Pre-Hospital Emergency Care Council

Governance Validation Framework

Assessment Report

EFAST EMS Ltd

June 2023

Pre-Hospital Emergency Care Council

Mission Statement

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

QUALITY ASSURANCE PROGRAMME

Governance Validation Framework
Quality Review Framework

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

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

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

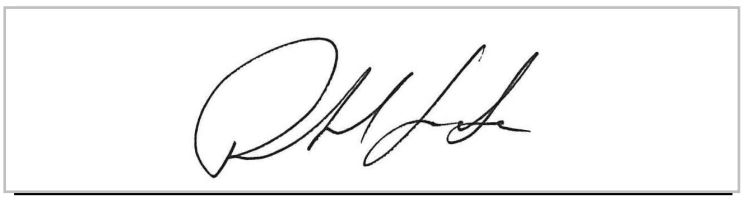
- The Governance Validation Framework (GVF), in place since 2018, monitors the CPG Service Providers that PHECC recognise to deliver pre-hospital emergency care in the community. Providers are required to be compliant with the GVF Standard (STN034) and its related criteria.
- The Quality Review Framework (QRF), in place since 2014, monitors the Recognised Institutions and Approved Training Institutions that PHECC recognise and approve to deliver education and training in pre-hospital emergency care. RI/ATI are required to maintain compliance with the Quality Review Framework (STN020) and its related standards.

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

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

It is important to note the provision of pre-hospital emergency care and its related education or training is constantly evolving, and quality improvement is a continuous process. However, this report formally records the Assessment Team's observations related to the specific time when the assessment was undertaken and is primarily based on the organisation's assessment submission against the Standard. Organisations should note that once selected for assessment, they are strongly encouraged to provide the evidence of compliance with the Standard and its criteria at the time of submission as the assessment is a 'snapshot in time', therefore in this respect, specifically during the factual accuracy process, documentation and/or evidence submitted by the organisation that relates to improvement activity undertaken immediately post assessment cannot be considered to amend assessment outcome(s).

2. Assessment Report Overview and Validation

Organisation Name	This report relates to EFAST EMS Ltd, a PHECC Recognised CPG Service Provider, licensed to deliver pre-hospital emergency care services in Ireland since 2019. Organisation are recognised by PHECC under S.I 109 of 2000 as amended by SI 575 of 2004 at the following clinical levels: ☑ Emergency Medical Technician ☑ Paramedic ☑ Advanced Paramedic ☐ Organisation also provides responder level services
Assessment type	☑ Planned ☐ Reactive
Process	☑ Desktop Review ☐ Online Management Engagement ☑ Onsite Management Engagement Weston Airport, Backwestonpark, Leixlip, Co Kildare, W23 XHF8. ☑ Practitioner Engagement Life Festival, Belvedere House, Mullingar Co Westmeath.
Outcome rating **Technical weighting applied** **Yes** ☐ **No** ☑	No of criterion assessed 44 Maximum score available 176 63% of Max = 111 **Assessment Results** Total score achieved 165 Total score as percentage 94% **Assessment Outcome Rating** **Acceptable**
Follow up action required	☑ Continue with normal quality improvement activities ☐ Improvement notice - follow up evidence required ☐ Conditional Approval ☐ Suspension notice ☐ Delisting process intiated
Reassessment costs	☑ Not applicable
Validated and approved for publication. **Director Signature** **Date**	 22/11/2023

3. Assessment Participants

Organisation	PHECC Assessment Team
Managing Director Chief Executive Officer	GVFA5966 Team Lead
Operations Manager Medical Director (Medical Council Reg No 188557	GVFA6815– Onsite Assessor
Advanced Paramedics Paramedics	GVFA6815 – Practitioner Engagement Assessor
Emergency Medical Technicans	

4. Initial Feedback Given

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

The following areas were identified as areas requiring improvement, or further potential for improvement areas: Induction training, privileging of practitioners, and equipment standardisation. 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 Assessment Team viewed evidence of policies and medical planning documents that the Provider has in place to deliver suitable pre-hospital care in their operating environments. The Provider conducts risk assessments for each event and suitable briefings are given to all levels of responders. Various grades of practitioners are deployed based on each assessment at various events and venues nationally.
Systems are in place for escalation of incidents or patients to a higher clinical grade if required, including 24-hour telephone access to the Medical Director.

Area(s) of Good Practice

The Assessment Team observed good practice in planning and preparation for events requiring medical and pre-hospital practitioner care. This includes working with external agencies and communication between practitioners and other staff at venues and events.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Assessment Team viewed documentation including staff handbook training documentation, and policies relating to patient dignity, cultural awareness, and communication. Practitioners were observed treating patients with courtesy, professionalism and respect.

Area(s) of Good Practice

The Provider has a staff handbook in place.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider has a bespoke call activation process for large public events, which utilises trained dispatchers and close interprofessional working with external agencies. An aide memoire checklist is used in call information gathering and dispatch.
Call logs were recorded and records of events and training for dispatchers were made available for the Assessment Team to examine.

Area(s) of Good Practice

The Provider has a robust call information gathering and activation procedure.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider has a process for patient identification and a suitable clinical record management policy. The Assessment Team verified practitioners applying appropriate procedures for patient identification and documentation of clinical records.

Area(s) of Good Practice

The Provider has procedures in place to ensure 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 Assessment Team evidenced the Provider's 'Patient Rights and Consent' policy. During Practitioner Engagement, practitioners were observed following procedures to gain informed consent from patients.

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 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 documented procedure within their 'Patient Rights and Consent' policy for the refusal of treatment and/or transport. Staff receive briefings prior to events regarding this policy and procedures. Systems are also in place for senior clinician or Medical Director support for instances where practitioners may need advice on refusal of care or transport.

Instances of refusal of treatment or transport are recorded for audit.

Area(s) of Good Practice

The Provider has a support system in place giving practitioners access to the Medical Director or a senior clinician when required.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider has a relevant policy in place. Training on respecting rights, dignity and autonomy of patients is part of the induction training. The Assessment Team observed practitioners treating patients with courtesy, respect and professionalism.

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 1

Criterion

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

Rating

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

Assessment Findings

The Provider is active in seeking feedback on services provided at events. The public are provided with easily visible and accessible means to give compliments or complaints directly to the Provider.

Area(s) of Good Practice

The Provider is proactive in seeking feedback from the public by providing various feedback methods.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

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 Assessment Team evidenced an appropriate complaints policy, and documents with a flowchart that includes encouragement to resolve complaints at origin, and an escalation process. The Provider includes the Medical Director in the complaints process if required, and to determine suitable timeframes for action in the complaints process. Where a complaint cannot be resolved within the Provider's complaints handling process, the Provider will use an external agency as an independent body for complaints handling.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider would benefit from adding information that clarifies the complaints flowchart and policy to include the option and process of contacting an external independent body for complaints handling.

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

Systems exist within the Provider's organisation to ensure all practitioners are operating within PHECC Clinical Practice Guidelines (CPG). The Provider has a clinical governance procedure in place and the Medical Director is involved in privileging practitioners to the current CPG.

Area(s) of Good Practice

The Provider's Medical Director has significant involvement within the Provider's organisation.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider has a detailed handover policy that uses a recognised handover tool. The Assessment Team verified a safe, structured process used by practitioners for patient handovers at hospital and within medical teams.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider has a limited number of vehicles, which were observed to be in good condition and appeared clean . The Assessment team verified relevant records regarding vehicle servicing, insurance, and Commercial Vehicle Road Worthiness Test (CVRT).

The Provider has a detailed 'Safe Driving' policy which is in line with their organisation's activities.

Area(s) of Good Practice

Vehicles were compliant with requirements, both PHECC and legislative.

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 were provided with evidence of safe ambulance response driving. Not all practitioners within the organisation are driving trained, however the Provider, through planning processes, ensures that adequate numbers of driving trained staff are available at each event.

The Provider has a detailed Safe Driving policy and evidence was provided to the Assessment Team of driving training within the organisation. Mechanisms exist within the Safe Driving policy to investigate and review accidents and incidents regarding driving standards.

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 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 documented policy on driving under emergency conditions using lights and sirens. The Safe Driving policy appears to be suitable for this organisation.

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 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 verified documentation and procedures for fire safety and evacuation processes at the Provider's headquarters site. The Provider ensures that external sites and premises' fire safety plans are briefed to practitioners while onsite.

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 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 and Provider discussed current risk analysis and business continuity plans, which are in place for the organisation. The Provider is aware of potential risks to organisational operations and is making ongoing effort to mitigate risks to service delivery.

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 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 has good interagency collaboration and briefing sessions for practitioners before each planned event. Documentary evidence of planning for major incidents was provided to the Assessment Team.

Training has been provided for relevant practitioners regarding major incidents. The Provider reviews their training needs regularly for major incident planning.

Area(s) of Good Practice

The Provider has good inter-agency collaboration regarding major incident planning.

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 Provider is a newly established pre-hospital care organisation and is yet to establish three yearly audit programmes.

The Provider has conducted recent relevant audits that have been reviewed by senior managers and the Medical Director. The Assessment Team reviewed evidence of a change in the audit focus within the organisation due to the results of recent audits.

Area(s) of Good Practice

The Provider utilises feedback from audits to drive future audit (audit programme).

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider submitted an annual report, which includes detail of pre-hospital activities, audits, service level agreements, events attended, staffing levels and clinical care levels available at each event. The Provider also outlines future planning and includes relevant legal requirements within the annual report.

Area(s) of Good Practice

The Provider submitted a comprehensive annual report detailing relevant organisational and clinical activities.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Safe Care and Support

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

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Assessment Team reviewed evidence of an infection prevention control policy (IPC), which is suitable for the activities of the Provider.

The Provider encourages good IPC practice, and all necessary clinical waste disposal equipment was available at clinical areas. All ambulance vehicles are cleaned on site and on return to base by a cleaning operative. Ambulances used by the Provider are scheduled for regular deep cleaning.

Good IPC practice was observed, however, there is some variance in cleaning procedures and equipment availability at remote working sites.

Area(s) of Good Practice

The Assessment Team noted evidence of investment and planning regarding an IPC cleaning operative.

Area(s) for Improvement

The Provider should provide dedicated , standardised facilities and/or equipment at remote site working and at base HQ.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Assessment Team verified that a waste disposal contract is in place with a professional clinical waste disposal service. Tag numbers for clinical waste bags are collated and stored by the Provider.

The Provider was observed to segregate clinical and non-clinical waste appropriately in compliance with IPC policy.

Appropriate training in clinical waste segregation is provided.

Area(s) of Good Practice

The Provider has waste segregation training in place for staff.

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 verified the Provider is licensed with the Health Products Regulatory Authority (HPRA). During Practitioner Engagement it was observed that all relevant medications were available for use for each practitioner level at the event site.

The Provider works closely with the Medical Director regarding medicines management and has a comprehensive medicines management policy.

Area(s) of Good Practice

The Provider has robust medications management processes in place within their organisation.

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

The Provider has a good system of medicines availability, record keeping, tracking, security and replenishment.

The Assessment Team were provided with evidence of HPRA licensing and appropriate alerting processes.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Assessment Team evidenced that all appropriate equipment, for each level of practitioner, was available for patients. The Assessment Team reviewed service records of the Provider's ambulance and medical equipment.

Equipment manuals are available for all practitioners to view/refresh information and the Provider has a suitable equipment management policy in place.

During the Practitioner Engagement a minor equipment issue difficulty was noted, and this was reported and rectified within normal procedures.

The Provider has different models of ambulance equipment, which are modern and fit for purpose. Practitioners have been provided with training on this equipment and are afforded equipment familiarisation time whilst on duty. The Assessment Team noted that some items of medical equipment are from differing manufacturers, and each practitioner will require time for familiarity.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should standardise equipment where possible.

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 Provider utilises both in-house and online classroom environment to provide education in equipment and procedures for their practitioners.

Practitioners are afforded familiarisation time with equipment while on duty and equipment manuals are available to them. The Provider acknowledges some part time staff do not participate in the full induction programme.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should ensure the same induction training is given to both full time and part time staff.

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 Assessment Team verified the policies and procedures relating to child and adult safeguarding and noted they are appropriate for the Provider's organisation and their activities.

The Assessment Team verified evidence of suitable child protection training and Garda vetting procedures for practitioners employed by the Provider.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 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 Provider regularly updates relevant stakeholders from post event feedback and lessons learned if appropriate.

The Assessment Team were provided with evidence of clinical audit activity, which included feedback to practitioners regarding information governance and clinical procedures.

Audit results were reviewed by senior managers and the Medical Director, and future audits are planned as a result of audit findings.

Area(s) of Good Practice

The Provider conducts regular de-briefings and feedback to service providers of activity.

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 evidenced a suitable corporate governance policy ,which included an organisational chart. The Provider has an organisational structure that includes the Medical Director and external Quality Assurance personnel to assure good governance within the organisation.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

4.2 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 clear policy that details clinical governance reporting and accountability within the organisation. The Provider's clinical governance policy outlines the clinical governance structure and includes education, patient involvement, and clinical audit.

The Assessment Team verified evidence of suitable clinical governance processes within the Provider's organisation.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

4.3 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 Assessment Team were provided with evidence of significant involvement of the Medical Director within the Provider's organisation. The Provider is transitioning to a new Medical Director who has an awareness of expected responsibilities and activities of the role within the Provider's organisation.

Medical Director involvement within the organisation includes clinical audit and feedback, development of clinical policies and procedures, training and education, and investigation of clinical incidents.

Area(s) of Good Practice

The Provider's Medical Director is pro-actively involved in many of the Provider's activities and processes.

Area(s) for Improvement

The Provider should ensure that their Medical Director is familiar with the PHECC Medical Director Standard (STN032), which includes roles and responsibilities for the position of Medical Director.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Assessment Team evidenced consistency within the Provider's policies and documentation. The Provider has a policy template and a documented policy development process.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

4.5 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 Provider has active monitoring and reporting processes of clinical and non-clinical information. The Provider has a suitable communications policy outlining the principles and process of communications within the organisation.

The Provider's communication process involves electronic reporting systems and verbal briefings to practitioners where confirmation of receipt of alerts or information is acknowledged.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

4.6 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 Assessment Team evidenced a suitable risk management policy and business risk matrix for the Provider's organisation and activities. The Provider is aware of operational and clinical risks to its activities and takes action to mitigate these risks.

Area(s) of Good Practice

The Provider has a broad awareness of risks to activities relevant to its operational activities.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

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 facilitates induction training for new practitioners. Additional updates, briefings and continuing professional development are also provided. The Provider uses online educational platforms as well as face-to -face learning and development programmes.

For event planning, the Provider has specific processes to ensure appropriate levels of practitioners are available to provide pre-hospital care. Suitable processes are in place to verify practitioners are appropriately qualified to fulfil specific roles or levels of clinical practice.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Assessment Team verified documentary evidence of credentialling and privilege to practice procedures applied to EMT, Paramedic and Advanced Paramedic staff. The Provider's Medical Director is involved in the privileging of staff within the organisation.

The Provider ensures that training in child protection has been undertaken by practitioners, and that practitioners have been Garda vetted.

The Assessment Team verified additional evidence of appropriate educational qualifications, driving licence checks and ongoing education of practitioners.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Assessment team verified that a suitable English language policy is in place, and that the Provider ensures competency in English language for its staff. Within the English language policy, the Provider outlines testing and support measures where English may not be the primary language of their staff.

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

There is clear documentation of responsibilities and processes required from the Provider's employees. The Provider engages with an external human resources company to provide a fit-for-purpose employee handbook.

The Provider has induction training for full time staff and familiarisation training for part time staff. Induction and familiarisation training for full and part time staff appear appropriate, however it may be possible that some aspects of procedures and policies using different employee induction methods can expose the Provider to risk.

Area(s) of Good Practice

The Provider ensures online learning platforms are available to all staff.

Area(s) for Improvement

The Provider should ensure the same induction training is given to both full time and part time staff.

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 verified evidence of appropriate recruitment, verification, and ongoing support and development of staff within the organisation. As part of the Provider's induction programme, a mentoring period is provided to staff as outlined in the Provider's staff recruitment and development policy.

The Provider ensures online learning platforms are available to practitioners as well as continuing development and training programmes. Training programmes may be triggered from mandatory training, audits, or specific learning events.

Area(s) of Good Practice

The Provider has an online learning platform available to all practitioners.

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 determined that this criterion is not applicable for this Provider as they do not have students.

Area(s) of Good Practice

Area(s) for Improvement

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Assessment Team verified suitable health and safety policy, documents and procedures are in place, which included fire risk assessments for the Provider's HQ building. The Provider's staff handbook outlines the expected compliance standards for all staff.

Onsite safety briefings with accompanying written reports are regularly carried out and often involve external and statutory agencies. The Provider has mechanisms to utilise Critical Incident Stress Management (CISM) support for any staff who may require it.

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

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

Rating

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

Assessment Findings

The Provider outlines procedures for employee standards and rules of employment in its employee handbook. The Provider utilises in-house management structure and an external human resource agency to manage staff performance issues. The Provider's senior managers utilise, where necessary, the external human resource provider to investigate or process complaints.

Clinical and fitness-to-practice issues are managed within the organisation under the clinical governance structures, which involve senior management and the Medical Director. The Provider has had no incidents of fitness-to-practice issues, however, they are aware of the process and procedures of fitness-to-practice reporting to PHECC.

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

5.9 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 verified evidence of the Provider actively seeking feedback from practitioners, patients, and service users on all aspects of service delivery.

The Provider uses a variety of methods to seek feedback from service users and onward complaint and/or compliments processing. The Provider ensures varied methods of feedback are available to all service users and employees, including online, email, verbal and written methods of communication and feedback.

The Provider implements the display and use of QR codes at events to provide an easily accessible route for patients and the public to submit feedback.

Area(s) of Good Practice

The Provider ensures simple and easily accessible methods of feedback are available to all service users.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 6

Use of Information

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

Standard 6

Criterion

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

Rating

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

Assessment Findings

The Provider uses a recognised paper-based Patient Care Report (PCR) form as well as other suitable ambulance care records. The Assessment Team were provided with evidence of appropriate information collected in PCR and suitable records handover processes. The Assessment Team examined a sample of completed PCR and verified that they were completed to an appropriate standard.

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 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 verified practitioner compliance with GDPR and the Provider's clinical records policy.

At the Provider's HQ, there is a robust security process for PCR storage.

PCR completed at events site were always stored under the care of practitioners and/or administration staff.

Area(s) of Good Practice

The Provider has robust security for PCR storage at its Headquarters site.

Area(s) for Improvement

The Provider should consider a lockable storage process for PCR records at event sites, which will increase the security of information prior to destination storage facility.

Standard 6

Criterion

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

Rating

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

Assessment Findings

The Assessment Team evidenced a PCR policy and recent audits of PCRs. Audits included feedback to practitioners and prompted change for future audit focus. The Provider's Medical Director is involved in audit activities and the use of an audit tool is utilised within the organisation.

Area(s) of Good Practice

The Assessment Team found evidence of change in audit practices as a result of recent audit activity.

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 out-come rating in each individual standard.

COMBINED STANDARD SCORE						
Std 1	Std 2	Std 3	Std 4	Std 5	Std 6	TOTAL
35	39	27	23	30	11	**165**

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

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

No of criterion assessed	44
Maximum score available	176
63% of Max =	111
Assessment Results	
Total score achieved	165
Total score as percentage	94%
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 EFAST EMS Ltd in accordance with Council Policy for Recognition to Implement Clinical Practice Guidelines (POL003) is unaffected.

EFAST EMS Ltd should continue to develop their Quality Assurance (QA) systems and are required to develop and submit Quality Improvement Plan to gvf@phecc.ie. The Quality Improvement Plan (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 EFAST EMS Ltd in the upcoming licensing period.

EFAST EMS Ltd

Pre-Hospital Emergency Care Council

Assessment Outcome Rating

Acceptable

Standard 1: Person-Centred Care and Support

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

	Criteria	Rating Score
1.1	Patients have access to pre-hospital emergency care based on their identified needs and the Provider's scope of services.	4
1.2	Access to pre-hospital emergency care is not affected by discrimination.	4
1.3	The Provider ensures information from calls / activation is recorded accurately and dispatched according to priority.	4
1.4	The Provider develops and implements a process to ensure best practice for patient identification.	4
1.5	The Provider has a policy for informed consent.	4
1.6	The Provider has a policy in place in relation to the patient's refusal of treatment and/or transport.	4
1.7	The Provider ensures all patients are treated with compassion, respect, and dignity.	4
1.8	The Provider seeks feedback from patients and carers to improve services.	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.	3
2.2	The Provider has a standardised handover process in place to ensure the safe, timely, and structured exchange of information during handover of patients.	4
2.3	The Provider has a system in place to ensure the safety of their vehicles in line with legislation.	4
2.4	Training is provided for staff to transport patients safely, including during emergency situations.	4
2.5	The Provider has a policy on the use of emergency lights and sirens.	4
2.6	The Provider has a fire safety plan for any physical environments owned or used by their organisation.	4
2.7	The Provider ensures there is a business continuity plan for their organisation.	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.	2
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.	2
3.7	The Provider has a safeguarding policy to deal with children and vulnerable adults.	4
3.8	The Provider can demonstrate follow-up and actions taken as a result of audit and monitoring findings.	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.	3
4.4	Written documents, including policies and procedures are managed in a consistent and uniform way.	4
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.	4

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.	2
5.5	The Provider has an ongoing training and development programme in place to ensure employees, volunteers, and/or contractors have the required competencies to undertake their duties in line with their scope of practice.	4
5.6	The Provider has appropriate arrangements for the management and supervision of students (if applicable).	N/A
5.7	The Provider has systems in place to promote and protect the wellbeing, health, and safety of employees, volunteers and/or contractors.	4
5.8	The Provider has processes for the performance management of employees, volunteers, and/or contractors.	4
5.9	The Provider creates opportunities for employees, volunteers and/or contractors to feedback on all aspects of the service.	4
Standard 6: Use of Information		
Statement – The intent here is to ensure that there are information management policies in place to support the Provider providing best practice patient care. All episodes of patient care should be documented, and these records audited to measure compliance.		
	Criteria	**Rating Score**
6.1	The Provider ensures appropriate documentation is maintained for all patient care in accordance with the current PHECC Clinical Information Standards.	4
6.2	The Provider ensures confidentiality and security of data is protected.	3
6.3	The Provider has systems in place to measure the quality of healthcare records.	4

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