performance indicators (KPI) to measure operational performance. Improved input and oversight from the Medical Director into relation to audit process/themes would greatly benefit the Provider's organisation. Regular structured governance meetings would assist with internal processes, help identify potential issues and provide direction to key staff. This would also identify risk and help inform the risk register. While there are good overall infection prevention and control processes in place, there are some traceability issues with healthcare risk waste.
There is sufficient training in relation to child safeguarding but there is improvement required in identifying responsible/support persons within the Provider's organisation. The Annual Medical Director's Report requires more detail to reflect the organisational workload. Good organisational culture of dignity and respect identified. Overall organisational knowledge is strong within the ranks and there is a very good CISM and staff support system in place. It is apparent that the strength of the Provider's organisation is the staff. They were professional, courteous and demonstrated excellence in all interactions with the Assessment Team.
The Sergeant Major was commended for foresight, support and interaction within the organisation. Ambulances are very clean and overall equipment management is well structured.

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.

Assessment Panel Findings

1.1.1 At each facility, the Sergeant Major or the senior non-commissioned officer (NCO) is responsible for rostering crews 30 days in advance of roster start date. The minimum standard of crewing level is at the paramedic level when operating on behalf of a statutory ambulance service and EMT level for military camp service.

The assessment team were informed that there is a local memorandum of understanding in place with a statutory ambulance service provider since January 2018: to provide 24-hour ambulance cover every Thursday. This provides support to the statutory ambulance service and maintains skill levels within the Provider's organisation. At present, the Provider is not providing an emergency ambulance backup service to the statutory ambulance service provider due to their COVID-19 commitments.

If additional support from the Provider is requested, this is done through military chain of command - Director of Operations. Orders are then directed to local units and operational cells are tasked. This system is designed to ensure operational fortitude but it is obvious that it must take forward resource planning into consideration. The Assessment Team were reassured that the Provider can adequately manage the current level of activity within its own organisation with existing resources. The Medical Director regularly liaises with the statutory ambulance service provider's Medical Director. The Provider stated they plan and test responses to major incidents in conjunction with other agencies on a regular basis. This was evidenced within the Provider's documentation submitted prior to the assessment. Practitioners also advised the Assessment Team that they have been provided with training in major incident medical management.

1.1.2 When operating on behalf of the statutory ambulance service provider, the Provider is dispatched directly by National Emergency Operations Centre (NEOC) and communications are via the tetra system. However, there is no formal training programme for call handlers in relation to local calls but there is a standard operating procedure within the Curragh Camp. Dispatch and supporting information for ambulance crews within the Curragh Camp is via mobile telephone. There is a brief paper-based written record for each call. These calls are taken by the Camp Duty Officer via telephone. The Provider does not utilise voice recording systems to log calls. The Assessment Team could not evidence systems to review ambulance dispatch performance levels. During operation the ambulance is tasked as required with updated messages passed via the mobile phone. Crews use PHECC PCRs, however, the Assessment Team identified that there is confusion over which organisation has responsibility for, or access to, the information generated by these calls when operating on behalf of the statutory ambulance service provider. It was noted that there are various levels of training in relation to the tetra system.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

The Provider has the ability to provide support to the statutory ambulance service provider or support for other services as need arises. The Provider provides additional support to the health services in testing and vaccine administration during the COVID-19 pandemic.

Areas for Improvement

1.1.2 The Provider should conduct an analysis of the procedure for taking local calls to identify if there are additional requirements for voice recording of calls and/or additional training.
The Provider should organise a formal educational programme in the use of Tetra and the Mobile Data Terminal (available on ambulance) for the personnel at the Curragh Camp.

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 procedure for obtaining consent from patients was covered in recent CPG 'up-skilling process'. Patient refusal to travel to hospital is recorded on the PCR and recorded by the NEOC control via tetra. The call is then finished. The Provider's PCRs are the current PHECC recommended versions. During Practitioner Engagement, the practitioners were familiar of the requirement to obtain consent before carrying out an assessment, treatment or transport on a patient.

1.2.2 There have been no PCRs identified for clinical audit or reviewed by the Medical Director through the mechanism whereby a practitioner ticks a box to request a clinical audit. There was evidence of one audit of PCRs (15/04/20), which highlighted the need for correct recording of patient's refusal to travel to hospital. This identified the requirement for practitioners to assess capacity in relation to decision-making. The Senior NCO stated that this information is reviewed with the practitioner and is then revisited in the future.

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

1.2.2 There has been an audit of PCRs carried out by the Provider and the results have changed practitioners' practice.

Areas for Improvement

1.2.2 The Provider should develop a policy or directive to ensure that practitioners assess all patient's capacity in the event of their refusing to travel to hospital for treatment.

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

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	1.3.1 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.

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.3.1 There is a good ethos and culture of dignity and respect in the Provider's organisation. Practitioners are provided with good training in communications and possess good interpersonal skills. A staff code of conduct and behaviour is provided on induction into employment with the Provider. The military code of conduct covers all aspects of professional behaviour and during Practitioner Engagement it was evidenced that the Provider's staff are polite and professional in all interactions. Regular briefing sessions reinforce the concepts of dignity and respect. Reminders of respect are built into "signals corps" regularly and is communicated from the HR department. New communications/latest information or the statutory ambulance service provider's policies are communicated to crews by being placed on staff notice boards.
During Practitioner Engagement, the Assessor did not have the opportunity to observe practitioners/patient interactions by accompanying practitioners on operational ambulance calls. From extended conversations with both practitioners in attendance, the Assessor was confident that they have the manner to treat all their patients with dignity and respect.

1.3.2 The Provider stated that communication and professional skills training is included in training programmes. It is evident that a culture of kindness, consideration, and respect is embedded within this organisation.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

During assessment, all staff engaged well with the GVF process and were polite and professional at all times. The Provider is to be commended on the professionalism and exemplary standard of its staff.

Areas for Improvement

No specific observation noted by the Assessment Team.

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 There was no evidence of the conduction of service user or patient satisfaction surveys. If a patient or member of the public write to the Provider with compliments these are passed onto the practitioner and placed on the notice board. An online information system (information knowledge online - IKON) is also utilised to disseminate messages. Practitioners that demonstrate excellence or receive compliments are mentioned online. There were no complaints noted.

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 online IKON system for delivery of information and disseminate positive messages.

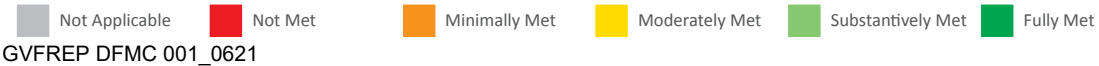
Areas for Improvement

1.4.1 The Provider should actively seek service user feedback and evaluate and use this information to help improve service delivery. There is a change of culture required in respect of putting processes in place that actively seek feedback.

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.



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 In relation to complaints, the Assessment Team were informed that there were none received by the Provider. In relation to complaints, there is a reporting process internally, however, this does apply to receiving complaints from patients. In relation to patient interactions completed on behalf of the statutory ambulance service provider, the complaints are made directly to the statutory ambulance service provider. It was described that practitioners ask patients to put complaints in writing but it is unclear how or where it should be addressed. Internally, there is a "Redress of wrongs system", which is taught and built into basic training and recorded in training diaries. There are no records though in relation to training specific to ambulance complaints. The Provider relies on training completed on a paramedic course completed with an external PHECC Recognised Institution in relation to complaints. During Practitioner Engagement, the practitioners' impression was that complaints are brought to the attention of the Provider through either the Director Medical Branch or the Camp General. They were not aware of how it may be dealt with but suggested that the Sergeant Major or another senior NCO would be the likely person to interview the crew and provide a report for the Director Medical Branch or the Camp General.

1.5.2 Records of complaints training were not available to the Assessment Team. The intention to sample training records was notified.

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

No specific observation noted by the Assessment Team.

Areas for Improvement

1.5.1 The Provider should develop processes and a training programme in relation to complaints from patients and disseminate this to all practitioners and record the training. This approach would bring clarity for all practitioners.

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 A local register of practitioners' status was provided to the Assessment Team. Up-skilling and competency levels are recorded on personal training files, which were verified by the Assessment Team. Due to COVID restrictions the Assessment Team were unable to witness practitioners' engagement with patients.

When PHECC issue new Clinical Practice Guidelines, the Provider's tutors and assistant tutors attend an external PHECC Recognised Institution for updating on the methodology of delivering instruction for the new up-skilling programme. The Provider utilises said Recognised Institution's presentations and deliver them to their own personnel under supervision. Records are then sent to said Recognised Institution and they issue the certificates of completion. The Sergeant Major manages this process. If there is a change of personnel managing this or any other process, there is a Hand-Over, Take-Over protocol in place before anyone can move onto another position. This is designed to ensure consistency of information and process. Safety messages can be disseminated by various methods within the Provider's organisation. All practitioners must check the notice boards when coming on duty or messages can be delivered formally on "Parade". Each practitioner also has an email address, which is not currently used to disseminate information and could be utilised for message delivery. The Provider also liaises with the statutory ambulance service provider when required to seek further information or clarity on clinical practice and guidelines.

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 Good practice of Hand-Over, Take-Over protocol to ensure consistency within the Provider's organisation.

The Provider has a number of mechanisms to disseminate information to practitioners, and receipt of this information can be verified at the beginning of every duty the practitioner undertakes.

Areas for Improvement

2.1.1 There are existing methods of communication in place that could be better used for dissemination of information, for example, email as a direct route of communication with practitioners.

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 When completing patient handovers the Provider uses MIST AT. This has been used since 2012. Individual cards (tac aides) are used to assist with operations. Practitioners use the PHECC developed IMIST-AMBO handover when operating on behalf of the statutory ambulance service provider. During Practitioner Engagement, practitioners were familiar with the use of IMIST-AMBO in relation to handover processes in the Emergency Department. The Provider utilises Ambulatory Care Report forms (ACRs) for Curragh Camp events where appropriate. These are used to record less acute events/cases. The ACRs are sent to the Medical Director's office where there is a record kept of the individual number, chief complaint, and practitioner's personal identification numbers (PIN). The ACRs are then placed into storage.

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 Good recognition of the importance of a structured handover protocol. Use of tac aides ensures consistency amongst practitioners. Use of PHECC IMIST–AMBO when providing care for statutory ambulance service provider.

Areas for Improvement

2.2.1 Recommend completing periodic audit/supervision of practitioners completing patient handover protocol.

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, the ambulance examined did not display tax or insurance discs. The Assessor was informed by the practitioners that discs are not displayed on any of the Provider's emergency ambulances. There is access to a mechanic at the Curragh Camp 24/7 and vehicle maintenance is also managed by a registered Mercedes-Benz dealership garage.

Practitioners carry out a pre-shift check on the vehicle and the equipment. This is recorded in an inspection book that checklists equipment, medications, and vehicle condition. If there are deficits noted during this inspection, they can be brought to the attention of the NCO on duty. Otherwise this book is checked on a weekly basis.

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

No specific observation noted by the Assessment Team.

Areas for Improvement

2.3.1 The Provider is advised to increase supervision by ensuring that inspection books are checked and countersigned, with completed books being stored for retrieval.

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

2.4.1/2 There was an example of oxygen percentages cited as an audit topic. An analgesia audit that measured pre and post management pain scores was also discussed. There was evidence of a PCR audit conducted in April 2020. The Medical Director was aware of the audit process, however, the Sergeant Major chose the audit theme, conducted and reported the findings in line with the required audit cycles. Audit results are sent to the Director Medical Branch. Collectively, results are communicated to practitioners via chain of command/Parade. There was no evidence of a review of key performance indicators or specific clinical audits targeted to meet specific needs or goals for the Provider's organisation.

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 There is evidence that clinical audits have been completed by the Provider.

Areas for Improvement

2.4.2 Recommend more consultation with the Medical Director in relation to audit topics and more input into audit design and delivery. While the Assessment Team recognises the enormity of the role of the Medical Director within the Provider's organisation, the Provider should implement key targets for review and audit. Regular audit, review, and feedback processes will help inform the Provider of good practice and areas of concern, as well as possible risks to stakeholders and the Provider's organisation as a whole.

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 There is evidence of good infection prevention control and clinical waste disposal. The Provider stated that infection prevention and control (IPC) training is provided to their practitioners in basic training, and policies exist covering all aspects of IPC, cleaning of ambulances and waste disposal. The Provider utilises the statutory ambulance service provider's policies and applies them to the Provider's organisation. They also use the statutory ambulance service provider's posters and documentation as they consider these to be suitable, and fit for purpose with a robust format. There is a regular, monthly deep clean of ambulances and a log is maintained. Ambulance clinical waste is not recorded or swan necked and tagged with an ID number, therefore there is a potential issue with tracking waste. Disposal of clinical waste is into large yellow locked bins within the Curragh Camp. There is a contract in place with a service provider for the disposal of healthcare risk waste and this is managed through the base medical services.

3.1.2 The Quartermaster Sergeant orders stock though a Management Information Framework (MIF), which is an inventory containing every item belonging to the Provider ranging from a Paracetamol tablet to a vehicle, and with each item having a Provider assigned number. If medical equipment is required that is not listed in the MIF, a Purchase Order number may be generated and the item sourced. Stock is signed out and if unused or if out of date, can be returned back to stores. Methoxyflurane is controlled and stored in a safe in the Curragh Camp. There was no sign out/in book for controlled medications available for viewing by the Assessment Team and there was no access to the controlled medications safe in St Bricin's Military Hospital as the local advanced practitioner was not on duty. During Practitioner Engagement in the Curragh Camp the availability of sufficient stock of controlled medications was verified. During Practitioner Engagement the Assessor identified that once medication stock leaves the MIF and enters the local stores or "Pick room", it is considered to be issued and can be freely taken from this store without further being recorded.

Adverse Incident policy is available to view within the Provider's organisation. The Provider has documentation that outlines the procedure practitioners must take in the event of an adverse incident or near-miss. During Practitioner Engagement, familiarity with an open disclosure policy and training was evident. Medications and equipment are sourced through the Pharmacist. However, the processes described by the Pharmacist do not fully align with the Provider's policy for controlled medications. Controlled drugs documentation, management and procedures within the Provider's organisation were observed to be non compliant with the Provider's own policy. During the onsite visit the Assessment Team witnessed an inappropriate sign in/out process for controlled drugs. This process is out of alignment with the Provider's controlled drugs medicine policy, which identifies that standardised Defence Forces Controlled Drugs Record books must have numbered pages and meet the requirements of sections 18 – 24 of the Misuse of Drugs Regulations.

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 Cont'd

3.1.3 The MIF system manages the equipment in a robust way. Practitioners can be updated in equipment use if required through scheduled training or on request. If new equipment is introduced, the Sergeant Major liaises with the manufacturer, designs the training programme, engages with the tutors who then roll out the training. The Provider regularly reviews equipment used in other statutory services and recommends its introduction if deemed appropriate. There is regular contact with the statutory ambulance service provider during training and the Provider's practitioners have access to their partner statutory ambulance service provider's online training forum.

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

3.1.1/2/3 There is good availability of equipment and stock for all ambulances. The Provider has extensive cleaning checklist for ambulances and a monthly log of ambulance cleaning exists. The observed ambulances and equipment were clean and tidy. The current clinical waste management policy is extensive.

Areas for Improvement

3.1.1 The Provider must ensure effective, supporting policies and safe processes for the identification and traceability of clinical waste generated within their organisation. The Provider shall improve its management of clinical waste systems to include correct management, tagging and recording of clinical waste. The Provider should consider training requirements for practitioners to improve the management of clinical waste.

3.1.2 The Provider must comply with legislative requirements to ensure security and traceability of movement of controlled drugs. The Provider shall review its current arrangements and improve its management, control and recording of controlled medications to align with HPRA/Department of Health licence requirements. Particular attention is required is the areas of signing in/out of medications; security of medications in service and at the end of the shift; recording of all medications received into the drug cabinet from the pharmacy taken to restock the drug bag, and/or returned to the pharmacy if out of date; ensuring appropriate documentation is available to practitioners to record accurate movement of controlled drugs in compliance with the Provider's own policy.
The Assessment Team acknowledge that there may be further improvements necessary on review of the relevant legislation and the management systems and processes that should apply to medication management.

3.1.3 The Provider should make available all equipment instruction manuals related to ambulance equipment on its internal electronic communications and online IKON system. This ensures easy access to operational and safety information regarding each piece of equipment.

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 During Practitioner Engagement, there was familiarisation with the reporting structures in relation to medication errors. Practitioners were also familiar with Open Disclosure principles as they had received training in this during 2017 CPG up-skilling. They were not aware of any medication error occurring within the Provider's organisation. One practitioner advised that they had initiated a process to replace all Ibuprofen 400mg tablets with 200mg concentration in order to reduce the risk of errors with this medication. This was also identified during the onsite engagement. The Quartermaster Sergeant advised that the changes in Ibuprofen stock had occurred on all of the Provider's ambulances. The Assessment Team support the proactive approach, which may reduce the likelihood of medication error within the Provider's organisation.

3.2.2 There is a documented process and policy for lessons learned, however, this appears to be a document that covers any event in the military. The Provider may wish to either amend this document or publish a new procedure that specifies the lessons learned process within the pre hospital setting. This would ensure a feedback loop process for patients and other stakeholders in the event of having to share lessons learned.

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 Adverse clinical events and open disclosure training included in up-skilling programmes.

Areas for Improvement

3.2.2 The Provider should continue to reinforce the concept of adverse clinical events training and use existing platforms to regularly disseminate this information (online IKON system and email practitioners).

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

3.3.1 There was no safeguarding officer identified within the Provider's organisation. During the onsite visit there was no availability of a specific child safeguarding statement, although the Provider does have a Director Medical Branch instruction document that provides specific information for practitioners outlining their responsibilities to report directly to Tusla, the child and family agency, any risks regarding child safety. This document also specifies exactly who is a mandated person within the Provider's organisation.

Child first training is part of the privileging process and to be privileged practitioners must submit a certificate of completion from Tusla. Certification is valid for three years. The Assessment Team observed that training is being completed by practitioners but it is not mandatory at present. During Practitioner Engagement, both practitioners had completed the Child First programme with Tusla They were aware that they are mandated persons under the Act and would not be privileged to practice without completion of the Tusla programme.

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

3.3.1 The Provider is to be commended for providing clear instructions to practitioners on their responsibilities as a mandated person, and the process to be followed in the event of a child being at risk.

Areas for Improvement

3.3.1 The Provider should appoint a Safeguarding Officer and ensure that Tusla training is documented as a mandatory requirement by the Provider to support the practitioner privileging system in compliance with the Child First legislation.

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 There is a Memorandum of Understanding in place with a statutory ambulance service provider but there are aspects that warrant further development. The Director Medical Branch is clearly identified as having overall clinical governance within the Provider's organisation. The role of the Medical Director encompasses managing on-campus medical assessments and the tasking of medics under their command. They also have oversight of the day-to-day running of the medical service and are assisted by a Deputy Medical Director. Their running of the ambulance corps involves daily input from the Officer in Charge of the Central Medical Unit at the rank of Colonel, who is non -medical, but is assisted by a medic at the rank of Lieutenant Colonel.

Part of this governance structure covers the section 'service delivery'. There was no involvement from any of the Provider's staff within the Central Medical Unit service delivery branch at the site visit. It was difficult to ascertain the relationship between the policy and clinical governance department and the service delivery department during the site visit. A greater insight into the organisation's governance structure and service delivery would have been gained with the input of staff from this department. The Medical Director stated they work closely with the senior NCOs and receive weekly briefings. These briefings are not structured using defined themes but deal with issues as they arise. When issues arise, they are identified to the Medical Director and are managed in conjunction with the Deputy Medical Director and the Senior NCOs.

4.1.2 The Medical Director is a registered medical professional and is aware of the roles and responsibilities required to be a PHECC recognised CPG service provider. They provide clinical oversight when required, oversee the privileging process for practitioners and maintain a strong ethos in relation to confidentiality. They also oversee the production of the Annual Medical Director's Report (AMDR) that is a PHECC requirement. The Medical Director reports to a Major General (non-clinical) and relies on their support to facilitate resourcing for the organisation.

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

No specific observation noted by the Assessment Team.

Areas for Improvement

4.1.1 Provide themes/agenda for discussion and ensure structured team briefings to proactively manage the ambulance within the organisation.

4.1.2 Improve the level of detail in the Medical Director's report to better reflect the organisational 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

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

Assessment Panel Findings

4.2.1 The Director Medical Branch provides a report to the Major General. Their annual plan for Director Medical Branch is based on KPI and reported quarterly. None of the KPI are specific for pre-hospital care practitioners. This does not include information gained from actively seeking data on incidents or complaints. The process is passive rather than active with no formalised structure in place. There is learning from audits, which has been fed out to the Provider's organisation.

The Provider stated that they have had no complaints therefore there is no evidence of organisational change as a result of this. No evidence was provided regarding incident reporting and monitoring and the Provider stated they act on any incidents that are reported and these are dealt with within the chain of command process. No evidence was provided on any international or local quality indicators that may be benchmarked against for service delivery.

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

No specific observation noted by the Assessment Team.

Areas for Improvement

4.2.1 The Provider should further develop their system of audit to incorporate the full audit cycle and support continuous improvement in the service. PHECC KPI should be reviewed to ascertain their relevance to the Provider's practice and the Provider would benefit from developing internal KPI specific to pre-hospital care. PCRs should be regularly audited to drive quality improvement. Previous audits may also be revisited to assess if improvements have been sustained.

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 health and safety, and risk management policy. It was noted that the Brigadier General was in overall charge of risk management and that the Director Medical Branch informs the Chief of Staff of risks identified. An NCO would be responsible for risk assessment and health and safety within their operational area and report to the Director Medical Branch. The Provider stated that there are no regular structured quality meetings to identify risks, and that no risk register exists. No corporate risk register or compliance gap records were provided for verification at the on-site visit.

During Practitioner Engagement, practitioners confirmed they had completed various driver training programmes during their career, however, they had not received any training in emergency driving. It was observed that practitioners were dressed in a variety of different uniforms. The Assessment Team were advised that there is no standard dress code in relation to high-viz jackets while operating on an emergency ambulance. The safety helmet utilised by practitioners is the same as those used by statutory services.

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 Assessment Team.

Areas for Improvement

4.3.1 The Provider should initiate a risk register and a process to review identified risks.

All practitioners licensed to drive an emergency ambulance should receive training in emergency driving.

The Provider should ensure that there is a required standard of uniform and PPE to wear while operating on ambulances.

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

Assessment Panel Findings

4.4.1 There are a number of notice boards outside of the duty room with sections available for information from PHECC, the Defence Forces particularly in relation to staff welfare, and advisories from the statutory ambulance service provider. Updates can also be given on Parade or directly by email to practitioners. Newsletters are also in place.

During Practitioner Engagement, it was identified that there were also risk assessments carried out by the statutory ambulance service provider's risk manager. The Assessment Team were informed that risk assessments are passed on to the Provider from the training team in the statutory ambulance service provider and are then forwarded to the Director Medical Branch for approval.

4.4.2 There was a submission of GVF self-assessment and supporting documents to enable the GVF process.

Areas of Best Practice

4.4.1 There are many routes for ensuring staff are updated with correct information.

Areas for Improvement

4.4.1 Regularise the dissemination of information from the statutory ambulance service provider to the Provider to ensure all relevant information is captured.

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 In relation to succession planning, a discussion took place during the on-site assessment. The Director Medical Branch has addressed and made suggestions internally to attract appropriate skill sets with technical pay related to skill sets. There are technical issues with this at present, which the Provider is actively addressing. The Provider endeavours to provide access to training to ensure skill set and motivation. Regard to promotion is included as part of the vision.
Capacity gaps highlighted by each section where personnel are scheduled to retire. There are also unexpected exits. There is not a scheduled process to address resources but as issues arise the Provider seeks approval for new resources.

The Provider stated that they aspire to plan for advanced paramedic and paramedic training status, however, they are under budgetary constraints. Paramedic training does take place through external Recognised Institution(s), however, the Provider stated that overseas deployments of staff impact on the number of paramedics they would like to train. There are no minimum required establishment numbers at practitioner level within the section to trigger recruitment.

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

No specific observation noted by the Assessment Team.

Areas for Improvement

5.1.1 Workforce planning should consider the establishment of a minimum establishment of personnel within the Provider's organisation to ensure continuity and capacity of the service.

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.

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

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

5.2.1/4 On induction into employment all staff are required to have English language competency and there is a process to verify this within pre-employment checks. No documents were available for verification of this process. There is a policy in place, however, the Assessment Team could not verify the process for assessing this. The Assessment Team were informed that mentoring occurs, however, there is no formal process in place. The Sergeant Major is the contact for someone that requires training.

5.2.2/3 On induction employees undergo a security and Garda vetting process. In order to practice within the Provider's organisation practitioners are required to be registered with PHECC as well as completing a practice privileges pro-forma containing at least 12 clinical contacts per annum. This is then submitted to the Director Medical Branch who will grant a practitioner privilege certificate. Within this application, the practitioner is also required to declare practice restrictions or legal convictions within the last year. The Provider has a process for de-privileging a practitioner. This would involve removing the practitioner from clinical engagement with patients, for example, removing to an administration role, and a subsequent investigation by the pre-hospital advisory group within the Provider's organisation.

All staff in this organisation are issued with a contract outlining their terms and conditions of employment.

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

5.22 - 5.2.4 The Provider has a robust privileging process in place that is well managed.

Areas for Improvement

5.22 - 5.2.4 There is a requirement for the Provider to establish a process to help inform PHECC of any issues that may occur with relation to privileging or other matters in accordance with the PHECC Licensed CPG Provider Notification Process (LIS020).

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 There is an interview process to enter the Provider's organisation. Induction training helps maintains the culture within the organisation. The Assessment Team support this practice and see it as a value adding process. Induction is a substantial 6-month programme, which includes training appropriate to overseas training. There is a personal appraisal plan process to help individual's identify areas for training, with continuous professional development (CPD) days assigned to help support staff. There is a broad range of external lecturers and programmes to facilitate relevant topics and help inform staff of key topics.

5.3.2 The Assessment Team completed random checks of up-skilling records and all were found to be available and correct. The Provider's personnel have considerable experience in infection control practices (Sierra Leone, 2014 Ebola outbreak). Donning and Doffing training was provided to the Provider's training team in March/April 2020 by a PHECC Recognised Institution. Internal training was then carried out by the Sergeant Major.

All training, including clinical training, completed by personnel is recorded on a Personnel Management System (PMS). The PMS records items of information about practitioners, such as training records, overseas visits, change of address etc. In relation to the clinical training, which PHECC registered practitioners complete, this must be documented and submitted with the required certificates to the NCO. Practitioners can outline areas where they feel they are deficient, which is then passed to the Director of Medical Branch, and inputted into the PMS. Following successful completion of all necessary requirements, the practitioner is privileged to practice by the Director of Medical Branch. If a practitioner does not complete the entire requirement to allow them to be privileged by the Director of Medical Branch they are allocated other roles within the Provider's organisation.

Practitioners returning from overseas must complete an induction programme when being reintroduced into local operations. This is to ensure they receive updates on policies, CPGs, new equipment or a new ambulance specification.

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 Very good process for induction within the Provider's organisation.

Areas for Improvement

No specific observation noted by the Assessment Team.

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 CISM trainers complete a two-week course. Staff are supported by a Critical Incident Management Team, which is comprised of around 10 personnel. This team can mobilise nationally and internationally as required. Practitioners can go through local system representative or other methods to access the team. There is a very proactive approach to CISM.

5.4.2 Issues are thoroughly investigated while ensuring everyone is kept informed. Personnel go to subject matter experts for advice. Experienced personnel provide this advice. Everything is recorded and training is used to remediate any issues in the first instance. There is no formal procedure currently in place, however, the Assessment Team were assured that practitioners would be de-privileged by the Director Medical Branch if required. There is no formal training in investigation.

5.4.3 There is an annual appraisal assessment for all personnel using a points-based system. Appraisal areas include deportment, physicality, and communications skills. There is a narrative included for all practitioners and this all affects progression. There are five competencies around promotion.

5.4.4 Redress of Wrongs policy: this is where PDFORRA may make representation on someone's behalf. A formal complaints procedure exists. A complaint can be raised against anyone within the service. Within this process the complaint may be dealt with a local or central level.
Regular workplace satisfaction surveys are completed.

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 is to be commended for the high-profile nature of its CISM programme and for actively promoting it within their organisation. It is clear through the engagement of all staff during the GVF process that they highly value the CISM programme within their organisation.

Areas for Improvement

No specific observation noted by the Assessment Team.

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

6.1.1 Access to patients' PCR are through Freedom of Information requests. Regular data protection questions come up on staff computers when they are logging on to reinforce data protection issues. There are alerts and support messages issued with every request to support this process. All information is traceable by who accessed it. The Major General has overall GDPR responsibility. They appoint a responsible officer to work on their behalf. There is a two/six-week programme for admin staff and training is included as part of induction training.

6.1.2 Audits are completed in relation to completeness of the PCRs. PCRs are completed on all calls by the Provider's practitioners. The PCR is kept in a locked cabinet in the front of the ambulance until the end of the shift or until the crew get back to their base and is then placed into a safe in the duty room. Redacted details of the calls are noted in a log sheet at the station. At the end of each month, the PCRs are compiled by the Sergeant Major and forwarded to the Director Medical Branch. The Sergeant Major has carried out an audit on PCRs nationally. These audit results were passed on to the Director Medical Branch. If a 'Serving Member' suffers a minor injury, not requiring hospitalisation, while on manoeuvres the practitioners may utilise an Ambulatory Care Report (ACR).

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

6.1.1 Use of the online IKON system to periodically inform staff of information governance procedures and obligations is an excellent way to communicate with members of this organisation.

There is a robust system in place for the management and storage of PCRs.

Areas for Improvement

6.1.2 The Provider should implement a regular system of clinical audit. This will ensure monitoring of any variation in clinical practice and inform the Provider of needs regarding future clinical training. Regular clinical audits will also help inform organisational KPI.

Report Summary

The PHECC Governance Validation Framework consists 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 Defence Forces Medical Corps are as follows:

Judgement Framework Level	External Assessment Assigned Level	Percentage
Not Applicable	1	2.3%
Not Met	0	0%
Minimally Met	4	9.3%
Moderately Met	15	34.9%
Substantively Met	15	34.9%
Fully Met	8	18.6%

GVF Site Assessment Summary - Defence Forces Medical Corps

	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.	**Substantive**
	1.1.2 The Licensed CPG Provider has systems, processes and procedures in place for taking calls, verifying addresses and dispatch to call.	**Minimal**
	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.	**Moderate**
	1.2.2 The Licensed CPG Provider has a policy/procedure in place in relation to the refusal of treatment and/or transport.	**Moderate**
	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.	**Substantive**
	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.	**Fully Met**
	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.	**Minimal**
	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.	**Moderate**
	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.	**Minimal**
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 privileged status to deliver and ensure safe and appropriate care.	**Fully Met**
	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.	**Substantive**
	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.	**Substantive**
	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).	**Substantive**
	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.	**Minimal**
	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.	**Substantive**
	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.	**Moderate**
	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.	**Moderate**
	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.	**Moderate**
	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.	**Moderate**
	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.	**Moderate**
	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.	**Moderate**
	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.	**Substantive**
	5.2.3 The Licensed CPG Provider conducts checks to confirm that all employees, contractors and/or volunteers have the appropriate qualifications and registrations.	**Fully Met**
	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.	**Substantive**
	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.	**Fully Met**
	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.	**Substantive**
	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.	**Fully Met**
	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).	**Moderate**
	5.4.5 The Licensed CPG Provider creates opportunities for staff to feedback on the quality and safety of the service they work in.	**Moderate**
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.	**Substantive**
	6.1.2 The Licensed CPG Provider has systems, processes and procedures in place to assure the data quality of healthcare records.	**Moderate**

Report Status

In accordance with the Council rules this GVF site-assessment does not trigger a requirement for PHECC to issue an improvement notice, attach conditions or withdraw recognition.

Council Rules for pre-hospital emergency care service Providers who apply for recognition to implement Clinical Practice Guidelines (POL003 V7) 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

The Defence Forces Medical Corps is required to submit their Quality Improvement Plan to gvf@phecc.ie. The Quality Improvement Plan will encompass any areas highlighted in the 'Areas for Improvement' and will identify and outline improvements to be actioned or planned at the Defence Forces Medical Corps in the upcoming licensing period.

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