Pre-Hospital Emergency Care Council

Governance Validation Framework

Site Assessment Report

Cara Ambulance Service Ltd

September 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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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 Cara Ambulance Service Ltd prior to the assessment and any evidence provided on assessment day(s) is reviewed and considered by the assessment team for assessment purposes.

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

The Licensed CPG Service Provider that is the subject of this report is Cara Ambulance Service Ltd, a private provider of pre-hospital emergency care services based in Cork. The on-site GVF assessment visits for this report were conducted during September 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 Cara Ambulance Service Ltd's organisation.

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

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

Overview of Licensed CPG Provider

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

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

Overview of Licensed CPG Provider

Assessment Details:

Licensed CPG Provider	Cara Ambulance Service Ltd
Type of Visit	Full GVF Assessment - GVFREP CAS 002_0922
Licensed CPG Provider Lead	GVFA7106
Date of Review	Practitioner Engagement - 07/09/2019 Site Assessment - 23/09/2019
Assessment Team	GVFA7106 - Team Lead GVFA1637 - Site Assessor GVFA3572 - Practitioner Engagement
Circumstances of this Site Assessment	GVF Assessment
Relevant Recent Visits	Onsite assessment conducted September 2022.

Assessment Details (continued):

Licensed CPG Provider Participants

Director/Operations Manager
Company Secretary
Medical Director (Medical Council Reg No 228767)
Paramedic x 1
Emergency Medical Technician x 1

Onsite Feedback

Verbal feedback related to the Assessment Team's initial findings was provided to the Senior Management Team of Cara Ambulance Service Ltd by the PHECC GVF Assessment Team Lead at the closing meeting. A number of items were identified as areas of potential improvement that include: record management, handover process, clinical audit, and PPG. There was agreement by all in attendance regarding the relevance and substance of the 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 Assessment Team reviewed the employee register/duty rotas of PHECC registered Practitioners with the Management Team to establish the core of workforce employed. Contingency is in place via relief staff should an unexpected absence occur.
The Provider has a satellite vehicle tracking system in situ to monitor timing of dispatch and transfers, and driver performance. Evidence was provided of monitoring of driver safety reports and how findings were translated into performance management.
The Provider engages in scheduled care conveyance only. The Assessment Team established that the Provider has no predetermined or agreed commitment to local or national major incident response.

1.1.2 The Assessment Team noted the Provider's policy outlining Patient Introduction, Assessment, Care Initiation, Reassessment and Release due for review in June 2023. The policy makes reference to patient identification during care initiation. The Assessment Team reviewed sequencing from booking to dispatch within the organisation with the Director. A historical call taking log was observed by the Assessment Team, which has now migrated to an electronic format. The call taking logs identify the Practitioners assigned to each call. Upon booking confirmation by the Director, call details with reference number are sent by text to Practitioners via the company mobile phone – pin required to access phone. Texts are deleted from work phones upon completion of call.

The Assessment Team established that the Provider does not maintain a record of the Practitioners who are assigned to non-transfer, event calls (Motor Rally).

The Assessment Team observed evidence that the Provider plans to further digitalise its practices via an information technology solution for call taking, dispatch and maintenance of relevant records. The Provider is committed to ongoing monthly audit of PCR.

The Assessment Team reviewed the procedure for attending calls with Practitioners and found this to be congruent with the provider's procedure.

The Assessment Team observed the presence of a medical translation booklet in the ambulance.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.1.1 The Provider has an access to care policy in situ that outlines the procedure for receiving calls, verifying calls, and dispatching appropriate resources for scheduled inter facility transfers.

1.1.2 The Provider is committed to continuously improving their processes through investment in information technology solutions that would further streamline the access to care process.

Areas for Improvement

1.1.1 The Provider should update its employee register to reflect current contracted staff.

1.1.2 The Provider should maintain records of all operational activity to include all events.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.2.1 The Provider is mainly involved in the provision of inter facility transfers through scheduled care conveyance. The Provider has a policy titled 'Uniform Care Delivery' that makes brief reference to patient consent. Practitioners were observed to verify patient identity and gain patient consent.

1.2.2 The Provider is mainly involved in the provision of inter facility transfers and therefore refusal of treatment and/or transport is uncommonly encountered. In discussion with Practitioners the Assessment Team noted that similarly Practitioners had not encountered an instance of patient non-consent/refusal of care.
The provider makes reference to refusal of care in the Patient Handover policy.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.2.1 The Assessment Team observed Practitioner compliance with patient identification and consent.

1.2.2 The Provider has a procedure in place for refusal of treatment and/or transport.

Areas for Improvement

No specific observation noted by the Assessment Team.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.3.1 The Provider's employee handbook outlines expected organisational conduct regarding confidentiality and employees sign a confidentiality agreement at outset of employment. The Assessment Team observed a sample of employee records, which verified this arrangement regarding confidentiality. The Provider's Patient Introduction, Assessment, Care Initiation, Reassessment and Release policy makes reference to patient introduction. The Provider's policies and procedures promote patient privacy, dignity and autonomy.

1.3.2 Practitioners were observed to interact in a respectful and warm manner with the patient in a busy environment.

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

Areas of Best Practice

1.3.1 The Provider's staff handbook and policies promote patient dignity and respect.

1.3.2 Practitioners' conduct reflects kindness and respects the dignity and privacy of the patient.

Areas for Improvement

No specific observation noted by the Assessment Team.

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

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

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

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

Assessment Panel Findings

1.4.1 The Provider has a patient satisfaction form, which is made available to its service users within the ambulance. The Assessment Team observed completed satisfaction forms. The satisfaction forms detailed positive patient experiences. The Assessment Team did not observe any negative feedback. The email and contact phone number for the Provider is provided on feedback sheets.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.4.1 The Provider has a mechanism in place to collect and review patient satisfaction data.

Areas for Improvement

1.4.1 Feedback sheets should contain a document version number and sign-posting to the relevant policy reference number.
Completed patient feedback sheets containing personal information should be removed from the ambulance cabin upon shift completion and stored securely.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.5.1 The Provider has a complaints management policy in place and it states an annual review date, however, this is contradicted by the mention of a 3 yearly review date of 2023. The policy outlines how a complaint is handled, outlining the proposed timeline within which a complaint is addressed. The policy makes reference to quality improvement arising from complaints. The Assessment Team discussed the handling of complaints with the Director/Operations Manager during the onsite assessment, however, they stated that no complaint had ever been received. The Medical Director confirmed also that he has had no involvement in complaints management.

1.5.2 The Practitioners present during site assessment were aware of the complaints policy and stated they would refer any complaints to the Director/Operations Manager via telephone. The Practitioners were not aware of any complaints having being made or of any change in organisational procedure following the investigation of a complaint.

Practitioners report that the feedback form with the Provider's contact details is available to all service users should they require them. The Assessment Team observed training records within staff files that demonstrated that the complaints procedure is covered at induction.

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 The Provider has a specific complaints management policy in situ.

1.5.2 The Provider covers complaints management at staff induction.

Areas for Improvement

No specific observation noted by the Assessment Team.

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 The Assessment Team reviewed the Provider's register of PHECC Practitioners; the register requires updating to reflect the cessation of all staff who have left the Provider's organisation for other employment, and the identified staff who are presently employed as core staff. The Assessment Team identified inconsistencies with the Provider's submitted register of employees.

The Assessment Team reviewed the employee personnel records of a selection of the Provider's staff and found the records to be complete in most circumstances, however 2 induction records could not be verified and some training records had expired or were about to expire. Additionally, on one staff record a PHECC registration was expired and later confirmed to be valid through the PHECC online Practitioner register.

The Assessment Team established that clinical updates or safety alerts are disseminated by email to staff. A new laptop is planned for the HQ ambulance base for Practitioners to access the Provider's PPG. The Assessment Team observed evidence of emails that had been sent to Practitioners in this regard and confirmed with Practitioners that they received such emails.

The Assessment Team witnessed the use of an electronic database that tracks expiry dates of PHECC annual registration and mandatory training. Staff induction checklists were observed in most staff records that covers mandatory training requirements. The Director/Operations Manager informed the Assessment Team that hand hygiene mandatory training is completed via HSELAND, however, this is not documented on staff files.

The Assessment Team identified that the Provider has an array of local PPG. The Assessment Team established that the motive for these documents is compliance with external audit rather than delivery of safe care. No documented evidence was obtained for ongoing routine clinical observation of staff by the Provider to ensure compliance with organisational PPPG and PHECC CPG.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.1.1 The Provider maintains an electronic record of Practitioners' registration, qualifications, and attendance at mandatory training.

Areas for Improvement

2.1.1 The Provider should ensure each employee record is complete, maintained, and consistent with their privileged status.
The Provider should, in conjunction with their Medical Director, develop and conduct scheduled training for all Practitioners to ensure translation of organisational PPG into practice and CPG updates.
The Provider should develop a mechanism to ensure existing staff have received and read new or updated PPG (consideration of PPG sign off declaration).
The Provider should conduct regular clinical observation shifts with documented evidence of same.
The Provider should review its organisational PPG with a view to standardised formatting and removing unnecessary PPG.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.2.1 The Provider makes reference to formal patient handover in the Patient Introduction, Assessment, Care Initiation, Reassessment and Release policy. The policy does not make reference to a recognised handover tool; for example, IMIST-AMBO. However, during the onsite assessment both the Director/Operations Manager and Practitioners referred to the IMIST-AMBO tool. The training records reviewed did not account for specific training in patient handover.

During Practitioner Engagement, Practitioners completed the PCR for use in handover to staff within the healthcare facility, however the attendance at an OPD appointment and subsequent return journey did not allow for traditional handover of patient as the patient remained in the care of the Provider's Practitioners throughout.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.2.1 The Provider has a documented patient handover procedure.

Areas for Improvement

2.2.1 The Provider should update the relevant procedure to include a recognised handover tool; IMIST-AMBO being the Provider's tool of choice as referenced in the onsite engagement.

The Provider should provide formal training on patient handover and retain evidence of Practitioner attendance.

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 The Provider has an established procedure for pre-shift vehicle checks, which includes relevant documentation and is in line with the recommendations of the Road Safety Authority. During Practitioner Engagement, Practitioners were observed completing pre-shift visual inspections of the vehicle, which had a valid insurance disc displayed. Pre-shift checks involved recording of documenting the vehicle's mileage and performing appropriate pre-shift equipment checks.

The Assessment Team observed evidence of vehicle engine and parts maintenance and CVRT certification and relevant daily inspection documentation. The Provider has recently invested in new vehicles, which represents significant modernisation. Conversion proof, verified manufacturer invoicing, and equipment servicing reports were viewed by the Assessment Team.

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 has a robust procedure for vehicle maintenance with appropriate checks in place, which ensures the roadworthiness of vehicles in line with legislation.

The Assessment Team observed Practitioner compliance with vehicle checks during Practitioner Engagement.

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 The Provider submitted an Annual Medical Director Report (AMDR), which includes the core components outlined in PHECC Council Rules POL003. The Assessment Team established that the Annual Medical Director Report is prepared by the Director/Operations Manager and signed by the Medical Director.

CPG reporting is not included in the AMDR. The report refers to KPI 1.1 hand washing and glove changing. The Assessment Team established that audit of handwashing and glove use is not done on a structured formal basis and is monitored informally by the Director/Operations Manager.

2.4.2 The Provider has a Clinical Audit policy, which is due for review in June 2023. This policy states that the Medical Director will review each clinical policy on an annual basis, however, the Assessment Team established during assessment that the Medical Director does not review each clinical policy on an annual basis.

The Provider also submitted a clinical audit report that concerns the completion of patient care reports (PCR). The audit concluded that current practice is satisfactory, however, some training would be required to improve performance. The Assessment Team observed reference to attendance at relevant online training in the training plan, however Practitioner attendance at this could not be verified.

During Practitioner Engagement, Practitioners stated they were not aware of any audits other than the PCR audit and were not aware of audit outcomes.
The Assessment Team could not identify the result of an audit that led to a change in policy, procedure or practice that demonstrated improvement following re-audit.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.4.1 The Provider has an Annual Medical Director's Report for 2021 which is compliant with PHECC Council Rules POL003.

2.4.2 The Provider has conducted clinical audit of PCR, which resulted in planned training for Practitioners.

Areas for Improvement

2.4.1 The Provider's Medical Director should contribute to the production of the Annual Medical Director's Report (AMDR) and ensure it complies with PHECC requirements for the report.

2.4.2 The Provider should formalise and broaden its plans for clinical audit.
The Provider should update the clinical audit policy to accurately reflect the role of the Medical Director.
The Provider should retain clear documentation of Practitioner attendance at training that is the direct result of the audit process.
The Provider should formalise its monitoring/auditing of hand hygiene.
The Provider should close the audit cycle by conveying audit results to Practitioners in an effort to apply learning from audit outcomes.

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.

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 Control Plan, updated in June 2020, and also has an Infection Prevention Control Policy (IPC) in situ. The policy makes reference to a number of further policies and procedures, which were viewed by the Assessment Team. The policy does not make specific reference to COVID-19. The IPC policy makes reference to an annual audit of compliance with the policy. The Assessment Team did not observe evidence of any infection control audits during the assessment. The Assessment Team observed evidence of a service level agreement with a clinical waste disposal company.

During Practitioner Engagement, Practitioners confirmed that they establish the patient's infectious status before dispatch. Within the ambulances the Assessment Team observed the presence of clean linen on the stretcher of the ambulance, the presence of appropriate personal protective equipment (PPE), the use of appropriate antimicrobial/decontamination wipes, the presence of wall mounted alcohol hand gel dispensers in the saloon of the ambulances, both vehicles had dispensers in 2 locations. It was noted that one hand gel dispenser on each ambulance was empty. Practitioners presented in clean uniforms with organisational identity reflected; they are provided with multiples as replacements.

During Practitioner Engagement, Practitioners were observed to regularly sanitise their hands and with appropriate wearing of surgical face masks throughout. Practitioners report to have completed their hand hygiene training completed through HSELand. FFP2 masks were worn when interacting with a patient. Practitioners were not aware of face fit testing of FFP2 masks. Full PPE, gowns, hand sanitising gel, goggles, FFP2 masks and clinical waste bags were available on the ambulance should they be required. COVID specific donning and doffing training was provided as confirmed by both Practitioners and senior management. COVID-19 risk assessment is in use by Practitioners; primary point of contact poster document available to Practitioners in the ambulance. The Assessment Team discussed the procedure for ambulance decontamination with Practitioners and found this to be satisfactory. The Assessment Team could not identify evidence of ambulance deep cleaning and the Director/Operations Manager stated that this was the responsibility of the staff using the ambulance. Practitioners are unaware of deep cleaning being carried out.

Both vehicles were observed to be clean and clutter free, with floors freshly mopped. Practitioners dissolve chlorine tablets to clean floors and surfaces of ambulance. A daily cleaning log was observed. Clinical waste bins were observed and available for use in the vehicle and in the station, with a large clinical waste bin outside the station that is collected regularly.

3.1.2 The provider has a Medicine Management policy, due for review in June 2023, that outlines the management of medications from requisition, storage, administration and disposal of medications. No controlled drugs are maintained by the Provider.

The assessment team observed records reflecting medication management and observed evidence of the appropriate disposal of expired medicines. A medication log book was presented to the Assessment Team, which flags earliest expiry dates. The Assessment Team confirmed that the Medical Director signs requisitions for medications. Management is responsible for the restocking/replacement of drugs.

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings Cont'd

The Assessment Team noted the presence of medications appropriate to the clinical level present during Practitioner Engagement. The medications bag was sealed by a numbered tag and appropriately stored in a locked press in the ambulance when not in use. The Assessment Team established that Practitioners had received a recent clinical notice regarding methoxyflurane. The Assessment Team could not identify a medication error event to review, however, as the Provider is engaged with routine inter facility transfers, medication administration rarely takes place and so errors are uncommon. Practitioners advise that they would report any incidents, adverse events and near misses to management by telephone in the first instance and would then complete an incident report form, available at the station. At HQ 2 safes were observed with 2 separate codes. Live CCTV footage targeted on the safety lockers is ongoing ,which was observed by the Assessment Team via the Director/Operations Manager's mobile phone.
Paramedic sealed bag tag number was noted, contents corresponded with drugs list. Detailed drugs list are maintained with the next earliest expiry date highlighted. The keys for each compartment are kept in separate key safes for EMT and Paramedic access. EMT do not have access to the Paramedic drugs bag. Oxygen and Entonox cylinders were stored securely, mounted in upright position and strapped in place within a compartment in the ambulance.

3.1.3 The Provider has an Equipment Inspection Testing, Maintenance and Procurement policy, due for review in June 2023, which makes reference to the maintenance, inspection and routine checks of equipment. The Provider requires Practitioners to check the equipment in the ambulance during their pre-shift checks. The Assessment Team observed recent evidence of invoicing from clinical engineering/maintenance services for medical gases, suction unit, patient monitor/defibrillator and stretcher. The assessment team found that some of the equipment in the ambulance did not have a servicing sticker, or the sticker present suggested that the item was due/over-due servicing. This was at odds with the servicing evidence previously observed.

The Assessment Team identified that the Provider has not asset tagged its equipment. The Assessment Team observed the ambulance to be clean, well-organised and well stocked, and medical gases present were of sufficient quantity and within servicing period. Practitioners report familiarity with use of equipment due to formal EMT/Paramedic training previously completed, and familiarisation training was provided when new defibrillators were introduced.

Specific equipment was observed by the Assessment Team:
Defibrillator: displayed in date service sticker.
Suction unit: no labelling or service stickers found. However, documented confirmation of servicing was observed, thus equipment labelling noted to be at odds with this recorded servicing history.
Patient Stretcher: Service sticker indicates 15/02/17. No other labelling or stickers found on stretcher. Director/Operations Manager confirmed verbally that the stretcher had been serviced, however, this was not verified. Contracted servicing due in October 2022 as confirmed by the Director/Operations Manager. Awaiting 2 new stretchers that have been ordered; invoice observed by Assessment Team. Consumables can be restocked at station as required.

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 has an Infection Control plan in place. There is evidence of appropriate clinical waste disposal and adequate supplies of PPE.

3.1.2 The Provider has a Medication Management policy in place, and, as identified by the Assessment Team, medications are managed in line with this policy.

Areas for Improvement

3.1.1 The Provider should conduct infection control audits as described in their policy.
The Provider should ensure that all alcohol hand gel dispensers are appropriately maintained.
The Provider should ensure that an explicit plan is in place regarding the deep cleaning of all vehicles.
COVID-19 risk assessment for use by ambulance services when primary point of contact poster document requires updating to most recent version (At time of report, Version 8.7 publication date 2022.)

3.1.3 The Provider should ensure that all key equipment is maintained and serviced in accordance with manufacturer's instructions.
The Provider has an Equipment Inspection Testing, Maintenance and Procurement policy in place. The provider should consider introducing asset tagging as per this policy, which is then reflected in an equipment register. The routine maintenance or repair of each piece of equipment should also be recorded in this register to ensure continuity of records with service history stickers clearly identifiable on each piece of equipment.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

3.2.1 The Provider has an Incident Reporting Identification, Documentation, Rectification, Review and Communication policy, which is due for review in June 2023. The stated aim of the policy is to enhance patient safety through review and communications of potential or actual adverse events. The policy makes reference to further documents, which were not submitted prior to assessment. The policy makes reference to the responsibilities of the chief ambulance officer, a role that does not exist within the Provider's organisation. The Assessment Team sought to evidence a near-miss or adverse incident and were informed that there were no examples of a clinical adverse events to review. The possibility of under-reporting of events was discussed at the closing on-site meeting: the Director/Operations Manager reassured the Assessment Team that open communication underpins all interactions between senior management and Practitioners.

The Director described a situation regarding staff performance, which he investigated, however, the staff member decided to cease employment once that investigation took place. In discussion with the Assessment Team, Practitioners cited awareness of the need to report adverse incidences and stated that they felt comfortable raising any concerns with the Director/Operations Manager. Practitioners have access to Incident Report Forms in the station to document incidents. It was noted that the Provider's medicine management policy does not reference the need for completion of an incident reporting form in the case of medication error.

3.2.2 The Assessment Team could not identify a specific event that has resulted in a change in practice or policy. The Director/Operations Manager did describe a change in practitioner shift times based on feedback he had received from staff.

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 has a policy for managing actual or potential adverse events. Practitioners were aware of the need to report adverse incidents and felt this would result in improvement where appropriate.

Areas for Improvement

3.2.1 The Incident Reporting – Identification, Documentation, Rectification, Review and policy should be updated to reflect the actual roles within the Provider's organisation. The Provider should include the management of medication error in this policy and should also consider if the further supplementary policies and procedures cited within this policy are necessary.

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 policy, which is due for review in June 2023. The policy states the Operations Manager/Chief Ambulance Officer will "appoint a staff member for safeguarding children" however, the policy does not identify this person specifically.
This Safeguarding policy refers within to a policy titled 'protection of patients from abuse' and another policy titled 'responding to allegations of abuse', which were not submitted prior to assessment.

The Provider has a documented Child Safeguarding Statement (no date of publication noted on said statement). The Safeguarding Statement identifies the Operations Manager as the 'child safety officer'. It was confirmed by the Director/Operations Manager that Practitioners complete safeguarding training via the online platform of HSELAND and this was verified in a random sample of staff records, which evidenced children's first, safeguarding training and Garda vetting.

In line with the protection of the public from harm, it was noted by the Assessment Team that Practitioners complete a COVID-19 risk assessment with infectious status detailed via handover.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

3.3.1 The Provider can demonstrate evidence of Garda vetting and children first training for Practitioners.

Areas for Improvement

3.3.1 The Provider should update the Safeguarding policy and a Child Safeguarding Statement to ensure consistency in terms of titles, roles and responsibilities. The policy should also identify the person responsible for safeguarding by name. The policy reference number should be amended as it conflicts with other policies of the same reference number but of a different topic.

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 The Director/Operations Manager is the named person responsible for clinical governance. The Assessment Team noted that the Medical Director has limited involvement with the Provider and is only involved if this is deemed necessary by the Director/Operations Manager. The Provider's submitted "Clinical Governance & Quality Assurance Committee" document has the same reference number as other submitted documents. This document states that the committee is formed by a number of positions within the company, which in reality do not exist or are in fact the same individual. It further states that meetings of the committee will take place quarterly and minutes of the meetings will be maintained by the Training Officer, and that the Committee is authorised by the Executive Management Committee. However, the membership of the Executive Management Committee is not outlined and is in fact the same individuals who form the Clinical Governance & Quality Assurance Committee. The document makes reference to principal policies that will guide the work of the committee, however, policy numbers and titles are at odds with what was submitted for review by the Assessment Team. Throughout the assessment the Assessment Team noted that issues with document control, formatting, versioning, and duplication are common. There were instances of submitted documents/records being inaccurate, incomplete or not being implemented.

4.1.2 The Provider has an identified Medical Director who is registered with the Irish medical Council and practices within the jurisdiction. The Assessment Team engaged with the Medical Director by means of a conference call during the onsite assessment. The Assessment Team established that the Medical Director is not involved in the day-to-day operation of the organisation, however, they do sign requisitions for medication, and are available to the Provider for advice. The Medical Director is not involved in the delivery of CPD training for Practitioners or development of the training plans as cited within the submitted documents. The Director/Operations Manager confirmed that training is provided by an outsourced arrangement or by in-house training. The Medical Director was vaguely aware of clinical audit that had taken place within the Provider's organisation. The Medical Director was not aware of any adverse incidents, and had not sanctioned any enhanced practice within the organisation. It was confirmed by the Director that clinical governance meetings are not held routinely with the Medical Director as alluded to in documentation submitted prior to assessment.

4.1.3 The Provider is tax compliant.

4.1.4 The Provider submitted evidence of medical indemnity, employer and public liability insurance. The Assessment Team observed evidence of insurance cover during assessment.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by Assessment Team.

Areas for Improvement

4.1.1 The Provider should update the Clinical Governance & Quality Assurance Committee document to reflect the actual governance structures within the organisation.
The Provider would benefit from widening the governance base and structures within their organisation.
The Provider should review its suite of PPG to ensure consistency with roles, responsibilities and titles, document hygiene, versioning, formatting and specified review cycles.

4.1.2 The Provider shall review the Medical Director Standard (Role and Responsibilities) (STN032) and further develop its relationship with the Medical Director in line with PHECC requirements.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.2.1 The Provider has completed clinical audits of PCRs and the Director/Operations Manager cited that the results of the audits had influenced the delivery of training within the organisation, however, the Assessment Team could not identify a documented link between the audit outcomes and translation into learning plans or Practitioner training attendance records.

The Provider makes reference to annual review of compliance with each of its submitted PPG, however, the Assessment Team did not identify any documented evidence of compliance monitoring with PPG submitted.

The Director/Operations Manager informed the Assessment Team that, in order to close the audit cycle loop, feedback from audit to Practitioners is provided by "on the job conversations".

During discussion with the Assessment Team the Provider indicated a willingness to improve organisational process by means of prospective investment in a digital management application.

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 is engaging in ongoing audit of PCR.

Areas for Improvement

4.2.1 The Provider should review its approach to clinical audit to broaden and formalise this in line with relevant organisational policy and procedure.
The Provider should consider developing an audit tool within PPG development to monitor the translation of PPG into practice.
The Provider should develop a formal mechanism to feedback to staff on safety and quality matters associated with the organisation, which may include a formal educational initiative as necessary.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.3.1 The Provider has a Risk Management Policy, which is due for review in July 2023. The document defines risk and makes reference to a risk matrix. The Assessment Team observed the maintenance of a 'safety data folder' that houses organisational risk assessments.

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 conducts organisational risk assessments and maintains related records.

Areas for Improvement

4.3.1 The Provider should consider the involvement of Practitioners in establishing risks and a review of existing risks.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.4.1 The Provider has a Communications policy in place. The Assessment Team observed evidence of the dissemination of clinical notices to Practitioners. The Provider does not confirm receipt of these notices electronically and therefore acknowledgment could not be evidenced. The Assessment Team identified that Practitioners had received electronic mail from the Provider concerning clinical notices. The Assessment Team noted that Practitioners were comfortable raising concerns with the Director/Operations Manager, and clearly reflected their valuing of the open communication channel that they have with him.

4.4.1 During onsite assessment, the Assessment Team verified that quarterly meetings are not routinely held with staff, nor are the twice-yearly bulletins issued, as identified in the Communications policy.

4.4.2 During on-site assessment, the Director/Operations Manager continuously demonstrated a willingness to engage with quality improvement. The Provider has engaged with the Governance Validation Framework assessment by means of the relevant documentation and self-assessment submission.

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 communicates clinical notices/alerts to Practitioners and promotes open communication within the organisation.

Areas for Improvement

4.4.1 The Provider should consider how they can verify receipt of clinical notices /alerts and that same are being understood and applied to practice by staff.
The Provider would benefit from issuing information bulletins and holding structured staff meetings as per their Communications policy.

Theme 5

Workforce

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.1.1 The Provider has a staff recruitment, selection, appointment and termination of employment policy in place.
The Assessment Team identified that the Provider has a small number of staff commensurate to the size of their organisation and clinical activity. The Provider has a contingency in place with a bank of relief staff to cover unplanned absences. The Director/Operations Manager expressed difficulty with staff turnover due to career progression amongst Practitioners but that this does not impact on business continuity due to the flexibility afforded to staff with rotas and shift patterns.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

5.1.1 The Provider has adequate workforce to maintain the level of clinical activity.
The work start and finish times were amended on foot of staff feedback to reflect actual activity patterns associated with interfacility transfers i.e. timing of transfers based on the actual timing of discharges.

Areas for Improvement

5.1.1. The Provider should consider how risk generated by staff turnover can be mitigated.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.2.1 The Provider has an English-Speaking Competency policy, which is due for review in July 2023. The policy identifies an acceptable academic English-speaking competency test, and identifies acceptable test scores.
Practitioners report clinical observations are carried out initially to mentor new recruits but are not routine thereafter.

5.2.2 The Provider has a Staff Credentials and Verifications policy, which is due for review in June 2023. The policy outlines how Practitioners undergo a number of pre-employment checks, which includes confirming their identification, qualifications and PHECC registration. The Assessment Team reviewed a random sample of Practitioner's personnel records, which contained copies of photographic identification, PHECC registration and training records. The Assessment Team evidenced that these files were mainly complete but in some instances training records had expired. In a small number of staff records, induction records were absent. The Provider's Staff Credentialing and Verifications policy does not make reference to renewals of PHECC registration or how this should be escalated. The Provider produced evidence of an electronic record of PHECC annual registration renewals and training records for staff with a section identifying expiry dates.

5.2.3 The Assessment Team noted some records contained a curriculum vitae and contract while some did not.

5.2.4 The Provider has a Garda Vetting policy, which is due for review in December 2023. The policy states that Garda vetting will be complete prior to commencement of duties. The Assessment Team identified Garda vetting reports for Practitioners in a sample review of staff personnel records. The policy does not state that a Practitioner must inform the Provider of a new charge of a criminal offence.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

5.2.1 The Provider has a documented English-Speaking Competency policy that identifies an appropriate academic test.

Areas for Improvement

5.2.2 The Provider should review the employee records to ensure consistency and compliance with its employee personnel records policy (copies of CV, training records, induction records).

5.2.3 The Provider shall update the Staff Credentials and Verifications policy to ensure it reflects the requirements of STN033 Requirements for Privileging PHECC Practitioners.

5.2.4 The Provider should review the Garda Vetting policy to make reference to declaring a new charge of criminal offence against a Practitioner and define the Provider's required vetting cycle.

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

Pre-Hospital Emergency Care Council

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

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

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.3.1 The Provider conducts a formal induction programme for new employees and maintains records of induction training. Upon a sample review of personnel records, induction records were observed with the exception of 2 employee records whereby the induction record was absent from the file. This was raised directly with the Director/Operations Manager during the onsite assessment.

5.3.2 The Provider has a staff education, training and supervision policy, which is due for review in June 2023. The Provider submitted a training plan, and a hybrid approach to training was verified by the Director/Operation's Manager. Some in-house training is provided by the Provider and other training is accommodated by the online platform of HSELAND. The training plan makes reference to Cardiac First Response, Hand Hygiene and Children First Training. The relevant certificates for these courses are held in the employee personnel records. The Provider maintains an electronic record of Practitioner attendance at other training, however, this was not evidenced by attendance sheets or certification.

The Provider is mainly involved with interfacility transfers, however, they also attend events such as Motor Rally. Practitioners stated they would welcome training on safety interventions for the protection of staff in the workplace and to manage potential and actual aggression in the workplace. No formal training in this area is currently provided.

5.3.3 The Provider does not engage with student practitioners as confirmed by the Director/Operations Manager; however, the Medicines policy refers to trainees as does the self-assessment, which states ‘a service level agreement is signed by both the student and management’.

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

5.3.1 The Provider should maintain consistent and accurate records of staff attendance at induction training.

5.3.2 The Provider should update the personnel records to reflect training certification and ensure a comprehensive system of recording of all training completed by staff. The Provider shall ensure that the training database and staff records are in harmony.
The Provider should develop the training programme to reflect the type of work the Provider undertakes, and for such an activity as motor rally, attention should be given to trauma management.
The Provider should consider feedback from staff in developing their training needs analysis.

5.3.3 The Provider should review organisational documentation to remove all references to students/trainees.

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 policy titled 'Dignity at Work and Post Incident Management', which refers to critical incident stress management and makes reference to provision of expert critical incident stress management (CISM) interventions, if Practitioners require such support. The Director/Operations Manager is trained to deliver CISM. The Assessment Team established that the Director/Operations Manager has an agreement with an CISM professional to provide CISM for Practitioners, if required. The Assessment Team could not evidence a service level agreement.
At Practitioner Engagement, Practitioners confirmed the availability of CISM should they require it and indicated that they would contact management in the first instance.

5.4.2 The Provider's staff handbook refers to the management of poor performance or misconduct.

5.4.3 The Provider's staff handbook outlines the disciplinary process for the management of misconduct up to and including dismissal.
Service user feedback forms, which are in situ in the ambulance, provides opportunity for patients and carers to feedback on the service delivery.

5.4.4 During Practitioner Engagement and at the onsite visit it was evident that staff are aware of the chain of command for reporting incidents/near-misses/adverse events. The Provider's staff handbook cites the procedure for making protected disclosures/whistleblowing, and outlines the circumstances where this applies. The Assessment Team observed the completion of open disclosure training in a random sample of employee personnel files.

5.4.5 Due to the size of the organisation, direct contact with the Director/Operations Manager is regular and access to management is daily, which lends itself to open communication. However, the mechanism to offer feedback from Practitioner to senior management could be formalised via structured staff meetings.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

5.4.5 There is a culture of open communication and disclosure within the Provider's organisation.

Areas for Improvement

5.4.1 The Provider should review the CISM policy and identify the main contact person for CISM. The Provider should establish a formal service level agreement with a CISM facilitator.

5.4.3 The Provider should engage in a structured appraisal/performance review process for staff members.

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 a document titled 'Clinical Record Information and Management', which defines clinical record types and outlines the retention periods for patient care reports (PCR) and how clinical records will be stored. The document states that 'senior management' are responsible for maintaining the confidentiality of clinical records, however, it does not identify by name the person responsible for data protection and information governance.

The Assessment Team observed the management of PCR and established that all PCR are placed in a locked compartment in the station post shift in keeping with data protection. The ambulance base is monitored by CCTV. PCR are transferred from the base once a week to the administrative office. The Assessment Team observed PCR stored in a locked cabinet within this administration office. The PCR are filed by year in an ordered fashion. The observed PCR were complete and legible. The Assessment Team established that the Provider is exploring alternative means to store clinical records.

6.1.2 The Provider reviews patient care documentation completed by Practitioners and the Assessment Team observed ongoing reviews of the performance of Practitioners completing PCR. The Assessment Team established that Practitioners are aware that the quality of PCR is monitored by the Provider.

General data management comment:
The Provider submitted PPG that had inconsistencies in standard document formatting i.e., identifiable publication date, review date, version number, document reference number, and document title.

During the engagement the Assessment Team were informed that the Provider is considering enhanced record management and retention systems to include scanning, encryption, microchipping and shredding in line with data protection and record retention legislation.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

6.1.2 The Provider reviews the performance of Practitioners completing patient care records.

Areas for Improvement

6.1.1 The Provider should update the Clinical Record Information and Management policy to include requirements for data protection, information governance and data retention.

The Provider should identify in its policies, the person responsible for data protection and information governance in their organisation.

6.1.2 The Provider should review all PPG and improve document management and document control.

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 Cara Ambulance Service Ltd are as follows:

Judgement Framework Level	External Assessment Assigned Level	Percentage
Not Applicable	0	0%
Not Met	0	0%
Minimally Met	3	7%
Moderately Met	7	16%
Substantively Met	18	42%
Fully Met	15	35%

GVF Site Assessment Summary - Cara Ambulance Service Ltd

	PHECC Requirement	Compliance level
Theme 1: Person-Centred Care and Support	**Standard 1.1 Patients have equitable access to healthcare services based on their assessed needs.**	
	1.1.1 The Licensed CPG Provider has systems, processes and procedures for the timely and clinically appropriate response to provide safe care and treatment to patient population they serve.	**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.	**Fully Met**
	Standard 1.3 Patients' dignity, privacy and autonomy are respected and promoted.	
	1.3.1 The Licensed CPG Provider has arrangements in place to promote patients' privacy, dignity and autonomy.	**Fully Met**
	1.3.2 The Licensed CPG Provider demonstrates a commitment to develop a culture where volunteers, contractors and/or employees involve and treat people with compassion, kindness, dignity and respect.	**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.	**Substantive**
	Standard 1.5 Patients' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	
	1.5.1 Patients' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	**Fully Met**
	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.	**Moderate**
	Standard 2.2 Patients receive integrated care, which is coordinated effectively within and between services.	
	2.2.1 The Licensed CPG Provider has a standardised handover process in place to ensure the safe, timely, and structured exchange of information during handover of patients.	**Moderate**
	Standard 2.3 Healthcare is provided in a physical environment, which supports the delivery of high-quality, safe, reliable care and protects the health and welfare of patients.	
	2.3.1 The Licensed CPG Provider has process, systems and procedures in place to ensure the road-worthiness of their patient transport vehicles in line with legislation.	**Fully Met**
	Standard 2.4 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	
	2.4.1 The Licensed CPG Provider submits an Annual Medical Director Report annually,* which informs the PHECC of clinical activities in the organisation and includes a CPG report (*Calendar year).	**Moderate**
	2.4.2 The Licensed CPG Provider has a systematic programme of clinical audit in line with the PHECC standards (STN019), which is used to monitor quality and outcomes and promote learning.	**Moderate**

Theme 3: Safe Care and Support	**Standard 3.1 Licensed CPG Providers protect patients from the risk of harm associated with the design and delivery of healthcare services.**	
	3.1.1 The Licensed CPG Provider has a reliable system in place to prevent and protect patients and staff from healthcare associated infections.	**Minimal**
	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.	**Moderate**
	3.2.2 The Licensed CPG Provider has a process for the sharing of lessons learned from patient safety incidents (including adverse events, near misses and no-harm events) and complaints, which have occurred locally, nationally or internationally with employees, contractors and/or volunteers.	**Substantive**
	Standard 3.3 Licensed CPG Providers ensure all reasonable measures are taken to protect patients from abuse.	
	3.3.1 The Licensed CPG Provider has policies/procedures in place to prevent harm or abuse occurring and take action where concerns arise.	**Substantive**
Theme 4: Leadership, Governance and Management	**Standard 4.1 Licensed CPG Providers have clear accountability arrangements to achieve the delivery of high-quality, safe and reliable healthcare.**	
	4.1.1 The Licensed CPG Provider has an established reporting and accountability structure for clinical governance.	**Moderate**
	4.1.2 The Licensed CPG Provider has an identified Medical Director who is registered with the Medical Council and who is based in this jurisdiction and who oversees the service.	**Minimal**
	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.	**Substantive**
	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**

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

Report Status

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

Council Rules for pre-hospital emergency care service Providers who apply for recognition to implement Clinical Practice Guidelines (POL003 V7) outlines that, where appropriate, full recognition to implement CPGs will be awarded for a three (3) year period. This approval will apply from the last approval date.

Quality Improvement Plan

Cara Ambulance Service Ltd is required to adjust and re-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 Cara Ambulance Service Ltd in the upcoming licensing period.

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