Pre-Hospital Emergency Care Council

Governance Validation Framework

Assessment Report

Irish Red Cross

September 2023

Pre-Hospital Emergency Care Council

Mission Statement

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

QUALITY ASSURANCE PROGRAMME

Governance Validation Framework
Quality Review Framework

Table of Contents

CONTENTS

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

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

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

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

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

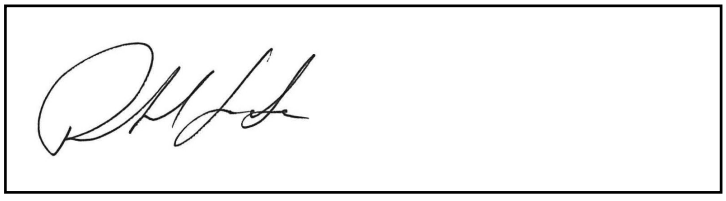
The GVF and the QRF relate to specific standards and identify the supporting components that PHECC recognised CPG service providers and approved organisations should have in place to ensure good governance and quality in delivery of education, pre-training, and operational hospital emergency care with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

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

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

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

2. Assessment Report Overview and Validation

Organisation Name	This report relates to the Irish Red Cross, a PHECC Recognised CPG Service Provider, licensed to deliver pre-hospital emergency care services in Ireland since 2010. The Irish Red Cross is recognised by PHECC under S.I 109 of 2000 as amended by SI 575 of 2004 at the following clinical levels: ☑ Emergency Medical Technician ☑ Paramedic ☑ Advanced Paramedic ☑ Organisation also provides responder level services
Assessment Type	☑ Planned ☐ Reactive
Process	☑ Desktop Review ☐ Online Management Engagement ☑ Onsite Management Engagement 16 Merrion Square Notth, D02 XF85 ☑ Practitioner Engagement Irish Truck & Argicultural Show, Dungarvan, Co Waterford
Outcome Rating **Technical Weighting Applied** **Yes** ☐ **No** ☑	See table below
Follow Up Action Required	☑ Continue with normal quality improvement activities ☐ Improvement notice - follow up evidence required ☐ Conditional Approval ☐ Suspension notice ☐ Delisting process intiated
Reassessment Costs	☑ Not applicable
Validated and Approved for Publication **Director Signature** **Date**	 14/02/2024

No of criterion assessed	45
Maximum score available	180
63% of Max =	113
Assessment Results	
Total score achieved	162
Total score as percentage	90%
Assessment Outcome Rating	**Acceptable**

3. Assessment Participants

Organisation	PHECC Assessment Team
Secretary General National Director of Units	Team Lead
National Medical Officer (Medical Council Reg No 14402) Regional Medical Director	Onsite Assessor
Head of National Services Head of Compliance and Legal Affairs	Practitioner Engagement Assessor
Regional Director of Units Practitioners	

4. Initial Feedback Given

PHECC acknowledged the participation of the Irish Red Cross in the GVF assessment and verbal feedback related to the Assessment Team's initial findings was provided to the Management of the Irish Red Cross by the Team Lead at the feedback meeting. There was broad agreement by the leadership of the Irish Red Cross with the Team's comments and indicative findings.

The following areas were identified as areas requiring improvement, or further potential for improvement areas: awareness of refusal of treatment and assisted decision making, infection prevention and control, training for risk assessment processes, updating of whistle-blower policy and improved version control of documents.

The body of this report contains further information in each case.

5. Rating Scale and Outcome Rating

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

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

6. Weighting Tolerance

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

7. Outcome Rating

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

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

8. Assessment Findings

The following are points of note:

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

Standard 1

Person-Centred Care and Support

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

Standard 1

Criterion

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

Rating

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

Assessment Findings

The terms staff, members and volunteers are used interchangeably throughout this report.

The Provider provides ambulance and event cover nationally, which is managed over four regions. The Assessment Team noted that patients treated by the service have access to pre-hospital emergency care based on their identified needs and the Provider's scope of services. The Provider has good systems in place to ensure appropriate practitioner levels, equipment and medications are available at duties and events.

The Provider actively seeks feedback and provides a QR code to patients to facilitate this and make feedback accessible to patients. Complaints dealt with by the National Medical Officer and National Director of units were evidenced during the onsite assessment and well managed. Lessons learned as a result of feedback are communicated to practitioners who receive an electronic memorandum via an online learning platform or email to ensure organisational learning occurs. Issues and complaints identified from patient feedback are included in practitioner Continuous Professional Competence (CPC) Education.

The Provider also conducts practitioner surveys, which inform CPC content. The National Medical Officer includes a session in audit outcomes as part of the CPC process. Practitioner surveys generated by the Provider, measure interventions, medications and equipment used, and the Provider uses feedback to target training and improve patient care.

Area(s) of Good Practice

The Provider ensures that there is an appropriately trained member and at least one PHECC registered practitioner at EMT level or above at each event.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

During the Practitioner Engagement, practitioners were observed as being professional and welcoming to all patients. Practitioners are aware of the organisation's discrimination policy. The Provider ensures that each member completes an induction course, which includes the seven fundamental principles including respect, dignity and equality policies.

The Provider has a patient-centred focus that empowers patients to make informed decisions about the services they receive. The views of patients are sought and analysed. Sources of this information include complaints, and compliments processes. A low number of complaints are reported as having been received.

Membership training records were also evidenced. The induction programme, completion of Garda vetting and children first safeguarding training are automatically recorded on the individual member profiles.

Area(s) of Good Practice

There is an obvious emphasis placed on respect and effective communication during induction and ongoing training.

Area(s) for Improvement

The Provider would benefit from ensuring that all complaints, especially verbal complaints are logged.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider does not respond directly to emergency call outs, however, they may be activated and mobilised by the statutory services when required. The Provider has clear guidance in relation to event / call booking and there are Standard Operating Procedures in place for the management of duties. Practitioners are equipped with tetra radios and training is provided. An appointed operational lead decides on practitioner deployment. Currently, the Provider uses event organisers who are experienced in the role, which is evidence of good planning. The Assessment Team were informed that there is a new online event training programme and new national booking form planned.

During Practitioner Engagement, the Provider delivered services at a remote site event and it was noted that practitioners positioned resources at multiple strategic locations for awareness/visibility and access for patients that required assistance. Accurate recording of patient information was observed.

Area(s) of Good Practice

The Provider provided support to the statutory services, successfully managing interfacility transfers at weekends. This was managed by regional directors who coordinated calls.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Assessment Team observed a very good standard of patient interaction, practitioner introductions and confirmation of name, date of birth, and other ancillary information requirements including consent. The Provider has Standard Operating Procedures that covers duty management and inter area duty coverage. Each patient is dealt with in line with agreed organisational procedures and Clinical Practice Guidelines (CPG).

The Assessment Team evidenced very good Ambulatory Care Report (ACR)/Patient Care Report (PCR) training material delivered to members, which includes the importance of patient identification.

Organisational procedures related to patient handover are in place. The Provider utilises IMIST AMBO at hospital handover and provides hospital staff with a copy of the PCR that has patient details.

The Provider evidenced rapid mobilisation of its resources to a recent large-scale incident. It related how it provided 60 personnel and 27 ambulances within one hour to help with patient transfers. The Provider reported that this represented an opportunity for members to achieve experience and to complete and monitor patient handovers.

Area(s) of Good Practice

The Provider has good Ambulatory Care Report (ACR)/Patient Care Report (PCR) training material, which includes the importance of patient identification.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

1.5 The Provider has a policy for informed consent.

Rating

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

Assessment Findings

The Provider has a draft Consent to Examine and Treatment policy and consent is referenced in multiple documents. During the Practitioner Engagement practitioners were observed obtaining consent from patients. Practitioners confirmed that they received training on the procedure.

The Assessment Team evidenced the Provider's consent policy. Informed consent is covered in all relevant training programmes and the Provider is currently reviewing the policy to ensure alignment with best practice. Training regarding patient consent is included in educational courses for all clinical levels within the Provider's organisation and consent is referenced in multiple policies reviewed by the Assessment Team.

An audit was conducted in capacity and consent, and patient consent was reported as having improved following the actioning of improvement advice from a previous GVF engagement.

The Provider is currently examining the new Assisted Decision Making (ADM) legislation. Future Training on ADM is planned in line with the Health Service Executives programmes.

Area(s) of Good Practice

There has been active reflection and improvement within the Provider's organisation regarding consent and capacity training.

Area(s) for Improvement

The Provider should finalise their consent policy and consider introducing a campaign of awareness for all staff. Training to introduce the Assisted Decision-Making (ADM) Act and its implications should be developed and all members should receive training in ADM.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider has a policy in place for Refusal of Treatment.

During Practitioner Engagement, discussion with practitioners identified inconsistencies between members understanding of the details and criteria of the Refusal of Treatment Policy.

The Assessment Team reviewed training material for all clinical levels and the refusal of treatment guide. The Provider proactively conducted an audit of patients who declined treatment in 2020 and delivered the findings to all practitioners as part of CPC education. The audit of patients who declined treatment helped reinforce awareness of the importance of capacity assessment amongst practitioners. The audit results showed very good compliance with completion of documentation. The intention is to repeat this audit in the future to measure improvement.

The Assessment Team also reviewed the Provider's patient Discharge and After Care Policy, which provides strong guidance around capacity assessment.

Area(s) of Good Practice

The Provider utilised the audit of patients results to improve awareness of the importance of capacity assessment amongst practitioners.

Area(s) for Improvement

The Provider should make further efforts to improve all members understanding and awareness of the refusal of treatment guide and the organisational and individual risks involved in this area.

Standard 1

Criterion

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

Rating

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

Assessment Findings

During Practitioner Engagement, it was observed that members ensured all patients are treated with compassion, respect, and dignity. A culture of respect and dignity was also evident during the onsite engagement.

The Assessment Team were informed that the Provider makes continual efforts to support respect and dignity for patients and staff. The Assessment Team evidenced the Provider's presentations related to ethics, code of conduct and respectful communications.

Area(s) of Good Practice

The Assessment Team observed good empathy amongst practitioners when dealing with patients and there was an obvious top-down culture of dignity, respect, and good communication.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Assessment Team observed members making patients aware of the facility to provide feedback. The Provider has developed a patient feedback tool to enable patients to provide feedback online using a QR code, which is in ambulances. Despite the good practice and active approach to seeking feedback, there are very low levels of feedback received. The Provider recognises that there needs to be a sustained focus in this area.

The Patient Discharge and Aftercare Policy include information about patient satisfaction survey forms.

The Assessment Team were informed of communication/feedback from headquarters to individuals regarding positive feedback submitted by service users which helps improve morale. When interviewed practitioners were unable to relate any global feedback communicated to them by the Provider.

Area(s) of Good Practice

The posted QR code and additional means of feedback is simple and accessible for patients.

Area(s) for Improvement

The Provider would benefit from increasing its communication of feedback received to practitioners.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider has a Complaints Policy, and the Assessment Team verified a link to both the policy and complaints email available on the Provider's website. The email address is continuously monitored.

There is no agreed timeframe for response to complaints in the Complaints Policy.

There are detailed written processes in place, which are outlined in a Standard Operating Guidelines (SOG) for complaints against the Provider and behaviour of its staff. The SOG includes agreed timeframes.

Area(s) of Good Practice

There are clear directions and links for making a complaint to the Provider.

Area(s) for Improvement

The Provider should further develop the Complaints Policy to include agreed timeframes to respond to complainants.

Standard 2

Effective Integrated Care and Safe Environment

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

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Assessment Team observed availability of the PHECC Clinical Practice Guidelines (CPG) on the Provider's vehicles. Members informed the Assessment Team of upskilling programmes undertaken and were aware of the availability of Continuous Professional Competency (CPC) support programmes.

CPG upskilling courses are completed using a blended learning approach: one day face-to-face and one day on an onlne learning platform. Practitioners who complete upskilling with other organisations are required to provide evidence of upskilling. The Provider's Emergency Medical Technicians upskilling is almost complete, and training for the remaining practitioners is planned soon.

The Assessment Team verified that the Provider encourages members to carry PHECC field guides and use them to crosscheck medications with another practitioner.

The Assessment Team viewed the Provider's Training Records Management system. Levels of upskilling are recorded, and Garda Vetting and Child Safeguarding processes are verified prior to practitioners being privileged to partake in clinical practice.

Area(s) of Good Practice

The Provider has good systems in place to ensure that practitioners use the CPG appropriate to their scope of practice.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

While there was no handover or transport of patients to further care during the assessment, the Assessment Team was informed of the use of IMIST-AMBO for patient handover. When managing patients for interfacility transfers, incident numbers were generated by the statutory service for the Provider to provide a support role. The Provider used the IMIST-AMBO handover format for these patients and practitioners ensured that files and personal belongings accompanied each patient. These duties helped members gain valuable experience and contributed to their patient contact CPC requirements.

The Provider has Standard Operating Procedures (SOP) in place for patient handovers. Patient handover training (IMIST-AMBO poster) standard is available on their online learning platform. The Assessment Team evidenced the Provider's presentation and poster for IMIST- AMBO.

Area(s) of Good Practice

The Provider places emphasis on a structured handover process and it is regularly included in member training.

Area(s) for Improvement

The Provider would benefit from adding the IMIST-AMBO patient handover method to the transport to hospital policy.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Assessment Team observed compliance with vehicle Insurance and CVRT certification during the Practitioner Engagement. Staff in headquarters monitors and completes all legislative requirements for the annual CRVT and Insurance policies are in place. The Provider is a registered organisation with the Road Safety Authority (RSA), and the RSA perform an annual visit.

The Provider self-monitors their active vehicle list and conducts 6-monthly servicing of vehicles as preventative maintenance. The RSA traffic light system red, orange, and green is used by the Provider. Maintenance is presently managed locally, and it is planned to manage this centrally in future.

Logbooks are paper based at present, however, the Provider is moving towards recording online and have piloted an internally developed new proprietary system in the Limerick region: defect reporting, tax, insurance, clinical records, availability of medications, equipment and sanitisation are included. The system records clinical level and PIN numbers and allows for EMT medication and equipment checks. This is an application that practitioners can use via their mobile phones or vehicle tablets.

The Provider recognises that the fleet is aging and is establishing a fleet renewal programme. The Assessment Team were informed that the Provider has a planned strategy to renew the fleet over the next 5 years. A tendering process is under development.

Area(s) of Good Practice

Vehicles were very clean and serviced, and equipment was fully serviced.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Assessment Team was informed of the need for all staff to undergo initial induction training including manual handling. Training in safe patient transport is included as part of the Provider Emergency Medical Technician course. The Provider provides training in patient handling.

There is a SOP for transporting to hospital and a separate procedure for non-emergency transport of patients.

Area(s) of Good Practice

There are standard operating procedures and training in place for the transport of patients.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider has a driver manual that references the use of lights and sirens, however, the Provider does not have a formal policy on their use. This document was last versioned in 2003.

The Assessment Team found a lack of awareness and discrepancy between staff regarding 'Blue Light' driving.

Blue lights and sirens are only recommended when it is clinically necessary. This is on a case-by-case basis. Principally, the decision rests with the driver. There is a driver panel and good records are maintained.

The Provider informed that they are in the process of developing a Blue Light and Sirens policy. There is also a plan for Emergency Services Driving Standard (ESDS) instructors to be developed in-house.

Area(s) of Good Practice

Despite not having a clear policy, the Assessment Team observed a unified attitude of caution while using emergency lights and sirens.

Area(s) for Improvement

The Provider shall update their driving policies and provide improved processes to guide driving, which should include the Provider's direction on the appropriate and safe use of lights and sirens. The training dimension of these updates shall also be addressed.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Assessment Team evidenced a documented fire evacuation policy. Head office maintains records of fire drills. There is a volunteer Health and Safety committee and volunteer Health and Safety manual in place. There is a schedule of 40-50 Provider premises nationally. A draft safety statement is in place.

The Provider plans to complete random Health and Safety audits in the future.

The Provider is contracting an external Health and Safety provider to review all premises under the Provider's control and this process will ensure that all required Health and Safety documentation is in place.

Area(s) of Good Practice

The Provider is proactively managing the health and safety requirements, including fire safety within their premises.

Area(s) for Improvement

The Provider should progress with health and safety audits and finalise the safety statement.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Assessment Team verified that the Provider has items relevant to business continuity noted on its risk register, and has continuity insurance in place. The Provider has management plans for various situations in place.

The Provider's premises and vehicles are in many different locations, which builds in redundancy and allows for better service continuity. Pre hospital care is only one aspect of the Provider's activities, however, it is well distributed nationally. The Provider has a felixible approach to working and core staff can work remotely. Computer records are regularly backed up and cyber insurance is in place.

Area(s) of Good Practice

The Provider is a resilient organisation that demonstrates ability to forward plan to ensure their service model remains available when required.

Area(s) for Improvement

The Provider would benefit from carrying out a robust risk assessment to support the business continuity related items on the risk register.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider regularly supports the relevant statutory services. The Provider has an Emergency Relief Memorandum of Understanding (MOU) in place with the Department of Business, Enterprise and Innovation that includes welfare issues. Statistics on assistance to statutory ambulance providers during Covid-19 pandemic are available. The Provider is listed under the framework for Major Emergency management as a voluntary organisation that may support the principal response agencies.

The Provider has twenty-four-wheel drive vehicles, including ambulances which can be deployed in difficulty to access areas of snow and ice conditions. There is a SOP in place for major incidents. The response the Provider provides to floods and severe weather brings additional welfare support to the principal response agencies. There are SOP for these respective responses in place which clearly and correctly detail staff limitations and safety considerations.

Area(s) of Good Practice

There is clear evidence that the Provider has a role in, actively plan for, and train for assisting with major incidents.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The audit programme is led by the National Medical Officer and the Clinical Governance Group who also manage clinical audit activities. The Assessment Team observed staff awareness of the current clinical audits. There is a comprehensive audit plan in place and staff are informed of the audit results in multiple formats to ensure organisational learning occurs.

There is evidence of clinical audits available to review and the Assessment Team reviewed a comprehensive audit list from 2015 until 2023. Audit results inform the activities of the Training Working Group and audit reports are included in practitioner CPC programmes. Audit reports are available on the Provider's online learning site for all staff.

The Provider has a clinical audit policy that is currently under review, and has established a clinical governance group that will set out audit programmes. There is a new three-year clinical audit plan commencing later this year.

Area(s) of Good Practice

The Provider and the National Medical Officer actively engage in the audit cycle and note the value of clinical audit.

Area(s) for Improvement

The Provider would benefit from adding observational audits such as hand hygiene and glove usage to the audit cycle.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider submits the CPG Service Provider Annual report as required to PHECC and is fully in compliance with the standard.

Area(s) of Good Practice

The Provider ensures their responsibilities under the quality standards are actively managed.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Safe Care and Support

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

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider has a written policy on infection control, as well as other policies related to hygiene in clinical settings. The Infection Control Policy does not refer to fit testing of FFP3 masks and this is not done.

The Assessment Team was presented with a folder of freshly printed policies and pages, which staff found difficult to navigate when asked for information regarding the Infection Prevention Control (IPC) policy.

Good hygiene practice was observed during Practitioner Engagement. The vehicle was cleaned in between each patient, however, staff were unsure of a structured process or required products for cleaning. This is despite an ambulance cleaning and sanitisation guide being available. The Provider introduced a proprietary aerosol system during COVID, which is deemed less corrosive than Chlorine tablets. There is no evidence of pre and post antimicrobial swabbing to confirm the effectiveness of this product. Funding for additional systems had been secured.

The Provider ensured there was sufficient PPE available during COVID. The Health and Safety committee had some concerns reported to it by staff around substandard PPE. This was acted on and is good evidence of the membership feedback loop in relation to safety concerns. Alcohol hand gels are distributed nationally. The Provider has received PPE donations following COVID. Training sessions on infection control is included in all the Provider's courses.

There are uniform and uniform laundry policies in place. Specific guidance on each piece of equipment and cleaning requirements is in place and the Assessment Team were informed that there is a proposal to develop a video to simplify training for new and current members.

Area(s) of Good Practice

Infection prevention and control practices are featured in multiple policies and included in initial training for all courses.

Area(s) for Improvement

The Provider should provide members with improved IPC training and ensure that effective IPC measures are being implemented. A programme for fit testing of FFP 3 face masks should be undertaken in line with Infection Prevention Guidelines. The efficacy of the propriety aerosol system should be established to give assurances to the Provider of its effectiveness.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider has a service level agreement with specialist waste disposal company for disposing of clinical waste. The contract is for twelve locations with a frequency of collections every twelve weeks. Clinical waste training is incorporated into FAR, EFR and EMT training courses. The Provider has a Clinical Waste Storage and Disposal Policy.

The Assessment Team observed appropriate waste facilities that included general waste and separate clinical waste. Staff stated there was a clinical waste bin at the base and that they phoned the waste management company when it required emptying.

Area(s) of Good Practice

There is evidence of good processes and training in place to ensure the effective and safe disposal of clinical waste.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Assessment Team observed medication administration and recording in line with best practice.
The Provider has a dedicated suite of policies in relation to medication management and is licensed by HPRA for medications included under the Misuse of Drugs Act, 1977. HPRA licences were verified by the Assessment Team.

Related policies include Responder and EMT Medication Policy, Paramedic and Advanced Paramedic Medication Policy and the Controlled Drugs Policy. The Provider has medication requisition, stock control and medication returns books for recording and control of medications. Methoxyflurane administration is recorded and must be linked to a PCR. There is a specific Methoxyflurane logbook on each vehicle and evidence of processes in place to highlight any unusual usage of Methoxyflurane, which is good practice. Training in Medication administration and recording is included in CFR, FAR, EFR and EMT courses.

Area(s) of Good Practice

There are effective policies and procedures for the storage and administration of controlled medications.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Criterion

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

Rating

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

Assessment Findings

During Practitioner Engagement, the practitioner information regarding the stated policies and procedures was verified. Medications are locally sourced upon request except Methoxyflurane, which is centrally issued through Headquarters.

There is an Incident Management Policy and procedure in place, which includes the reporting of adverse clinical events. The Assessment Team evidenced good systems in place to manage safety alerts and equipment recalls. HPRA and PHECC notifications are sent to a monitored email account. Alerts are addressed and managed via email, and by notifications on the online learinng platform and at unit level.

Controlled medications are stored at three locations nationally with future plans for a fourth site. There is an Advanced Paramedic tasked with responsibility for each site. The requirement for carrying controlled medications is low. When they are required to be available, they are stored in a locked vehicle, in a locked safe.

Area(s) of Good Practice

Management of Methoxyflurane is robustly managed.

Area(s) for Improvement

It would be beneficial for the Provider to develop an Adverse Clinical Events Policy separate to the Incident Management Policy.
The Provider may also consider how improving integration of medication ordering systems could improve standardisation nationally.

Standard 3

Criterion

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

Rating

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

Assessment Findings

There is an Ambulance Equipment Policy in place. The area Director of Units has responsibility for overall unit equipment management.

Staff stated that there is no dedicated spare medical equipment facility. Equipment that requires replacement is substituted from other vehicles not in use on that day. There is uniformity in the purchasing of Automated External Defibrillator's, stretchers, and mainstay items, which streamlines training and interoperability between units.

Most ambulances are equipped for EMT level practitioners. The Provider has policies, systems and structures in place to ensure the availability of medical devices and consumables. Diagnostics kits are now standardised with each practitioner receiving a standard issue. Servicing of equipment is now done by one provider nationally. Records are currently maintained locally and are planned to be held nationally.

All equipment inspected during the Practitioner Engagement was verified as being in-date.

Area(s) of Good Practice

The standardisation of equipment is beneficial in the development of training material, servicing, and bulk purchasing cost savings.

Area(s) for Improvement

The Provider should implement central recording of equipment, medical devices, and service records, which will be beneficial for managing servicing dates, etc, and will support monitoring and audit in this area.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Assessment Team viewed the Provider's Ambulance Equipment Policy.

The Assessment Team was informed that all staff receive induction training that includes therapeutic equipment. Each unit undertakes personalised training each week. Training content is based on practitioner needs. Training attendance is recorded but content is not.

The use of all standard diagnostic and treatment equipment is covered on all EFR and EMT courses. Ongoing training in use of equipment is included in CPC and recertification sessions. Local unit training includes equipment familiarisation sessions.

Area(s) of Good Practice

The Assessment Team observed good teamwork and a supportive ethos in action.

Area(s) for Improvement

The Provider would benefit from implementing a programme of training for each unit based on practitioner needs and recording the content of the training.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider has a Safeguarding Policy in place, which the staff are aware of, as verified by the Assessment Team. There is a National Safeguarding Committee in place, which meets regularly. The Provider is currently recruiting for a specialist national safeguarding officer.

Mandatory safeguarding training is part of the induction process for all new probationary members. Full membership is dependent on completion of this training.

When questioned about the Safeguarding Policy and practitioner responsibilities regarding reporting, the Assessment Team discovered a lack of awareness of practitioner responsibility under the legislation. Specifically, practitioners were not aware of their personal requirement to report any suspicion and stated they would tell the Gardaí or nurse.

Area(s) of Good Practice

The Provider has a safeguarding policy, which is mandatory for all members.

Area(s) for Improvement

The Provider shall improve its members' awareness of their safeguarding reporting responsibilities and in particular any reporting process they are required to follow.
The Provider's Safeguarding Policy should reference and include vulnerable adults.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Assessment Team verified evidence of self-assessment and the use of the audit cycle to ensure change occurs. The Provider provided the Assessment Team with evidence that feedback from audits have improved practitioner behaviour and improved organisational knowledge.

Clinical audit outcome sessions are delivered by the national medical officer as part of CPC sessions. Review of Incidents, adverse clinical events and lessons learned are disseminated via the unit training structure.

Area(s) of Good Practice

Audit cycle results are used to drive change within the Provider's organisation.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Leadership and Goverance

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

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Assessment Team reviewed the Provider's organisational structure. The governance structures are set out in statute and follow the Provider's constitution and operating rules.

The Provider maintains a certified Triple Lock Standard in keeping with the Charity Institute of Ireland's highest standards in transparent reporting, ethical fundraising, and strong governance structures.

The Provider's Board oversees the work of the many established committees each of which has defined terms of reference in place. The Board appoints and oversees all key roles within the Provider's organisation. Accountability for corporate governance lies with the Board members.

Area(s) of Good Practice

The Provider's Board has detailed terms of reference and oversight of the committees that carry out the key organisational functions and there is clear responsibility for oversight.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

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

Rating

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

Assessment Findings

There is a Clinical Governance Policy in place that details the roles and responsibilities of the established Clinical Governance Group. This is led by the National Medical Officer who is supported by three regional medical officers and nine other group members. The terms of reference are clearly detailed, and the group hold quarterly meetings and more if required. The Clinical Governance Group has been established to make certain that systems and processes are effective and robust to ensure the delivery of quality care and patient safety.

The policy in relation to clinical governance is currently being reviewed and updated. The Assessment Team reviewed detailed meeting minutes, which evidenced the work of the group. Each of the members of the Clinical Governance Group, including the medical officers are long term committed members who are knowledgeable in the organisational processes.

Area(s) of Good Practice

There is a strong Clinical Governance Group in place to provide oversight of delivery of care and patient safety.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Provider's National Medical Officer (NMO) is the Medical Director, is registered with the Medical Council and takes an active role in the oversight and support of the clinical governance structures, education, privileging process and policy development.

In discussion, it was obvious that the NMO understands and engages fully in the many roles and responsibilities of the Medical Director. The NMO allocates significant weekly time to work related to the Provider and contributes additional hours as required. The NMO also attends events at which the Provider delivers pre-hospital emergency care.

Area(s) of Good Practice

The Assessment Team commend the NMO's approach and ability to communicate with all practitioner levels.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Provider has detailed policies and procedures in many key areas, however, the document management and review processes are not as streamlined and controlled as they could be.

The Assessment Team note that not all members were aware of policy availability on the online learning platform and not all policies are available to members. The Provider is currently working on a standardised process for the internal management of documentation to address this gap.

There is a draft “policy of policies” in development, which has been viewed by the Assessment Team.

Area(s) of Good Practice

There are good policies in place that have been developed internally.

Area(s) for Improvement

The Provider shall ensure that all members have access to relevant policies. The Provider should conduct a review of current policies and consider implementing a quality management system for its documents.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Assessment Team were informed that communication from the Provider's HQ is through direct email, online learning platform and unit training nights. The Provider is registered with HPRA to receive alerts and has set up a dedicated email address to receive notifications from regulatory bodies.

Area(s) of Good Practice

There are systems in place to notify members of recommendations and health alerts.

Area(s) for Improvement

The Provider would benefit from initiating a feedback / loop system of confirmation when disseminating information.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Provider has developed a draft Risk Management Policy, which has been reviewed by the Assessment Team.

The risk management system includes a risk register, a risk management plan, and an audit process. There is an Audit and Risk Committee in place with agreed terms of reference. The committee make recommendations for consideration by the Board in relation to the risk register.

Area(s) of Good Practice

The Assessment team confirmed existence of a comprehensive approach to risk management.

Area(s) for Improvement

The Provider's risk management policy should be formalised, and associated training made available to members.

Standard 5

Workforce Planning

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

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider has guidelines detailing the required structure and operational levels for units. The Provider assesses the level of cover required in advance of events and ensures appropriate practitioner levels are in place. Events are pre-booked and local units are used where possible. When assisting the statutory services additional units are mobilised to provide support.

The Assessment Team met with different levels of responder and practitioner during the engagement. Members stated that there is always a practitioner level member available at all events.

Area(s) of Good Practice

The Provider has guidelines and processes in place to ensure it can provide services for events and support of the statutory services

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider maintains a Practitioner Register and there is a privileging process in place that complies with PHECC guidelines. A privileging letter is issued and signed by the Medical Director and National Director of Units, which is in full compliance with the PHECC standard.

In order to be privileged, practitioners must be on the PHECC register, CFRA current, have CPG upskilling status recorded, have Garda Vetting and Child Safeguarding verified before being issued with privileging letter.

The Assessment Team reviewed the Provider's Practitioner Operational Register (POR) and examples of privileging letters. The Provider also asks practitioners to complete a commitment to Service form. The Assessment Team reviewed the Provider's Training Records Management system.

Area(s) of Good Practice

The Assessment team verified good processes in place to ensure practitioners' credentials are in date, and that they receive annual letters of privileging.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider's English Language Competency Policy and assessment form is aligned with the current policy. There is a translation booklet available on each ambulance.

There is a policy and procedure in place covering the English competency assurance process. There is documentation on English language competency available for inspection where applicable alongside mentoring for new recruits to the Provider. There is also a set minimum standard for English language competency. The Provider is currently reviewing how these procedures work in practice to ensure good implementation.
.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

Typically, the Provider's services are provided on a voluntary basis so there is no employer / employee relationship. However, there are detailed HR processes in place for key issues such as complaints, disciplinary processes, and recruitment for key roles.

The Provider has a process in place for the induction of new members. There is training available for members on the delivery of services, and a variety of SOPs, policies and a volunteer handbook covering activities.

The induction programme includes items on the values and vision of the Provider.
Probationary Membership requires new members to complete Induction and Safeguarding Courses before full membership. SOP 51 - Mentoring process for Externally Qualified EMTS.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

Incident reporting should be promoted within the Provider's organisation, and training on risk management processes included at induction.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Assessment Team were informed of on-going training including CFR and CFR-A recertification and CPC events as well as case discussions at training nights. The Provider offers regular upskilling to practitioners for new CPG guidelines. There is an annual CPC Education plan in place, which is designed following the completion of practitioner surveys. All staff training records are captured. CPG upskilling is recorded and available for review.

Area(s) of Good Practice

The Provider places importance on ensuring members' continuous education needs are met.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Assessment Team were informed that students from in-house courses are not considered students in the traditional sense as they are existing members. They ensure their own members are included and supported when providing patient care. The Provider's student EMT are required to wear the Provider's working uniform, safety footwear and hi vis outerwear while on placement with the statutory services. The statutory ambulance service conducts a health and safety briefing induction before placements commence. Garda vetting is mandatory for the Provider's volunteers, and this must be in place prior to clinical placements being conducted.
There is a Memorandum of Understanding (MOU) in place with the statutory ambulance service. There is an Ambulance Observer Procedure in place and students must complete an experiential Logbook. Placements are observational only.

Area(s) of Good Practice

The Provider has good processes and arrangements in place to support students at the Provider's duties, and when on placement with other services.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

During the Practitioner Engagement, all members were in uniform and welfare arrangements were in place. The Provider has a range of supports for practitioners with 186 interventions over a 3-year period. Only a minor amount of these relate to ambulance work.

The Provider is affiliated to Critical Incident Stress Management (CISM) network Ireland. If members require support this is provided using trained peer supporters. Clinical psychologists are available when required. The programme lead is a clinical psychologist and there are 12 peer supporters nationally. There is a national coordinator for the Provider. There is a CISM reference card with contact numbers for members. There are courses available in psychological first aid courses.

Area(s) of Good Practice

The Provider has invested in welfare and health and safety processes to support practitioners and volunteers.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

There is a Fitness to Practice Policy in place and processes for post duty debriefing after duties and supporting members. There are documented complaints processes for both internal and external complaints.

During discussion the Assessment Team were informed that no members had had any interaction with a supervisor or mentor for performance appraisal. The members stated they would appreciate more interaction with the 'Regional Officer' or supervisor/mentor for on-going clinical support and access to learning more from these senior members.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should consider introducing a programme of clinical support and progression discussions at unit level. Improvements in this area should provide members with clear direction, increase learning opportunities, and assist individuals with personal development. It will also benefit the Provider in better understanding member's needs.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Assessment Team reviewed the 'Incident Report' system, which can be used for any feedback or recording of any incidents. The on-line Incident Form can only be completed as an 'Adverse Event' to get through to a reporting page. It was initially designed as an Adverse Incident reporting form and is currently being used by facility to report any incident.

There is a Whistle-blowing policy in place. The Assessment team were informed that practitioners are encouraged to voice their feedback on areas of improvement, and there is a line of communication in place to support this. Members are aware of who they report to and can do so without fear of adverse consequences to themselves. The Provider has recently updated its incident reporting guidance to better facilitate input from practitioners.

Area(s) of Good Practice

The on-line Adverse Incident/event form is available and is easily accessible.

Area(s) for Improvement

The Provider should consider reworking the reporting system and its forms to include other reportable areas, i.e. near miss, non-clinical and assault.

Standard 6

Use of Information

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

Standard 6

Criterion

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

Rating

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

Assessment Findings

The Provider has a policy on clinical records management and training is provided on handling patient care information. There is a Data Protection Officer available for support and advice in Head Office.

The Assessment Team observed appropriate patient care recording on an Ambulatory Care Report (ACR). The ACR was legible and stored securely using the lock box on ambulance and then into registered post where they are stored in HQ in a fireproof safe.

A member of the clinical governance group audits the ACR/ PCR for completion and legibility. The annual report includes information on the number and type of completion records.

Area(s) of Good Practice

There is training in ACR/PCR completion included in all of the Provider's courses that include data protection and storage processes.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 6

Criterion

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

Rating

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

Assessment Findings

The Assessment Team witnessed appropriate secure storage of the patient ACR in a lockable metal box fixed to the ambulance wall. The Provider has policies in place for data protection and for the management of clinical records. Records are held securely in Head Office or archived, and the Provider has a designated Data Protection Officer within Head Office to support with any queries.

Area(s) of Good Practice

The Provider has ensured there are processes and policies in place to ensure confidentiality and protection of data is maintained.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 6

Criterion

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

Rating

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

Assessment Findings

A review of records is performed to ensure these are complete, legible and accurate. Practitioners are trained in clinical record keeping and data identified in clinical records is fed back to staff. The Provider has conducted previous audits of patient information and plans to do so again on a scheduled basis as part of a clinical audit programme.

The Assessment Team reviewed an audit of the quality of the completion of History and Clinical Status Sections of Patient Care Reports. Additional audits are also available. This is evidence of measurement of the quality of record completion.

Area(s) of Good Practice

The Provider has audited the completion of patient records.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

9. Report Outcome and Rating Summary

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

COMBINED STANDARD SCORE

Std 1	Std 2	Std 3	Std 4	Std 5	Std 6	TOTAL
33	37	28	21	31	12	162

STANDARD ACCEPTABLE/NOT ACCEPTABLE

Std 1	Std 2	Std 3	Std 4	Std 5	Std 6
Acceptable	Acceptable	Acceptable	Acceptable	Acceptable	Acceptable

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

No of criterion assessed	45
Maximum score available	180
63% of Max =	113
Assessment Results	
Total score achieved	162
Total score as percentage	90%
Assessment Outcome Rating	**Acceptable**

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

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

Irish Red Cross

Assessment Outcome Rating

Acceptable

Standard 1: Person-Centred Care and Support

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

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

Standard 2: Effective Integrated Care and Safe Environment

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

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

Standard 3: Safe Care and Support		
Statement – The intent here is to evaluate risk management and reporting systems. Other safety issues are measured: Infection prevention and control (IPC), waste management, safeguarding, and medication management are patient safety issues that require specific attention in this standard. The sudden outbreak of transmissible diseases means practices have to rapidly adapt existing emergency plans to manage services and reduce the transmission of infection. Utilising PHECC CPGs provide important sources of best practice.		
Criteria		**Rating Score**
3.1	The Provider describes in a plan or policy the content of the infection prevention and control programme.	3
3.2	The Provider segregates and manages waste according to hazard level and disposes of same, according to best practice.	4
3.3	The Provider ensures that medications are administered in accordance with the relevant laws and regulation.	4
3.4	The Provider has systems and processes to ensure safe medication practices including, but not limited to, availability, storage, administration, expiration, disposal and recall alert.	4
3.5	The Provider ensures that there are systems in place to ensure the availability of medical devices and consumables.	3
3.6	Employees, volunteers and/or contractors with the relevant competencies receive training on the safe use of the Provider's diagnostic and therapeutic equipment.	4
3.7	The Provider has a safeguarding policy to deal with children and vulnerable adults.	2
3.8	The Provider can demonstrate follow-up and actions taken as a result of audit and monitoring findings.	4
Standard 4: Leadership and Governance		
Statement – The Provider is responsibly governed to its defined purpose. A clear understanding of responsibilities and accountabilities lead to role clarity and will support the implementation of appropriate policies. Clinical and corporate governance are distinguished and the leaderships commitment to patient safety is evaluated. Risk management is included as it is a significant part of any governance framework and should include a reporting system. A robust communication policy can mitigate a number of adverse events and both internal and external systems should be in place.		
Criteria		**Rating Score**
4.1	The Provider has a documented structure and accountability for corporate governance.	4
4.2	The Provider has a documented structure and accountability for clinical governance.	4
4.3	The Provider has a Medical Director, who is registered with the Medical Council, with general or specialist registration who provides oversight and support for Clinical Governance.	4
4.4	Written documents, including policies and procedures are managed in a consistent and uniform way.	2
4.5	The Provider has a system for monitoring and circulating new recommendations issued by PHECC, other regulatory bodies, and public health alerts.	4
4.6	The Provider develops a risk management plan that includes a reporting system and a process for identifying potential risks.	3

Standard 5: Workforce Planning		
Statement – The intent here is to ensure staff are registered and trained to provide care appropriate to their role. Staff need to be trained on safety issues at the onset of employment and at regular intervals during their employment. Orientation, both organisational and role specific, should be provided to all new staff. Staff learning and professional development needs, specific to pre-hospital emergency care should be identified, documented, and addressed. A health and safety programme is concerned with protecting the wellbeing, health, and safety of people employed by the Provider.		
	Criteria	**Rating Score**
5.1	There is a staffing structure developed for the Provider that identifies the number, types, and required qualifications of staff required to provide the service.	4
5.2	The Provider ensures that Practitioners are Licensed by PHECC, Credentialed, and Privileged prior to delivering pre-hospital care.	4
5.3	The Provider has a process in place to satisfy itself of the Practitioner's English language competency where English is not the Practitioner's first language.	4
5.4	The Provider ensures employees volunteers, and/or contractors understand their responsibilities in relation to the safety and quality of services.	3
5.5	The Provider has an ongoing training and development programme in place to ensure employees, volunteers, and/or contractors have the required competencies to undertake their duties in line with their scope of practice.	4
5.6	The Provider has appropriate arrangements for the management and supervision of students (if applicable).	4
5.7	The Provider has systems in place to promote and protect the wellbeing, health, and safety of employees, volunteers and/or contractors.	4
5.8	The Provider has processes for the performance management of employees, volunteers, and/or contractors.	1
5.9	The Provider creates opportunities for employees, volunteers and/or contractors to feedback on all aspects of the service.	3
Standard 6: Use of Information		
Statement – The intent here is to ensure that there are information management policies in place to support the Provider providing best practice patient care. All episodes of patient care should be documented, and these records audited to measure compliance.		
	Criteria	**Rating Score**
6.1	The Provider ensures appropriate documentation is maintained for all patient care in accordance with the current PHECC Clinical Information Standards.	4
6.2	The Provider ensures confidentiality and security of data is protected.	4
6.3	The Provider has systems in place to measure the quality of healthcare records.	4

Pre-Hospital Emergency Care Council

2nd Floor
Beech House
Milennium Park
Osberstown
Naas
Co Kildare
W91 TK7N

Phone: +353 (0)45 882042
Email: info@phecc.ie
Web: www.phecc.ie