Pre-Hospital Emergency Care Council

Governance Validation Framework

Site Assessment Report

HEART ER Ltd

November 2022

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

Pre-Hospital Emergency Care Council

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Table of Contents

Introduction

Assessment Report

Report Summary

Executive Summary

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

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

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

The Licensed CPG Service Provider that is the subject of this report is HEART ER Ltd, a private Provider of pre-hospital emergency care services bases in Co Laois. The on-site GVF assessment visits for this report were conducted during November 2022 by an Assessment Team drawn from a panel of subject matter experts selected and trained by PHECC to conduct the on-site assessments.

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

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

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

Overview of Licensed CPG Provider

Established in 2009, HEART ER Ltd is a private ambulance service based in Portlaoise, Co. Laois. HEART ER Ltd provide a nationwide service, facilitating patient transfers both to and from private and public hospitals. The service is 24-hour, seven days per week.

HEART ER Ltd also provide health and safety support services to events and provide air ambulance and repatriation services as required.

Their base, located at Unit 1 Clonminam Industrial Estate, Portlaoise, Co Laois, has facilities for up to 10 ambulances, and includes a deep cleaning facility.

HEART ER Ltd are Recognised by the Pre-Hospital Emergency Care Council (PHECC) to deliver pre-hospital emergency care service at the clinical level of Emergency Medical Technician, Paramedic and Advanced Paramedic.

Information used to create this overview was supplied by the Provider.

For more information visit: www.hearter.ie

Overview of Licensed CPG Provider

Assessment Details:

Licensed CPG Provider	HEART ER Ltd
Type of Visit	GVF Assessment - GVFREP HRT 002_1122
Licensed CPG Provider Lead	GVFA 6916
Date of Review	November 2022
Assessment Team	GVFA 6916 - Lead Assessor GVFA 7106 - Onsite Assessor GVFA 6815 - Practitioner Engagement Sites visited by the PHECC GVF assessment team during the assessment process were as follows: Site 1 - Unit 1 Clonminam Industrial Estate, Portlaoise. Site 2 - Heart ER Admin Centre, Kellyville, Portlaoise, Co Laois.
Circumstances of this Site Assessment	GVF Assessment
Relevant Recent Visits	GVF Assessment November 2022

Assessment Details (continued):

Licensed CPG Provider Participants

Managing Director
Accountant
Medical Director (Medical Council Reg No 295424)
Paramedic x 1
EMT x 1

Onsite Feedback

Verbal feedback related to the GVF Assessment Team's initial findings was provided to the Senior Management Team of HEART ER Ltd by the PHECC GVF Assessment Team Lead at the closing meeting. During the closing meeting a number of items were identified to the Provider as areas of potential improvement, such as, training, measuring patient satisfaction, updating PPPG, and document control. There was general agreement by all in attendance regarding the relevance and substance of the GVF Assessment Team's comments and indicative findings.

Judgement Framework

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

Theme 1

Person Centred
Care and Support

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

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

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.1.1 The Provider has a mix of EMT and Paramedics employed for daily duties. Advanced Paramedics are employed on an ad-hoc basis and are deployed when specifically requested for events and patient repatriations from abroad. Rosters are issued in advance and contingency is in place to cover unplanned absences. Policy submitted by the Provider details the Provider's qualification, education, planning and recruitment process.

1.1.2 A robust call taking process is in situ, which was verified by Assessment Team. Two allocated call takers are assigned to this process. The Managing Director also engages in call taking, primarily after hours.
A paper-based system is utilised to capture initial call information received via telephone. A review of this preprinted call sheet demonstrates that it is comprehensive and assists with decision making in relation to the tasking for the call. The Provider's dataset includes the patient's weight to ensure that the appropriate equipment is available.

Patient's clinical need is identified at the call taking stage and relevant Practitioners are assigned to the call based on the patient's status i.e. clinical level matched to patient need.

The Provider has an 'Access to Care Policy'. The Provider also has an 'Effective Communication' policy that outlines requirements regarding information obtained and documented for each patient transfer. The Provider stated that utilising of Eircodes has enabled increased accuracy of location and led to improved effectiveness. The Provider's online vehicle monitoring platform enables a 'live tracking' of vehicles to enhance efficiency and timeliness.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.1.2 The Provider's preprinted call taking forms ensures that all pertinent information is captured. Vehicle tracking software and the digital management system shows the Provider's commitment to electronic management of processes.

Areas for Improvement

1.1.1 The Provider's policy, Staff Qualifications, Education, Planning and Recruitment, was developed in 2015 and should be updated to reflect growth and development and contemporaneous requirements.

1.1.2 The Provider's 'access to care' policy page 3 is a replica of the documented 'effective communications' policy. The Provider should consider if both policies are required.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.2.1 During Practitioner Engagement it was evidenced that consent was sought and confirmed for several assessment processes during the transfers.

Upon arrival at a healthcare facility, the Practitioners verified all patient details as per the integrated digital management system and confirmed patient identity with the patient by cross referencing against the patient's ID bracelet. Patient consent is documented on the electronic Patient Care Report (ePCR).

1.2.2 The Provider has a 'patient refusal to travel' form, which is used to document cases of non-consent to transfer/treatment. During Practitioner Engagement Practitioners advised that they infrequently encounter a refusal to travel situation. In such circumstances the capacity of the patient is ascertained and nursing and medical staff are engaged with and if necessary, the Provider's manager is contacted. It was further advised that if the patient has capacity and they do not wish to travel, the patient is not transported. Interactions with all staff following a refusal is documented onto the ePCR.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.2.2 'Right to refuse' is addressed in the Provider's training programmes and recorded appropriately on both the ePCR and the patient's refusal form held in each ambulance cab. A Patient Refusal of Treatment and/or Transport policy 2021 is in situ to guide Practitioners through the management of non-consent.

Areas for Improvement

1.2.2 The Provider should insert a reference to Garda notification into the patient refusal to travel documentation in the event a patient without capacity refuses care and/or transport.

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

Pre-Hospital Emergency Care Council

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

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

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

Assessment Panel Findings

1.3.1 The Managing Director advised that promotion of patient's privacy, dignity and autonomy commences at induction training and is encouraged throughout their organisation. The Managing Director periodically monitors this aspect of care. During Practitioner Engagement, Practitioner's observed conduct was deemed to be appropriate and in line with this policy. The Assessment Team were informed of plans to introduce supervision of Practitioners, which will provide further assurance. It is noted that there is no reference to dignity and autonomy of the patient in the Staff Qualifications, Education, Planning and Recruitment policy.

The Assessment Team were informed that a second driver is occasionally assigned on longer journeys to mitigate driver/Practitioner fatigue.

1.3.2 During the Practitioner Engagement patients were treated with dignity and respect and high standard communications between the Practitioners and the patients was observed. In discussions with both management and staff the Assessment Team identified an organisational culture of kindness, consideration and respect for patients. The Provider has a process in place where they match up ambulance crews with specific patients that are receiving long term treatments in order for both parties to develop an on-going rapport. The Managing Director emphasised the value their organisation places on patient centred care, which is a declared focus of their induction programme.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.3.1 Crew are monitored by the Managing Director on an ad-hoc basis. The Provider operates a 'buddy' system of senior and junior partnering to support the Practitioners and ensure safe care.

Areas for Improvement

1.3.1 The Provider should insert a reference to dignity and autonomy of the patient within the Staff Qualifications, Education, Planning and Recruitment policy.

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

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

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

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

Assessment Panel Findings

1.4.1. Prior to the COVID-19 pandemic patients had access to patient satisfaction cards titled 'rate my crew' which enabled compliments or complaints to be made, however, the restrictions from the pandemic resulted in this process ceasing. Consideration is being given by the Provider as to how best to re-establish the feedback process from patients. The Provider outlined that they frequently receive unsolicited cards, e-mails and letters complementing the service/staff.

Unsolicited feedback is received by call-takers commending the practice of the Practitioners in the form of compliments, which informs the feedback process. The Provider had not considered these complements as a form of patient satisfaction.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the Assessment Team.

Areas for Improvement

1.4.1. The Provider should implement a process of measuring patient satisfaction.

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

Pre-Hospital Emergency Care Council

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.5.1. The Assessment Team observed evidence of a complaints' procedure and process. However, the Provider has not clearly defined what constitutes a complaint. Complaints may be received through phone or post. Their policy is to address a complaint within 14 days. Routine complaints are addressed internally and clinical complaints are referred to the Medical Director. The Provider could not outline their escalation process for serious or unresolved complaints.

1.5.2. In discussion, Practitioners advised that they are aware of the organisational complaints process and know how to advise a patient on how to make a complaint. Practitioners report that complaints may be made to the Service Managers from a number of sources such as the patient or the family or the receiving hospital staff.

The Provider has a Client Complaint policy. A review of staff records identified that Practitioners are provided with complaints management training at induction.

If a staff member is the subject of the complaint, the Provider will defer to an external HR service. Complaints are acknowledged in writing within 7 days and a target for resolving them is within 14 days. If the complaint is clinical in nature the Managing Director and Medical Director is informed and is involved in any review.

A member of the management team has undertaken 'lean management' training and provided an example where a trend was identified leading to delays in transferring patients in some nursing homes. Relevant timelines were validated in the electronic PCR system and through presentation of data to hospital management this issue was addressed and resolved to the mutual benefit of both organisations.

External HR support arrangements are in situ to manage situations that would be escalated beyond the immediate management structure of the Provider.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.5.1 A transparent process exists to manage complaints in a timely manner.

Areas for Improvement

1.5.1. The Provider should define 'complaint', record all complaints received, and develop an escalation process for serious or unresolved complaints. The Provider should consider a measurement criterion for complaints not resolved within the specified 14-day timeline.

The Provider should consider dissemination of learning from both complaints and compliments received to enable cross communication across the organisation, celebrating wins and re-mediating areas of complaint.

Theme 2

Effective Care and Support

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.1.1. A copy of the current PHECC Clinical Practice Guidelines (CPG) is available on all ambulance. The Provider reports that induction training outlines that the standard of care is the PHECC CPG. Each Practitioner is privileged by the Medical Director. A quarterly training day is held with the Medical Director to address training issues.
The Provider has an established policy in place, Staff Qualifications, Education, Planning and Recruitment.

The Medical Director outlined that the nature of the work that the Provider is involved in allows appropriate planning as the Provider is not dealing with undifferentiated patients. This allows for appropriate clinical level of competency to be assigned to each patient transfer. This lends itself to care being provided according to CPG.

If Practitioners arrive at a location and the presentation of the patient differs to the details provided at call booking stage, Practitioners will make contact with the office and in turn the Medical Director may be contacted to discuss the case. The organisation's integrated electronic system allows a 'live' look in and the ePCR can be accessed. The Provider reports this as a safeguarding mechanism.

The Medical Director made reference to the use of Cyclizine; in recent times there was an increased use of this medication noted. The Office Manager receives a notification to say a medication bag has been opened and requires replenishing, this alerts a medication use as does the ePCR. The Medical Director reviews all ePCR and ensures that the medication administration was appropriate. This increased use was attributable to recent training/updates provided to Practitioners regarding appropriate management of nausea and vomiting.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.1.1 The Medical Director is actively involved in review of ePCR and will be consulted if patient status varies according to initial call booking detail.

Areas for Improvement

No specific observations noted by the Assessment Team.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.2.1. The Assessment Team confirmed that the communications between the Practitioners and the medical/nursing staff was very good. The handover process, both on taking responsibility for the patient and at handover, was clear and concise. The ISBAR process is reported by the Provider as being utilised, however, this is not specifically specified in the related policy and there is currently no monitoring of the handover process.

Training on the use of ISBAR was reported as being provided at induction and at ongoing training. The Medical Director clarified that the nature of the business does not warrant an IMIST-AMBO approach. The Provider has a plan in place to introduce formal observation via 'ride along' scenarios. It is anticipated, that this monitoring will lead to a more structured performance management process going forward.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the Assessment Team.

Areas for Improvement

2.2.1 The Provider should specify the ISBAR process as the Provider's agreed handover process and implement a monitoring process to ensure compliance.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.3.1 All vehicles viewed by the Assessment Team had a current CVRT, road tax and Insurance certificates displayed, and were observed to be clean and serviceable. The Provider has a policy, Fleet Management, that outlines the daily requirements regarding vehicle maintenance. A checklist is completed on the Provider's integrated electronic system, which documents all observations by Practitioners.

As all vehicles are logged on, an odometer read is recorded each morning. Any identified vehicle defects are reported to the office electronically. The Provider confirmed that they undergo audits every two years by the Road Safety Authority (RSA).

Additionally, an electronic vehicle tracking system supports safe driving as alerts are sent to the office if drivers deviate from national road speed limits.

The Assessment Team observed the Provider's integrated electronic system and the information it produces, which lends itself to safe practice. During Practitioner Engagement, it was evidenced that all Practitioners logged onto the integrated electronic system at the start of their shift.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.3.1 The Provider's integrated electronic system and the vehicle tracking system in use provides good monitoring of driver behaviour and measures vehicle roadworthiness.

Areas for Improvement

No specific observation noted by the Assessment Team.

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

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider provides an annual CPG report to the PHECC, which includes all the core components outlined in PHECC Council Rules POL003 (Section 23.1-23.10).
PHECC Requirements	2.4.1 The Licensed CPG Provider submits an Annual Medical Director report annually,* which informs the PHECC of clinical activities in the organisation and includes a CPG report (*Calendar year).
PHECC Statement	The Licensed CPG Provider undertakes an ongoing programme of clinical audit, as appropriate, which involves an appropriate combination of structure, process and outcome audits and implements the full audit cycle to support the quality improvement.
PHECC Requirements	2.4.2 The Licensed CPG Provider has a systematic programme of clinical audit in line with PHECC standards (STN019), which is used to monitor quality and outcomes and promote learning.

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.4.1. Risk mitigation is cited as an area of concern by the Provider who detailed the activity being taken to address the ambiguity associated with who is leading clinical care when healthcare professionals other than the Provider's Practitioners travel on the ambulance.

The Medical Director's involvement with the Provider is both proactive and reactive. The Medical Director contributes to staff training, maintenance of competence, validation of staff competence and was well versed in the day-to-day business of the Provider. Evidence of ongoing audit was noted in the submitted audit reports pertaining to ePCRs and to DNAR status.

2.4.2 Three clinical audits were reviewed by the Assessment Team: two were structure audits on completeness of PCR and Do Not Attempt Resusitation (DNAR) data captured for appropriate patients. The Medical Director cited an increased volume of patients being transported with a DNAR in place. Variations in documented DNAR was noted and improvement was required to protect Practitioners. Documented DNAR status is requested by Practitioners at the point of handover. A process of photographing the DNAR and uploading it to the Provider's integrated electronic system has now been introduced. The third audit was a process audit on the treatment of nausea during transport. The Provider reports that a medication audit led to the identification of under use of anti-emetic medication where it was documented that the patient was nauseous on long journeys. The Provider confirmed that every PCR is audited.

The Provider submitted a Clinical Audit policy that does not comply with standard document formatting.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.4.1 The Provider submitted an annual Medical Director's report, which provides evidence of active involvement of the Medical Director and ongoing clinical audit.

2.4.2 The Provider conducts clinical audits utilising the data from completed PCR.

Areas for Improvement

2.4.2 The Provider should update their Clinical Audit policy to include formatting, company name or logo, date of development, version number and date for review.

The Provider may wish to consider an outcome audit within the next audit cycle.

Theme 3

Safe Care and Support

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

3.1.1 The Provider has an infection prevention and control policy; 'Health and Safety at Work Prevention and Control of Infections'. The Medical Director facilitates Practitioner inoculations.

The Provider has a Vehicle Cleaning policy, which outlines the ambulance cleaning schedule. The Provider outlined the process of daily cleaning of ambulance vehicles and deep cleaning on a monthly basis. They stock products for floor, internal surfaces and glass cleaning. Bacterial wipes are available to wipe down all surfaces between calls. Disposable linen is used to minimise cross contamination.

Infection prevention and control (IPC) is referenced in the 'health and safety at work; biological agents and chemicals in the healthcare sector' policy which covers staff health and hygiene. A third policy titled 'health and safety at work; prevention and control of infections' replicates some details from the aforementioned policy. A specific Covid-19 policy has been developed by the Provider, which covers the management of transfers of Covid-19 presentations. The Fleet Management policy also refers to IPC.

The Provider confirmed that they maintain a mask-wearing policy when in contact with patients, which is not formally set out in any policy. Infectious status is identified at the call booking stage to guide staff re PPE and if an ambulance would need to be stood down post transfer for appropriate cleaning. This infections status is documented on the ePCR.

The wearing of gloves was discussed with the Provider and caution issued relating to potential overuse of gloves which may lead to a reduced consciousness re: breaking the chain of infection and hand hygiene.

During Practitioner Engagement it was noted that the ambulance allocated for the day was very clean, and cleaning materials, such as paper towels, disinfectant spray and blood spillage kit were on the vehicle. There was a hand sanitiser dispenser available in the rear of the ambulance. Large clinical waste bags were available on the ambulance. There was no clinical waste bin available for immediate use in the ambulance saloon. At the end of each call, the stretcher, worktops and equipment were sanitised and prepared for the next call. Practitioners advised that most clinical waste is disposed within the hospital system. Clinical waste not disposed of in the hospital is bagged and brought back to station. Within the station is a large locked clinical waste bin in which the bagged clinical waste bags are stored. The clinical waste bags are not tagged. When required, the office manager will arrange for this waste to be collected through an approved clinical waste company.

At the end of the shift the saloon of the ambulance is cleaned and prepared for the next day. There is a cleaning bay within the ambulance station, which has a cabinet housing cleaning and disinfectant material to facilitate this cleaning. Practitioners advised that a deep clean occurs on a regular basis, which is recorded.

Assessment Panel Findings Cont'd

3.1.2 The Assessment Team verified that the required medications were available for EMT and Paramedic levels. A significant safe has been fitted at the base to store the medications.
The Provider has developed a Medication Management policy, which specifically relates to controlled medications, but the title does not indicate this. The Provider does not possess a licence from HPRA for controlled medications for Advanced Paramedic (AP) use currently, despite being approved by PHECC at this level. Other AP specific medications were also not available. The Provider, however, did indicate that AP may be deployed at events should the event organiser require them. The Provider did not furnish a policy that outlines the roles and responsibilities of each member of the organisation for all stages of medication management, the acquisition, collection, storage, administration of medication - medication rights, recording use, reporting use of medication, and requesting replenishing of medications.

A robust system exists in respect of the acquisition, storage, reporting use of medication and requesting replenishing of medications via the administrative office. Medication stock is monitored by the office manager. The Medical Director writes a prescription, and the medications are dispensed by a local pharmacist. Medications pouches are sealed and tagged and are housed in the equipment cabinet in the station. During Practitioner Engagement the EMT and Paramedic medication bags/pouches were checked and all medications relevant to their practice were available and in date. They are signed in/out on a daily basis. The paramedic pouches are housed in a safe in a locked room. They are not sealed or tagged. They are signed in/out on a daily basis. If a medication is not available for restock the Practitioner is allowed to remove another pouch. The administration of medications is recorded on the ePCR and noted on the medication check list.

3.1.3 There was adequate stocks of EMT and paramedic level equipment, however, AP specific equipment, such as intubation equipment, was not obviously available. The Provider has a Work Equipment policy, which does not outline the roles and responsibilities of each Practitioner at the beginning and end of their shift. The Assessment Team identified that there was sufficient equipment on the ambulance to utilise all the EMT and Paramedic CPG. This equipment was checked at the commencement of the shift and recorded on the Provider's integrated electronic system. The Provider operates a “pick store” in the station, which was available to Practitioners to restock consumables, and has a system for recording what is removed from the store.

Practitioners advised that there was no delay in accessing equipment. Equipment not immediately available is ordered through a medical equipment company. A white board at the base is utilised by the Practitioners to note equipment which is not immediately available from the equipment store. Senior Managers monitor this board and respond to requests for equipment.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

3.1.1 The Provider's deep clean facilities at the ambulance base are very good.

Areas for Improvement

3.1.1 The Provider should consider

- Updating the Health and Safety at Work Prevention and Control of Infections policy to reflect that the Medical Director will facilitate inoculations.
- Streamlining its infection prevention and control (IPC) guidance into one policy to cover all aspects of IPC.
- Provide a receptacle in the saloon of the ambulance for the immediate collection of clinical waste. The mops, buckets and cloths should be colour coded and a cleaning chart located on the inside of the locker to indicate a cleaning regime.
- Review the location of the hand sanitiser in the vehicle to remove the possibility of any leak from the dispenser.

3.1.2 The Provider should

- Develop a policy that outlines the roles and responsibilities of each member of the organisation for all stages of medication management.
- Apply to the HPRA for a licence for controlled medications and make available other Advanced Paramedic's specific medications.
- Remove medication documentation sheets with information, scan/file/shred as appropriate.
- Tag Paramedic pouches in the same manner as the EMT pouches.

3.1.3 The Provider should

- Develop PPPG to detail the roles and responsibilities of each Practitioner.
- Ensure adequate stocks of specific equipment is available when Advanced Paramedics are deployed.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

3.2.1 The Assessment Team identified a culture of open disclosure and Practitioner understanding of their responsibilities to raise concerns, and record patient safety incidents. This was supported by the policy Critical Incident/Accident Reporting.

The Incident recording procedure is robust utilising a proprietary software package, where digitally all incidents, including patient related incidents, are recorded. A non-punitive approach is used in the organisation to encourage reporting of incidents/near misses. There is also a communications box in the ambulance base for staff.

Practitioners were familiar with the process for reporting adverse clinical events and advised that there was a section on the Provider's digital management system for reporting both clinical and non-clinical events. They further advised that there was a no-blame culture within the organisation when an incident is reported.

3.2.2 The proprietary software package is utilised to advise all staff of incidents and outcomes. Training updates and team meetings are scheduled for weekends to ensure staff attendance as most activity is Monday to Friday. Training and staff meetings provide opportunities to share lessons learned. There is a whole-team approach to institutional learning, which includes the admin team attending training and meetings.

The Medical Director relayed a scenario whereby reflection led to the identification that staff did not always report an incident whereby the patient presentation was not according to the detail provided at the call booking stage. Video vignettes are used to share snapshot updates and uploaded on the Providers software package; the Practitioner receives a learning notification by email and notified of their requirement to watch/read the update. A timeline can be assigned; example' date to review by'. Verification is given by the digital system to confirm the Practitioner has read or watched an update.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

3.2.1 The Provider encourages open disclosure with incident reporting in a non-punitive manner.

3.2.2 The Provider has a good system in place to provide regular updates electronically and in person.

Areas for Improvement

No specific observation noted by the Assessment Team

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

3.3.1. The Provider has a safeguarding statement and a safeguarding guideline in situ, however, date of publication, company logo/identity and date for review are absent from both documents. The Provider has a Garda vetting policy in place.

All ambulances are fitted with CCTV to safeguard both patients and staff and footage can be accessed up to 6 months prior. The Child Safeguarding Statement in place makes no reference to mandatory reporting as required by the Child First Act 2015. Staff confirmed to the Assessment Team that they are made aware of their mandatory role in reporting any concerns re child protection and safeguarding. The Assessment Team observed evidence of mandatory training in the area of children's first online training and safeguarding updates within staff files. An external trainer is employed to provide safeguarding training.

Practitioners provide a feedback loop when they identify areas of concern such as unsuitable accommodation at the destination. The Medical Director provided a scenario that occurred which indicates staff awareness of their role in the protection of the public from harm and vulnerability. The Medical Director is reassured by the calls he receives from crews if any concern arises for patient safety.

The Assessment Team were also advised that regularly, prison officers, healthcare assistants, a parent (in the case of a minor) or a family member will be permitted to travel with the patient and a guardian is always present when a pediatric patient is being transported.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the Assessment Team.

Areas for Improvement

3.3.1 The Provider should update its safeguarding statement to include mandatory reporting.
The Provider should consider developing formal PPPG regarding child protection and safeguarding roles and responsibilities that would incorporate its safeguarding statement within a standardised format with a version number, date of publication, date of review, company identifier/logo.

Theme 4

Leadership, Governance and Management

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

Pre-Hospital Emergency Care Council

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

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

4.1.3 The CPG Provider is compliant with taxation laws.

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.1.1 In reviewing the Provider's submitted Clinical Governance document, it is not clear if this is a policy, procedure or a guideline. The responsibilities outlined in the Clinical Governance document indicates that the Medical Director has line management responsibilities over Practitioners. In the Staff Qualifications, Education, Planning and Recruitment policy the Medical Director is portrayed as the occupational health physician for the Provider. In discussion, it was clarified that the Medical Director will also identify appropriate referral to CISM.

The Medical Director confirmed that he refers staff on for inoculation and does not inoculate them directly. During discussions it transpired that the Medical Director has functional responsibilities and not line responsibilities for Practitioners as implied in several documents. Clarity was sought and it was confirmed that the reporting relationship is from Practitioner to Managing Director. Practitioners may make contact directly with the Medical Director should they have a clinical issue. 'Fact checking' case by case will be done directly between Practitioners and the Provider. The Medical Director's reporting relationship to the Provider was queried.

The Assessment Team established that the Medical Director provides active Clinical Governance and plays both a proactive and active role in the organisation. The clinical governance document states that the Provider has in place 'a reporting structure for clinicians directly to our Medical Director and also a clinical tutor who can support them and provide clear guidelines'. In the event that the Medical Director is not available, a contingency is in place with an Advanced Paramedic who also facilitates training for the Provider. It was confirmed that only medications used predominantly in repatriating' cases will be flagged with the Medical Director. The Advanced Paramedic will not link with the Medical Director for all medication used in day-to-day practice.

4.1.2 The Provider's Medical Director is registered with the Medical Council at the required registration level. It is apparent that the Medical Director has a very active participation within the organisation.

4.1.3 The Provider is tax compliant.

4.1.4 The Provider submitted up to date certificates evidencing required cover.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

4.1.1 The Provider's Medical Director plays an active role in Clinical Governance.

Areas for Improvement

4.1.1 The Provider should update the Clinical Governance document to

- Implement document control to specify the type of PPPG it is
- Reflect that the Medical Director has functional and not line management responsibilities over Practitioners
- Clarify the chain of command; that all staff report directly to the management team of the Provider

The Provider shall clarify the Medical Director's line of reporting within the Provider's management structure in all other related documents.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.2.1 Data is captured on the Provider's software system utilising the PCR. All PCR are audited by the Medical Director. In particular, medications administered are reviewed. Audit on PCR completion ensures a high proportion of PCR completion. The digital system is introduced to Practitioners during induction training.

The Provider does not currently carry out planned observation of Practitioner's performance. Prior to COVID-19 a PHECC tutor was engaged to complete ride along to oversee Practitioner quality. The Provider informed the Assessment Team that this process is planned to recommence shortly and has identified an experienced Advanced Paramedic to perform opportunistic 'ride along' to monitor staff conduct and practice.

The Provider stated its values system that underpins all training, that it invests in people, values staff safety and believes in treating its staff well, instilling the importance of dignity at work and duty of care.

The Provider discussed how they minimise risk and improve quality through induction, regular training sessions, and rotation of staff to have junior shadow senior and learn from the experienced.

Driver safety and managing driver fatigue is strongly encouraged and the Managing Director, an Emergency Service Driving instructor, accompanies staff to sample and observe driver patterns.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

4.2.1 The Provider conducts ongoing clinical audit of PCR.

Areas for Improvement

4.2.1 The Provider should consider expanding the level of clinical audit to include outcome audits.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.3.1 The Provider has a risk assessment document, however, this document does not clarify if it is a statement, policy, procedure or guideline. The Safeguarding policy submitted does not have reference to the Child First Act 2015 and in particular mandated reporting by PHECC Practitioners.

The Assessment Team identified that the Provider monitored the penalty points of their drivers within the Fleet Management policy. The Provider's Fitness to Practice policy states that licences must be produced and the Provider seeks copies of driver licence for staff files. Practitioners confirmed that a copy of the Practitioner's driving licence was required to be forwarded to the Managing Director every six months. Practitioners are required to notify the Managing Director regarding receipt of penalty points.

There is no reference to a requirement for PHECC licences to be held by Practitioners within the documentation provided. The Provider identified this as an oversight and that they annually check Practitioners for their current PHECC licence.
Mandatory reporting of a death by PHECC paramedics and advanced paramedics is a requirement of the Coroners (amendment) Act 2019, on examination, it was confirmed to the Assessment Team that Practitioners were not made aware of this.

The Provider had no controlled medications on the premises. An Garda Síochána furnished a letter to support the Provider's application to HPRA for controlled medications. A licence for Midazolam use is in situ. Medications on site are observed as being stored securely. Locks are on the safes and entry doors and there is controlled access to the admin HQ and ambulance base.

The electronic monitoring system sends alerts to management if driver behaviour is not in line with speed limits. If any moving violations are identified, management indicated that the Practitioner will re-train and be monitored by the Managing Director on journeys.

The Provider has an up-to-date safety statement, and the risk register is held within the safety statement. Regarding annual renewals, the digital management system will flag renewal dates for management to seek up to date registration certificates. During Practitioner Engagement it was evidenced that access to the management system is available to all staff, on the station PC, ambulance tablets and on their mobile devices. All policy documents are available to staff any time. The digital management system ensures Practitioners have access to all of their training details and timelines, and ensures that the staff are aware of their own training requirements.

New staff are required to complete the Road Safety Authority (RSA) , Emergency Services Driving Standard (ESDS) theory and have their driving assessed. The Managing Director is an RSA ESDS approved driving instructor and performs a driving assessment on employment commencement. There is a phased approach to driver development.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

4.3.1 The Provider's integrated digital system and the vehicle monitoring system provide robust measures to drive safety of practice.

Areas for Improvement

4.3.1 The Provider should clarify the status of the 'risk assessment' document, and also the number of penalty points that are acceptable for driving duties.

The Provider should consider including a 'legal mandatory' requirement advice document for Practitioners for such things as reporting of death and reporting abuse of children and vulnerable adults etc.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.4.1 The Provider has a messaging system within the digital software platform to ensure staff receive alerts and updates in a timely manner. The digital system feeds into compliance monitoring, and management are notified when Practitioners read an update. Practitioners cannot proceed with use of the Provider's digital system if the alert requirements are not complied with. The Provider also hosts quarterly training meetings.

4.4.2 The Provider has endeavored to be compliant with all aspects of the PHECC GVF.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

4.4.1 The Provider has invested in systems to manage communications and compliance.

Areas for Improvement

No specific observation noted by the Assessment Team.

Theme 5

Workforce

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.1.1 The Provider acknowledges the challenges in recruiting and retaining staff as they experience frustration with workforce planning activity as staff leave to fulfill Practitioner positions with the other services, particularly EMT wishing to progress to Paramedic level. The Provider hopes to mitigate this risk through the development of a PHECC Recognised Institution to teach EMT.

It was noted that in the Staff Qualifications, Education, Planning and Recruitment policy both the EMT and Paramedic job descriptions refer to the 2017 CPG care principles.

Requirements within the Paramedic job description were discussed.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the Assessment Team.

Areas for Improvement

5.1.1 The Provider should develop a policy for workforce planning to support this ongoing activity and its continuity. EMT and Paramedic job descriptions should be updated to refer to the current care principles and remove reference to specific Paramedic requirements, as discussed with the Managing Director.

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

Pre-Hospital Emergency Care Council

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.2.1 The Provider has a comprehensive English language policy pertaining to Practitioners whose first language is not English.

5.2.2 The Provider has processes to check qualifications and registration of all Practitioners. As a safeguarding mechanism, the integrated digital system sends alerts to management to flag when annual registration renewals are due. Staff are then contacted to submit their updated registration.

5.2.3 An annual check to confirm PHECC registration is conducted. The Provider has a recruitment document in place which details the requirements of all Practitioners at employment contracting stage. The Assessment Team observed assurances regarding up-to-date qualifications and registration present in each staff file. However, there was no evidence of an individual privileging letter being issued to each Practitioner by the Medical Director.

5.2.4 Garda vetting is carried out on all Practitioners prior to employment and on a rolling three-year basis. The Provider's policy does not specify conviction classifications that are absolute contraindications for employment. The Office Manager is the designated person for Garda Vetting.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the Assessment Team.

Areas for Improvement

5.2.2 The Provider would benefit from the introduction of a process to ensure database accuracy of staff qualifications/registration.

5.2.3 The Provider's Medical Director should issue individual privileging status letters to each Practitioner.

5.2.4 The Provider should formally document, within the staff handbook, the process to manage Practitioners should a Practitioner be convicted of a criminal offensive whilst employed by the Provider. The Provider should detail what is deemed an issue of concern and document the specified action that will take place upon disclosure of the offense/issue of concern.

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

Pre-Hospital Emergency Care Council

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

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

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.3.1 The Assessment Team evidenced a comprehensive process for induction and orientation for new Practitioners. The Provider has a staff handbook, which is supplied to all Practitioners at induction. This handbook covers managing attendance, use of social media, misconduct, GDPR, health and safety and the grievance process. The Provider's safety statement is held in the main administrative office and a copy is available for staff at the ambulance base.

5.3.2 The Assessment Team evidenced a comprehensive system for managing training and development needs within the Provider's organisation. This includes four days CPD training for Practitioners annually under the direction of the Medical Director. The Provider employs one PHECC tutor and has plans to engage one more to facilitating training updates. The Medical Director has developed and implemented an EMT 2021 CPG upskilling programme for all their Practitioners. However, the Provider is not a PHECC Recognised Institution (RI) and there is no evidence that a PHECC Tutor was involved in the programme. The Medical Director's report incorrectly indicated that the Provider did have RI approval, however, they are a PHECC Approved Training Institution.
The Provider's Paramedics also attended the EMT 2021 CPG upskilling but there is no evidence that they have completed the additional paramedic upskilling of the 2021 CPG medications and interventions.
The Medical Director expressed a concern with sharing his programme content with PHECC as it is commercially sensitive.

The Provider's premises can accommodate virtual training with well-established ICT systems to support its use. The Assessment Team observed evidence of ongoing training for staff held within their staff files and also uploaded to the integrated digital management system.

Training within the service is carried out by a number of individuals, including the Training Manager and the Supervisor. CFR is carried out by a qualified instructor and equipment familiarisation is carried out by the Training Manager. The Medical Director provides scenario-based training in the organisation.

Records of training are saved digitally and for mandatory training Practitioners will receive email notices at regular times advising them that they are due for training/recertification. The digital management system does not permit a Practitioner to log onto the system if they are out of certification.

5.3.3 The Provider does not currently accept Practitioner students for placements, due to COVID-19 restrictions. This has been classified as 'not applicable' as a result.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the Assessment Team.

Areas for Improvement

5.3.2 The Provider should submit the EMT 2021 upskilling programme to PHECC for retrospective approval. The Provider should also make arrangements to ensure the paramedic Practitioners are upskilled to the paramedic 2021 CPG through an approved RI. The Supervisor should be encouraged to complete a recognised training process in order to achieve the assistant tutor/tutor status.

The Provider needs to ensure that all familiarisation/training is carried out in a structured manner and recorded by suitably qualified persons.

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

Pre-Hospital Emergency Care Council

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

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

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

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

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.4.1. The Provider has a Critical Incident Stress Management policy, which states that this policy and procedure will be reviewed yearly, however, there is no evidence of yearly review since the last review carried out in 2019.
The Provider has a CISM programme in place supported by staff and management. This programme, however, does not have access directly to external support. Employees are required to currently report a CISM issue directly to senior management. During Practitioner Engagement Practitioners confirmed that there is an active CISM process within the organisation, with the Training Manager as the first point of contact. Practitioners had utilised the process and stated that the owner was very supportive of the staff during these events.

5.4.2 The Provider has a Fitness to Practice policy, however, the document was not dated, had no version number, or a date for review.

5.4.3 The Provider has a vehicle tracking system that enables the organisation to monitor the exact location of all vehicles. The Managing Director occasionally shares driving duties with Practitioners and monitors their behaviour while in-situ. Regarding absence of formal observation of performance, the Provider related a plan to employ an Advanced Paramedic to conduct unannounced 'ride-along' with crews.

All PCR are audited, which can potentially identify poor performances of a clinical nature. Audit of the PCR shows areas for improvement for example; staff must complete 3 set of vital sign assessment on journeys > 30 minutes duration. Where this is not met, the digital management system will identify same and it can be addressed with that staff member.

5.4.4 The Safeguarding policy outlines a comprehensive approach to ensuring a patient centred approach. The Assessment Team noted that a culture of reporting poor performance is encouraged by the non-punitive approach to reporting such incidents.

5.4.5 The Provider's software system enables reporting of incidents in real time. The Provider holds scheduled training sessions and staff meetings with a whole-team approach to share lessons from any incidents, complaints and compliments. The staff have opportunity to provide confidential feedback via a communications box at the ambulance base. The Provider is auditing the documented clinical lead per patient transfer, in particularly if the clinical lead in not employed by the Provider.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the Assessment Team.

Areas for Improvement

5.4.1. The Provider should expand the CISM programme to permit Practitioners to have access directly to external support without having to consult with Senior Management initially. The Provider should amend its CISM policy document if it cannot achieve yearly review of compliance with the CISM process.

5.4.2 The Provider should update the Fitness to Practice policy to include date, version number and date for review.

5.4.3 The Provider would benefit from improving capabilities of identifying poor or variable staff performance.

5.4.4 The Provider should revise its documentation to reflect that it does not use volunteers.

5.4.5 The Provider would benefit from clarifying the process for determining who is clinical lead on a crew.

Theme 6

Use of Information

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

Pre-Hospital Emergency Care Council

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

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

6.1.1. The Provider has an IT & Communications policy, an Effective Communications procedure document and a Record Management policy. The Assessment Team identified that there is no destruction policy to support disposal of existing paper based clinical records that have exceeded their required storage timeframes.

The Provider stated that all documentation is housed within the digital management system including the capture of PCR data, which is securely stored in the cloud. The Assessment Team evidenced ePCR being completed on the iPad allocated to each ambulance. The documentation was completed appropriately for the patients encountered. All transfer forms (private or public transfer) are stored in a locked cabinet in the cab of the ambulance when completed. At the end of the shift, the forms are removed from the cab and placed in a locked box in the crew room on the station.

As a rule, ePCRs do not form part of the hospital patient record, as there is no facility to print off the form in the ambulance or hospital. If the hospital requires a copy of the PCR, this is organised through the Provider's office. Paper PCR are held within the ambulance cab to enable a hard copy to be presented for Emergency Department use if immediately required.

6.1.2 The Provider’s software system has protections built in to reduce inappropriate population of fields i.e. the Blood Glucose value cannot exceed two whole figures, which in turn prevents error in documentation. The structure audit of PCR completion percentage submitted was of high quality.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

6.1.1 The process of documentation safety from commencement to placing in the locked box in the crew room was well managed.

Areas for Improvement

6.1.1 The Provider should consider developing a document destruction policy prior to destroying paper-based clinical records that have surpassed their storage requirement timeframes. Re overall document hygiene: The Provider should review its entire suite of policies, procedures, protocols and guidelines (PPPG) to apply a standardised format, to include, company identifier/logo, date of development, date for review, and include version numbering. Many documents require updating in line with best practice; a 3 year PPPG review cycle.

Report Summary

Report Summary

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

Judgement Framework Level	External Assessment Assigned Level	Percentage
Not Applicable	1	2%
Not Met	0	0%
Minimally Met	0	0%
Moderately Met	1	2%
Substantively Met	20	47%
Fully Met	21	49%

GVF Site Assessment Summary - HEART ER LTD

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

Theme 3: Safe Care and Support	**Standard 3.1 Licensed CPG Providers protect patients from the risk of harm associated with the design and delivery of healthcare services.**	
	3.1.1 The Licensed CPG Provider has a reliable system in place to prevent and protect patients and staff from healthcare associated infections.	**Substantive**
	3.1.2 The Licensed CPG Provider ensures that there are systems, processes and procedures in place to ensure medicines availability, storage, stocking and disposal processes for the administration of pre-hospital emergency care.	**Substantive**
	3.1.3 The Licensed CPG Provider ensures that there are systems, processes and procedures in place to ensure equipment/medical device availability, storage, stocking and disposal for the administration of pre-hospital emergency care.	**Substantive**
	Standard 3.2 Licensed CPG Providers effectively identify, manage, respond to and report on patient-safety incidents.	
	3.2.1 The Licensed CPG Provider has structured incident reporting and investigation mechanisms, which support and encourage volunteers, contractors and/or employees to report adverse events, near-misses and no-harm events.	**Fully Met**
	3.2.2 The Licensed CPG Provider has a process for the sharing of lessons learned from patient safety incidents (including adverse events, near misses and no-harm events) and complaints, which have occurred locally, nationally or internationally with employees, contractors and/or volunteers.	**Fully Met**
	Standard 3.3 Licensed CPG Providers ensure all reasonable measures are taken to protect patients from abuse.	
	3.3.1 The Licensed CPG Provider has policies/procedures in place to prevent harm or abuse occurring and take action where concerns arise.	**Substantive**
Theme 4: Leadership, Governance and Management	**Standard 4.1 Licensed CPG Providers have clear accountability arrangements to achieve the delivery of high-quality, safe and reliable healthcare.**	
	4.1.1 The Licensed CPG Provider has an established reporting and accountability structure for clinical governance.	**Substantive**
	4.1.2 The Licensed CPG Provider has an identified Medical Director who is registered with the Medical Council and who is based in this jurisdiction and who oversees the service.	**Fully Met**
	4.1.3 The Licensed CPG Provider is compliant with tax laws.	**Fully Met**
	4.1.4 The Licensed CPG Provider has documentary evidence of the required insurance policies.	**Fully Met**
	Standard 4.2 Licensed CPG Providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	
	4.2.1 The Licensed CPG Provider has systems, process and practices in place to utilise safety and quality information to highlight areas of improvement and improve the quality and safety of the service.	**Fully Met**
	Standard 4.3 The conduct and provision of healthcare services are compliant with relevant Irish and European legislation.	
	4.3.1 The Licensed CPG Provider has systems, processes and procedures in place to ensure compliance with statutory legislation relating to the provision of safe and effective care.	**Substantive**
	Standard 4.4 Licensed CPG Providers act on standards and alerts and take into account recommendation(s) and guidance, as formally issued by relevant regulatory bodies as they apply to their service.	
	4.4.1 The Licensed CPG Provider has a process in place to ensure the appropriate communication and adoption of new recommendation(s) and guidance issued by the PHECC and other regulatory bodies.	**Fully Met**
	4.4.2 The Licensed CPG Provider is compliant with the PHECC Governance Validation framework.	**Fully Met**
	Standard 5.1 Licensed CPG Providers plan, organise and manage their workforce (volunteers, contractors and/or employees) to achieve the service objectives for high-quality, safe and reliable healthcare.	

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

Report Status

In accordance with the Council rules this GVF site-assessment does not trigger a requirement for PHECC to issue an improvement notice, attach conditions or withdraw recognition.
Council Rules for Pre-Hospital emergency care service Providers who apply for recognition to implement Clinical Practice Guidelines (POL003 V7) outlines that, where appropriate, full recognition to implement CPG will be awarded for a three (3) year period. This approval will apply from the last approval date.

Quality Improvement Plan

HEART ER Ltd is required to adjust and submit their Quality Improvement Plan to gvf@phecc.ie. This adjustment of the Quality Improvement Plan will encompass any areas highlighted in the 'Areas for Improvement' and will identify and outline improvements to be actioned or planned at HEART ER Ltd in the upcoming licensing period.

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