COMMUNITY PARAMEDICINE IN IRELAND

Pre-Hospital Emergency Care Council

A Framework for the Specialist Paramedic - Community Care

MISSION STATEMENT

'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.'

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Published by:
Pre-Hospital Emergency Care Council
June 2022

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VERSION HISTORY

(Please visit the PHECC website to confirm current version.)

STN036 Specialist Paramedic - Community Care Framework		
Version	Date	Details
1	July 2022	Approved by Council

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1 INTRODUCTION

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1 INTRODUCTION

'Community Paramedicine provides community-centred healthcare services that bridge primary and emergency care and includes expanded roles such as health promotion and disease/injury prevention, as well as acute assessment and treatment of chronic illness exacerbation and minor illness/injury.'1

The creation of a new clinical practitioner, the Specialist Paramedic – Community Care, is approved by the Pre-Hospital Emergency Care Council (PHECC). This practitioner grade will form the foundation for the development and expansion of Community Paramedicine in Ireland. This framework document describes the scope and nature of the new Specialist Paramedic – Community Care role, which will align to the Sláintecare principles of delivering the right care, in the right place, at the right time.2

A new practitioner registration grade 'Specialist Paramedic – Community Care' is approved by PHECC Council and is necessary to facilitate the formal introduction of Specialist Paramedics in Community Care to the Irish Health Care System. New primary legislation underpinning PHECC's functions will be required to define this specialist grade.

This document sets out the additional core elements necessary to support the further development of Community Paramedicine delivered by Specialist Paramedics – Community Care in Ireland. It considers roles and professional responsibilities, scope of practice and educational foundations. It also considers essential system-level facilitators such as governance, clinical supervision and support, professional development, and the maintenance of competency, in addition to quality assurance, research, audit and service improvement.

A Specialist Paramedic – Community Care is a pre-hospital and community care expert who possesses a unique and complex body of knowledge and skill relating to the assessment and management of patient health issues in the community. A Specialist Paramedic – Community Care provides care for patients within their scope of practice and facilitates safe and appropriate care in the community. They adopt a flexible approach to care that is responsive to the needs of the community in which they practice. A Specialist Paramedic – Community Care achieves these aims by collaborating and integrating with existing and future health and social care services that operate in the community.

Community Paramedicine and the Specialist Paramedic – Community Care are evolving entities. This framework constitutes a living document that will be updated in tandem with this evolution. The sections that follow consider important, high-level constructs that will support healthcare services that aim to deliver Community Paramedicine via the Specialist Paramedic – Community Care role. The aim is not to be prescriptive but rather to offer a framework that will allow individual healthcare services and the Specialist Paramedics – Community Care they employ to provide safe, effective care. It is envisaged that healthcare services and Specialist Paramedics – Community Care will translate the principles considered herein to deliver effective models that are appropriate to local context.

THE VISION:

'To provide a responsive, high-quality, world-class framework for community paramedicine that empowers our practitioners to work both autonomously and collaboratively for the benefit of the patient.'

2 FRAMEWORK DEVELOPMENT METHODOLOGY

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2 FRAMEWORK DEVELOPMENT METHODOLOGY

The initial groundwork for the development of this Community Paramedicine Framework commenced in 2018 with the establishment of a PHECC Medical Advisory Committee (MAC) working group chaired by Mr Hillary Collins and supported by Dr Brian Power, PHECC Clinical Programme Manager. This group considered the experiences of the Co-operation and Working Together (CAWT) Community Paramedicine pilot project and subsequent National Ambulance Service (NAS) Specialist Paramedic – Community Care pilot, along with reviews of the international literature on Community Paramedicine. This led to the production of the report 'The Introduction of Community Paramedicine into Ireland', which was endorsed by the PHECC Council in August 2020. This detailed report outlined the following 13 key recommendations to support the introduction of Community Paramedicine into Ireland.

These recommendations laid the foundation for a subsequent MAC sub-committee to plan a roadmap for this framework's development and related to several domains, such as:

- Title of specialist practitioner
- The role of community paramedicine in the shift of care from acute services to the community and relationship within the wider Sláintecare model
- Setting of competencies and scope of practice for specialist paramedics – community care
- Wide stakeholder engagement to facilitate development of a community paramedicine model
- Setting of standards
- Setting of educational outcomes and standards
- Guidance on robust governance structures
- The need for legislative change to enable community paramedicine models

A complete list of the thirteen recommendations is included in appendix 1.

Following the approval of 'The introduction of Community Paramedicine into Ireland' report by the PHECC Council, an expert group of Community Paramedicine stakeholders and experienced practitioners was assembled as the Community Paramedicine MAC sub-committee in September 2021. The aim of this sub-committee is to develop a framework for the introduction of Community Paramedicine on behalf of PHECC. This framework is developed via a national and international consultative and collaborative process facilitated by the PHECC Medical Advisory Committee (MAC) sub-committee on Community Paramedicine. Figure 1 summarises the key steps in this process.

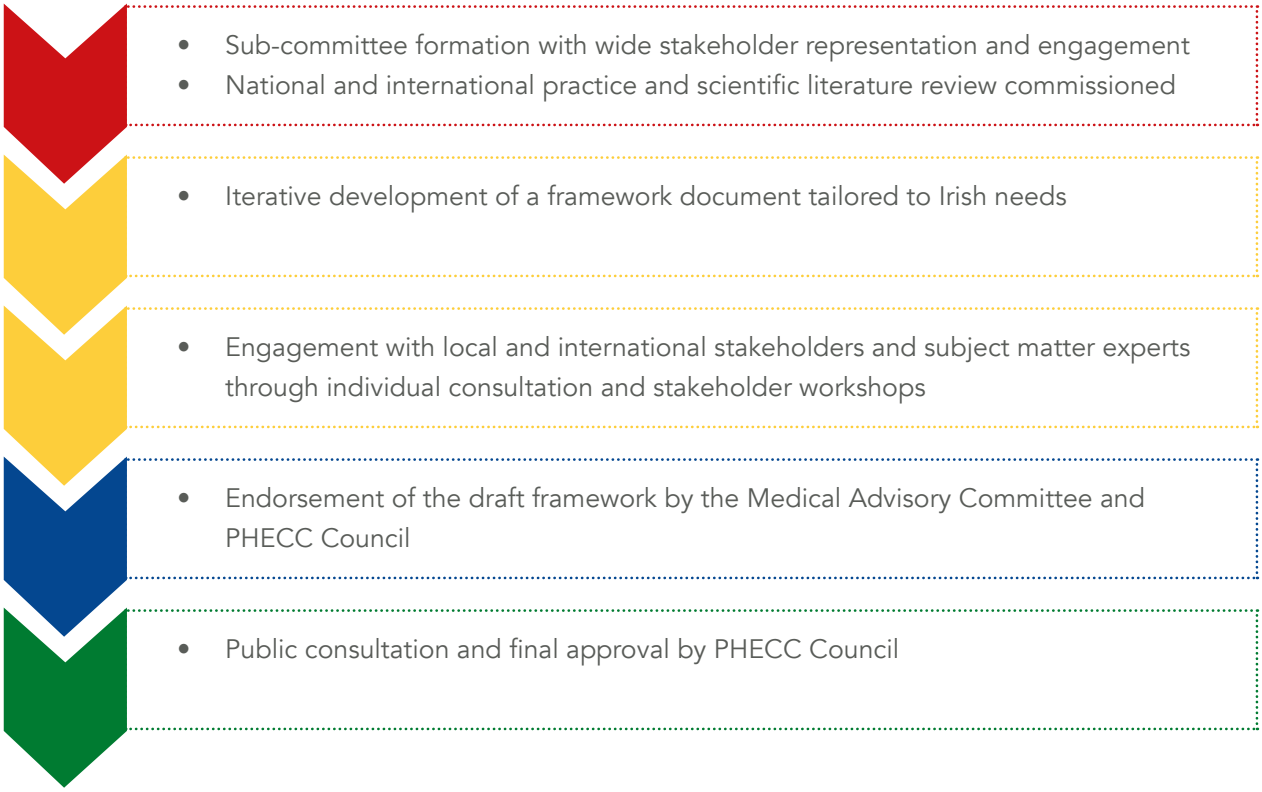


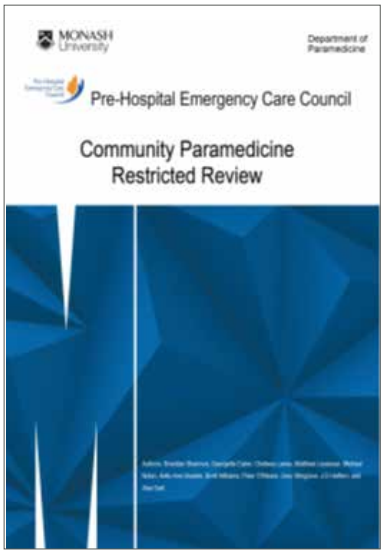
Figure 1: Framework Development

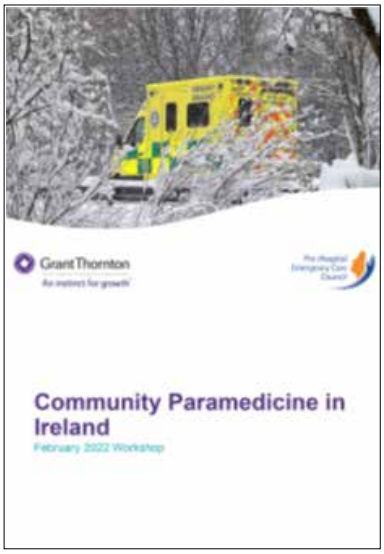
MEMBERSHIP OF THE MAC COMMUNITY PARAMEDICINE SUB-COMMITTEE

The sub-committee is chaired by Assoc. Prof. Tomás Barry, Academic GP, and Vice-Chair of the PHECC Medical Advisory Committee. Membership (Table 1) includes a wide range of stakeholders representative of the sector. Members include patient representatives, academic partners, service providers and PHECC practitioners. Following two successful Community Paramedicine pilot programmes, experienced practitioners who participated in these pilots are represented on the sub-committee. The sub-committee is supported and advised by Mr Ray Carney, PHECC Programme Manager and Advanced Paramedic.

Name	Affiliation
Assoc. Prof. Tomás Barry	Chair of sub-committee Academic GP Vice-Chair of PHECC Medical Advisory Committee
Ms Bridget Clarke	Vice-Chair of sub-committee NAS Lead, Out of Hospital Cardiac Arrest Strategy and Associated Specialist Programmes
Prof. Cathal O'Donnell	Clinical Director, National Ambulance Service
D/O Martin O'Reilly	EMS Support Officer, Dublin Fire Brigade
Ms Ann Mc Dermott	NAS Specialist Paramedic – Community Care, CAWT programme
Mr Declan Smith	NAS Specialist Paramedic – Community Care, CAWT programme
Mr Brendan Finan	NAS Specialist Paramedic – Community Care, CAWT programme
Mr Padraig Glynn	NAS Specialist Paramedic – Community Care, NAS Pilot Programme
Ms Fiona Bardon	Patient Representative, nominated by the Irish Heart Foundation
Ms Ann McCabe Kelly	Patient Representative, nominated by Patient Safety Ireland
Dr Rosa McNamara	Consultant in Emergency Medicine EDITH Programme, St Vincent's University Hospital
Ms Virginia Pye	National Lead for PHN Services, Health Service Executive
Dr Seamus Clarke	General Practitioner, CAWT Project
Ms Georgina Passmore	Clinical Paramedic Tutor, University of Limerick (UL) Advanced Practitioner, Wales Ambulance Service
Mr Kieran Henry	Senior Lecturer in Paramedicine, University College Cork (UCC) Advanced Paramedic
Ms Pauline Ackermann	Head of Clinical Services, Beaumont Hospital Pathfinder Project
Ms Rita McDonald	Nursing Practice Development Co-ordinator, Public Health Nursing, HSE

Table 1: PHECC MAC Community Paramedicine sub-committee membership





Community Paramedicine programmes have been implemented across a wide range of both rural and urban settings in many countries and have utilised various models of care. To inform framework development, Monash University was commissioned to conduct a practice scoping exercise that considered over 30 models in jurisdictions including Australia, Canada, Finland, the United States of America and the United Kingdom. This was delivered in January 2022, https://www.phecit.ie/CP Scoping Exercise.[3]

Monash University was also commissioned to conduct a rapid systematic review of scientific literature. This review considered published research on a range of areas such as education, models of delivery, scope of practice and outcomes. This was delivered in February 2022, https://www.phecit.ie/CP Literature Review [4]

Informed by the initial Monash University exercises, the Framework was developed through an iterative process during which the sub-committee consulted with a wide variety of local and international stakeholders. A formal, collaborative workshop was held in February 2022. It involved over 45 stakeholders and was facilitated by Grant Thornton. A wide range of topics related to Community Paramedicine was discussed during the workshop, including the competency framework, scope of practice, education standards, governance, and clinical support/supervision. Following the workshop an internal feedback report was produced that in turn was used to further support framework development.

The MAC Community Paramedicine sub-committee conducted two internal workshops in April and May 2022 during which the sub-committee further developed each section of the draft framework. A specific sub-group was also formed to begin reviewing educational domains and competencies, with further development planned via a parallel PHECC competency framework and education standards review of all clinical practitioner levels.

The final phase of framework development involved approval of the draft framework by the PHECC Medical Advisory Committee and Council. This was followed by a period of public consultation and final PHECC Council approval taking account of feedback received.

3 ROLE AND PROFESSIONAL RESPONSIBILITIES

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3 ROLE AND PROFESSIONAL RESPONSIBILITIES

3.1 Definition of Paramedicine

Definition of Paramedicine

Paramedicine is a domain of practice and health profession that specialises across a range of settings including, but not limited to, emergency and primary care. Paramedics work in a variety of clinical settings such as emergency medical services, ambulance services, hospitals and clinics as well as non-clinical roles, such as education, leadership, public health and research. Paramedics possess complex knowledge and skills, a broad scope of practice and are an essential part of the healthcare system 5.

The term "Community Paramedicine" is not consistently defined. However, the scope and role sit within the definition above.

3.2 The PHECC Model of Community Paramedicine

Community Paramedicine in Ireland exists at the interface of community healthcare need, Specialist Paramedic – Community Care and healthcare services that employ these specialists.

Figure 2: Community Paramedicine

- Health services develop Specialist Paramedic – Community Care services in collaboration with specialist paramedics based on community needs assessment.
- The 'health service' concept represents Licensed CPG Service Providers (at specialist paramedic level) working in integrated partnership with other interdisciplinary services.
- The Licensed CPG Service Provider (at specialist paramedic level) will act as a fulcrum for Specialist Paramedic – Community Care services, with central but not sole responsibility for health system facilitators. Integrated partnerships with other health services will be required to fulfil Specialist Paramedic – Community Care services. For instance, ongoing partnerships with primary care services will be required to facilitate training, mentorship, supervision, and ongoing professional development in this non-traditional role. In some circumstances, defined additional partnerships may be required to fulfil specific training needs and maintain competency in specific areas of practice, for example, palliative care.

3.3 Alignment with Advanced Clinical Practice

As in other jurisdictions, specialist paramedic – community care will represent 'advanced clinical practitioners' and, as such, their scope will routinely incorporate the four pillars of advanced practice, namely clinical practice, leadership and management, education, and research, audit and quality improvement.[6]

3.3.1 Clinical Practice

- A Specialist Paramedic - Community Care is a skilled and experienced emergency and community care practitioner who is trained to and maintains a high standard of clinical competence.
- A Specialist Paramedic - Community Care is competent in providing care to patients in a home or close-to-home setting, to include referral to appropriate support services.
- A Specialist Paramedic - Community Care undertakes comprehensive assessment and management of defined patient presentations, either autonomously or as part of a primary care team, according to illness severity and clinical need.
- A Specialist Paramedic - Community Care possesses an enhanced skill set in patient assessment, management, and encompasses autonomous and complex decision-making.

3.3.2 Leadership and Management

- The role of the Specialist Paramedic – Community Care includes service development and leadership
- The role of the Specialist Paramedic – Community Care includes providing expert clinical and decision-making support to other PHECC-registered practitioners and other clinicians managing patients as part of a multi-disciplinary primary care team.
- Whilst the treatment and in some instances referral of patients with certain conditions who access the health service through the 999/112 system will form a substantial component of the work of a Specialist Paramedic – Community Care, the ability to seamlessly integrate with other elements of the healthcare system involved in the care of patients is a key component of this grade.

3.3.3 Education

- The role of the Specialist Paramedic – Community Care includes the provision of clinical education, supervision, and mentorship to colleagues.

3.3.4 Research, Audit and Quality Improvement

- Community Paramedicine is a novel and evolving field of practice. Research, audit and quality improvement represent important facilitators of the development of the role of the Specialist Paramedic – Community Care in Ireland. Specialist Paramedics in Community Care are competent in research/audit/quality improvement, and job plans will routinely incorporate dedicated time for these activities.

3.4 Potential Settings where Specialist Paramedic – Community Care may work

The Specialist Paramedic – Community Care will have the potential to contribute positively to key healthcare areas and services including but not limited to:

- Ambulance Services
- Primary Care
- Urgent Care Centres
- GP Out-of-Hours Services
- Telephone Triage Systems (Hear and Treat)
- Mental Health Services
- Addiction Support Services
- Local Injury Units
- Admission avoidance initiatives
- Community Health Organisations
- Bespoke support roles based on local requirements
- Proactive preventative care (particularly in relation to chronic disease management)
- Older person and frailty initiatives
- Alternative Care Models such as current Pathfinder/EDITH/Alternative Pre-hospital Pathway (APP) Team initiatives
- Community Clinics
- Remote Patient Monitoring
- Palliative Care
- Influenza and COVID-19 surge initiatives

3.5 Professional Responsibility of the Specialist Paramedic – Community Care

- A Specialist Paramedic – Community Care is required to comply with all PHECC POL005 Code of Professional Conduct and Ethics requirements and maintain their name on the PHECC Register. A Specialist Paramedic – Community Care is also required to maintain a high standard of continuing professional competence (CPC). Pending the development of a formal PHECC CPC system, Specialist Paramedics – Community Care should maintain a personal portfolio of CPC activities based on their own developmental needs. The pillars of advanced practice should be represented across this portfolio. Specialist Paramedics – Community Care can be guided by an approach analogous to schemes operated by other health profession regulators in Ireland by including a minimum of 50 credits (hours) of CPC each year incorporating external, internal and audit/quality improvement activities.

- During Specialist Paramedic – Community Care training, they will have extensive exposure to primary care settings including General Practice. Beyond this initial training, ongoing rotational experience in primary care is viewed as an essential facilitator of specialist Community Paramedicine both in terms of further development and in maintenance of competency in clinical practice in primary care. PHECC recommends that, in general, Specialist Paramedics – Community Care spend a minimum of 0.2 FTE contributing to care in a direct primary care setting.

4 SCOPE OF PRACTICE

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4 SCOPE OF PRACTICE

Community Paramedicine is an evolving field of practice. The Specialist Paramedic – Community Care scope of practice taxonomy outlined below should be regularly reviewed and updated periodically. Health services that employ Specialist Paramedics – Community Care should agree and clearly document scope of practice at individual practitioner level.

A Specialist Paramedic – Community Care will bring high-level decision-making to patient care. Skills and competencies are grounded in a thorough understanding of the pathophysiology of and therapeutic approaches to common illness and injury, in addition to models of primary, acute and integrated care across the entirety of the healthcare system. Non-technical skills, complex reasoning, relationship building, communication and flexibility will be of critical importance.

Where appropriate, the Specialist Paramedic – Community Care can facilitate definitive treatment and appropriate patient disposition, including referral to other care settings or discharge in the community. The specialist Paramedic – Community Care will also work with existing multi-disciplinary teams to coordinate the management of chronic illness and complex healthcare presentations over time. The scope of practice of the Specialist Paramedic – Community Care retains the flexibility to allow responsiveness to local community needs. Individual Specialist Paramedics – Community Care may in future take on further specialised roles (e.g., in palliative care/community mental health), supported by their health service provider (Licensed CPG Service Provider) with appropriately enhanced, bespoke training and governance structures. The scope of practice of an individual Specialist Paramedic – Community Care is developed in collaboration with local healthcare services and facilitated via the Licensed CPG Service Provider that privileges an individual Specialist Paramedic – Community Care. The Specialist Paramedic – Community Care will ultimately be responsible for operating within their individual scope of practice and competency.

4.1 Specialist Paramedic – Community Care: Taxonomy of Scope of Practice

The following taxonomy considers Specialist Paramedic – Community Care scope of practice at three levels. The first level represents those **clinical presentations** that a Specialist Paramedic – Community Care is expected to be familiar with and manage, either independently or with the support of medical on-line or other community support resources. The second level considers the **key clinical practice elements** that fall within Specialist Paramedic – Community Care scope. The final level considers **component technical skills** that a Specialist Paramedic – Community Care may employ.

Each element is coded as green, yellow, red, or grey. A **green** element is a core scope of practice element. A Specialist Paramedic – Community Care is expected to be competent in this element at the endpoint of their formal, specialist training with system level support. A **yellow** element is one that some Specialist Paramedics – Community Care may go on to achieve full competency in, beyond their formal Specialist Paramedic –Community Care training. A Specialist Paramedic – Community Care will have had a significant educational grounding in and clinical exposure to a yellow element during their formal training and can become fully competent with some additional training, and system level support including clinical sign-off. A **red** element is one that a Specialist Paramedic – Community Care will have had some educational grounding in and clinical exposure to at the endpoint of their formal training. Selected individuals who are provided with significant post-qualification training may become competent in a red element, depending on individual community need and high-level system supports, including clinical sign-off and ongoing quality assurance. A grey element represents a potential core skill for some/all Specialist Paramedics – Community Care in the future; however, such an element will require substantial system level developments and further training to facilitate.

Code	CLINICAL PRESENTATIONS *(Common and important illnesses across all age groups that are amenable to community management)*
	Acute psycho-social distress without red flag features
	Acute headache without red flag features
	Mild epistaxis
	Excess ear wax
	Acute toothache
	Acute exacerbation of mild to moderate asthma
	Acute non-infective exacerbation of mild to moderate COPD
	Exacerbation of known eczema/psoriasis
	Minor burns and scalds
	Soft tissue sprain injuries, including acute mild to moderate neck and back pain without red flag features
	Minor skin wounds, abrasions and lacerations
	Mechanical falls without significant injury sustained
	Seizure in known epileptic without red flag feature
	Hypoglycaemia in known diabetic without red flag feature
	Uncomplicated syncope
	Undifferentiated abdominal pain/discomfort without red flag features
	Upper and lower respiratory tract infections: • Acute sinusitis • Pharyngitis/tonsillitis • Otitis externa • Otitis media • Acute bronchitis • Infective exacerbation of COPD • Community acquired pneumonia • Pneumonia and aspiration pneumonia in residential care facilities • Acute Covid-19
	Influenza
	Urinary tract infections: • Uncomplicated lower UTI • Acute pyelonephritis
	Gastro-intestinal infections: • Acute gastroenteritis • Threadworms

	Skin/soft tissue infections • Animal/human bite • Cellulitis • Candida • Conjunctivitis • Dermatophyte infection • Folliculitis • Head lice • Minor abscess • Scabies • Impetigo • Paronychia • Chickenpox/shingles
	Oral/dental infections • Dental abscess • Candida
	Sexually transmitted infections
	Heath promotion and pro-active care
	Chronic disease management as it pertains to prevalent community conditions: • Asthma • COPD • Type 2 diabetes • Mental health • Cardiovascular disease including hypertension, dyslipidaemia, ischemic heart disease, atrial fibrillation, heart failure and stroke
	Frailty
	Substance misuse and addiction
	Homelessness
	Chronic severe mental illness
	Specialist palliative care
KEY CLINICAL PRACTICE ELEMENTS	
	Proficient communication with patients, families, other healthcare staff
	Tailoring care to individual patient need
	Relationship building with patients, families, other healthcare staff and agencies over time
	Direct referral to other health and social care services
	Handover of care to other health and social care services
	Clinical history taking (at the level of a competent medical generalist) as pertinent to all medical systems
	Clinical examination of all medical systems (at the level of a competent medical generalist)
	Psychiatric history taking and mental state examination (at the level of a competent medical generalist)

	Clinical data interpretation
	Interpretation of common primary care blood tests
	Interpretation of urinalysis
	Therapeutics pertinent to clinical presentations that fall within scope of practice
	Medication administration pertinent to clinical presentations that fall within scope of practice
	Prescribing and de-prescribing pertinent to clinical presentations that fall within scope of practice
	Risk assessment
	Safety netting
	Acting as a Physician Extender
	Boundary setting (limitation awareness)
	Patient advocacy
	Provision of clinical supervision and education
	Personal and professional development
	Maintaining professional competency
	Research
	Audit
	Quality improvement
	Management
	Remote telemedicine support
	Resource dispatch
COMPONENT TECHNICAL SKILLS	
	Wound care
	Suturing of simple skin lacerations
	Phlebotomy
	Ear lavage
	Wound closure with adhesive glue
	Otoscopy
	Ophthalmoscopy
	Urinary catheterisation
	Dipstick urinalysis
	Swab taking
	Insertion of sub-cutaneous catheter for hydration or for the administration of palliative care medications
	Vaccination
	Intravenous access
	Use of point-of-care ultrasound
	Use of point-of-care blood testing

5 EDUCATIONAL DOMAINS AND COMPETENCIES

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5 EDUCATIONAL DOMAINS AND COMPETENCIES

An ongoing PHECC project is updating the suite of competency frameworks and education standards for Paramedic and Advanced Paramedic grade practice. Specialist Paramedics – Community Care will have progressed through these grades at earlier points in their careers, and at each grade practitioners will achieve foundation competencies for the next grade.

It is essential that a specific and detailed competency framework be developed for the Specialist Paramedic – Community Care. This will serve as the foundation for education and training. Furthermore, it is also essential that this framework aligns with competency frameworks at Paramedic and Advanced Paramedic grades to allow for coherent educational design and career progression. The wider PHECC competency framework project will incorporate the Specialist Paramedic – Community Care role. The competency framework for the Specialist Paramedic – Community Care will be informed by the content of this document and will be finalised by quarter three of 2022. Once finalised, the competency framework for the Specialist Paramedic – Community Care will be added here.

For illustrative purposes, Figure 3 details draft core domains that may be utilised for the Specialist Paramedic – Community Care. These domains are coherent with current draft domains at Paramedic and Advanced Paramedic grades.

Figure 3 illustrates the core domains (inner wheel) for PHECC practitioners at EMT, Paramedic and Advanced Paramedic levels.* The outer wheel illustrates proposed domains for Specialist Paramedic – Community Care.

***Subject to change in line with final PHECC Practitioner Education Competency Framework**

6 EDUCATION AND TRAINING

Pre-Hospital Emergency Care Council

6 EDUCATION AND TRAINING

6.1 Legal and Regulatory Context

Pursuant to SI No 109 of 2000 as amended by SI No 575 of 2004, the functions of the Pre-Hospital Emergency Care Council (the 'Council') are:[7]

(f) advise the Minister, recognised institutions and such other persons as it may consider appropriate of the standards which should inform education and training in relation to pre-hospital emergency care. (S.I. No. 575 of 2004)

(g) advise the Minister of the specific content of recognised courses; (S.I. No. 109 of 2000)

(i) assess from time to time, as occasion may require, but in any event no less that once in every three years -

  (i) the suitability of the education and training in pre-hospital emergency care provided by an institution recognised by the Council for such purpose,

  (ii) the standards of theoretical and practical knowledge required for qualifications in pre-hospital emergency care, (S.I. No. 109 of 2000)

This document supersedes previous Council Education and Training Standards and is part of the suite of publications explicitly linked to and informing education and training in paramedicine.

A comprehensive competency framework and education standard for Community Paramedicine delivered by the Specialist Paramedic – Community Care is currently in development. In advance, this document makes a series of high-level general recommendations that can inform the definitive competency framework and education standard.

6.2 Training for the Role of Specialist Paramedic – Community Care

Training for the role of Specialist Paramedic – Community Care is delivered by a recognised higher education institution(s) and constitutes an Irish National Framework of Qualifications (NFQ), Level 9 Masters award.

- Higher education institution(s) delivering such programme(s) are required to develop partnership arrangements with clinical services that facilitate the supervised clinical practice component of the qualification. Supervised clinical practice and other academic components of a given training programme should be fully integrated across the programme.
- Each individual training programme should be informed by and address the entirety of the PHECC competency framework and education standard for the Specialist Paramedic – Community Care role (currently in development).
- Each training programme must address each of the pillars of advanced practice as they pertain to the Specialist Paramedic – Community Care role, namely clinical practice, leadership and management, education, and research.
- Each individual training programme must be delivered by a faculty with an appropriate mixture of skill and experience. A critical mass should be qualified/practising as a Specialist Paramedic – Community Care or have a scope of academic activity and clinical practice that firmly aligns to that of the Specialist Paramedic – Community Care.
- An individual training programme must incorporate extensive supervised clinical practice placements to include primary care, acute care, and ambulance service settings. Clinical placements should vary and should include the spectrum of community care services relevant to the role.

Clinical placements must include a minimum of 500 hours spent in general practice or other relevant primary care setting. An additional minimum of 120 hours should be spent in relevant acute care, unscheduled care, and specialist care settings where experience can be gained that is relevant to the scope of the role. Time spent in delivering Community Paramedicine services within core ambulance services during training is not included in these recommended minimum placement periods.

- Sufficient time is needed to allow trainees to assimilate the knowledge, skills and attitudes required of the Specialist Paramedic – Community Care and to develop the suite of competencies expected of this Specialist Paramedic – Community Care grade. A programme of minimum duration of two years is recommended.
- It is expected that trainees will provide Community Paramedicine services during their training and that appropriate supervision and clinical governance arrangements will facilitate a transition toward increasing autonomy over the course of a given training programme.
- Candidates who complete and fulfil all of the requirements of a PHECC-recognised Level 9 Masters training programme in specialist Community Paramedicine will be eligible for registration at Specialist Paramedic – Community Care grade.

6.3 Entry to Training

Candidates admitted to training for the role of Specialist Paramedic - Community Care should hold a NFQ Level 8 Honours Bachelor's Degree award or equivalent. Holders of the Graduate Diploma in Emergency Medical Science (Advanced Paramedic) are eligible for admission.

Consideration should be given by recognised higher education institution(s) to developing a Graduate Diploma bridging qualification that would allow paramedics who do not hold a NFQ Level 8 Honours Bachelor's Degree award (or equivalent) but have substantial practical experience in paramedicine and proven aptitude for the Community Paramedicine role to access a Level 9 training programme in Specialist Paramedicine.

In addition, candidates admitted to training must possess at least three years' experience with full registration as an Advanced Paramedic or five years' experience with full registration as a Paramedic.

6.4 Alternative Pathways to Registration

Paramedics and Advanced Paramedics who can demonstrate that they have attained the PHECC competencies and capabilities of a Specialist Paramedic – Community Care via an alternative developmental pathway such as that associated with the CAWT or NAS Community Paramedicine pilots, and who hold a Master's degree (or higher) which is relevant to the field of advanced practice can apply for registration as a Specialist Paramedic – Community Care. Applications will be reviewed using the PHECC Competency Framework pertaining to a Specialist Paramedic – Community Care (in development) and decisions made on a case-by-case basis. Applicants must meet PHECC standards for registration to have their name placed on the Specialist Paramedic – Community Care division of the register.

6.5 Ongoing Training

The flexible nature of the Specialist Paramedic – Community Care role and the requirement that the role be responsive to community healthcare needs requires that from time to time additional elements are added to a given Specialist Paramedic – Community Care scope of practice. Such additional elements must be evidenced-based, safe, have a clear rationale for their introduction and be feasibly delivered by Specialist Paramedics – Community Care.

Any such additional scope will require additional training beyond a Specialist Paramedic – Community Care's initial Level 9 training programme. In such circumstances, health services, Licenced CPG Service Providers and relevant Specialist Paramedics – Community Care will collaborate to develop appropriate training delivered by clinical experts who already employ the relevant activity or skillset. The relevant training should be robust and transparent. Such training must include a process for clinical competency sign-off by a clinician who is already experienced and competent in the relevant additional clinical activity.

7 CLINICAL PRACTICE GUIDANCE

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7 CLINICAL PRACTICE GUIDANCE

Community Paramedicine delivered by Specialist Paramedics – Community Care is defined by complex decision making and clinical care. Heretofore, the Pre-Hospital Emergency Care Council have produced specific clinical practice guidelines for defined clinical emergency situations. These clinical practice guidelines have traditionally adopted an algorithmic approach and have had a narrow focus.

It is recognised that this type of guidance is not well suited to inform community paramedicine delivered by the Specialist Paramedic - Community Care. Nonetheless some guidance is necessary to inform practice in what is a novel and emerging area of healthcare.

To this end initial clinical practice guidance constituting an overarching model of practice for specialist community paramedicine has been developed as a central component of this framework. This initial model of practice is illustrated below.

This model of practice has been informed by the entirety of the framework development process including reviews of international evidence and best practice, local and international expert consultation and iterative development at the level of the sub-committee.

The PHECC model of practice for the Specialist Paramedic – Community Care considers the complexity of community paramedicine practice. It highlights necessary health system level facilitators along with Specialist Paramedic – Community Care attributes that underpin a care process that is driven by community healthcare needs.

The central care process at the heart of the model involves enhanced comprehensive assessment, holistic treatment plan formulation and appropriate follow up. Established concepts from general practice consultation models such as a broad bio-psycho-social focus, and the importance of communication, safety netting and continuity are incorporated within the model. Importantly, Specialist Paramedics – Community Care retain their ability to provide established emergency care approaches when necessary.

Importantly Specialist Paramedics – Community Care and health services have shared responsibility for and ownership of key facilitators. It is envisaged that health services working in conjunction with Specialist Paramedics – Community Care will proactively generate specific local level policies and guidance to support practice. This guidance will be tailored to the specific context in which a service is delivered. Flexibility and integration are important facilitators both on the part of individual Specialist Paramedics – Community Care and health services.

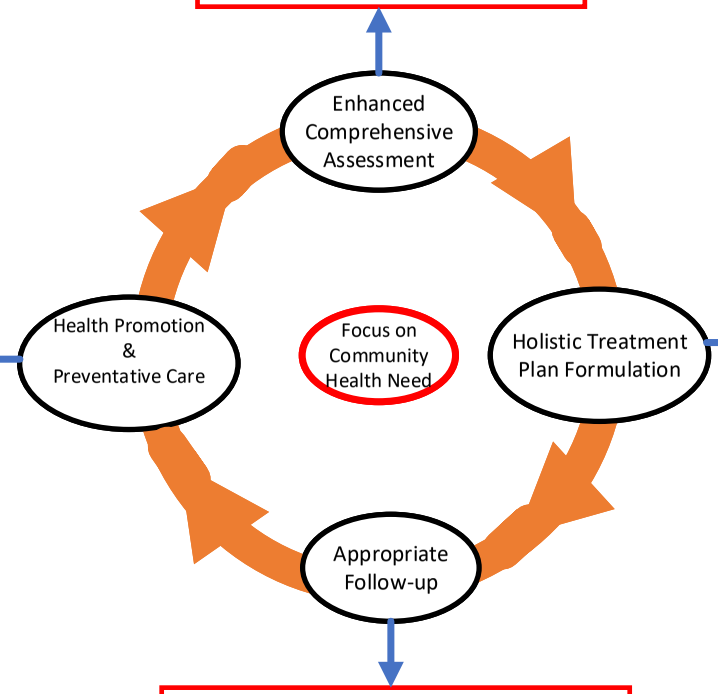
Specialist Paramedic – Community Care

CPG – Model of Practice

Community Care

Pre-Hospital Emergency Care Council

Bio-psycho-social framework
Consideration of patient & family ideas, concerns, expectations & priorities



- Risk-balanced and shared decision making
- Informed by awareness of, and support by, integration with health and social care services & supports
- Deployment of relevant technical/procedural skills and medication administration when appropriate
- Other Therapeutic Approaches
- Treatment in the most appropriate setting, including non-conveyance when appropriate
- Safety Netting

Proactive and preventative care where appropriate

Community Paramedic Attribute Facilitators

- Community focused
- Flexibility – service development guided by community needs assessment
- SHARED Ownership of service development, governance, CPC, supervision
- Relationship building with primary and secondary care, patients and families
- Adaptability to health service requirements over time

- Linkage with GP, Primary Care Team & other appropriate Health & Social Services

- Ongoing care/continuity where appropriate

Health System Facilitators

- Community focused
- Flexibility – service development guided by community needs assessment
- Clarity of scope at individual & service level
- Bespoke training to support scope as required
- Standard Operating Procedures to support scope as required
- Enhanced clinical governance
- Embedded Audit, Research and Service Development
- Clinical & Professional Supervision
- Supportive technology and data flow
- Adaptability to changing population health needs

Emergency Care using established paramedic model when required

Document Number: STN036 *Published: June 2022*
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8 MEDICATION TREATMENT

Pre-Hospital Emergency Care Council

8 MEDICATION TREATMENT

8.1 Introduction

Treatment with prescription medication can form part of a Specialist Paramedic – Community Care treatment plan. In many situations, medication treatment in this context is distinct from established PHECC emergency procedures where a defined list of medication must be carried and immediately available for administration under defined clinical practice guideline protocols. In many situations, a Specialist Paramedic – Community Care treatment plan will include a course of treatment over a number of days rather than a single dose of a given medication.

When a Specialist Paramedic – Community Care considers that a patient may benefit from a prescription medication s(he) can act as a physician extender and facilitate an online medical consultation, either with that patient's own general practitioner or a medical doctor who provides remote support via the Specialist Paramedic – Community Care privileging agency. This will result in an appropriate prescription that can be filled at a community pharmacy.

Beyond the above physician extender mechanism, it is recognised that there are advantages to the Specialist Paramedic – Community Care both carrying some relevant medication that would be available for immediate administration and, in future, also functioning as a non-medical prescriber. These elements of Community Paramedicine medication treatment require further development, including legislative change. Legal advice has been sought in terms of how best to progress these issues. In the interim, a Community Paramedicine medication master list has been compiled to highlight those medications considered to have most relevance to Specialist Paramedic – Community Care practice and to facilitate their addition to the schedule which forms the legal basis for existing medication administration by PHECC practitioners in Ireland.

8.2 Specialist Paramedic – Community Care: List of Key Relevant Medications

Note 1: Medications already approved for administration by Paramedics and Advanced Paramedics as well as medication considered relevant to the scope of practice of a Specialist Paramedic – Community Care are listed by condition below.

Note 2: Some medications are duplicated depending on indications.

Note 3: The medications list below includes medications that are considered most likely to be included in a Specialist Paramedic – Community Care's treatment plan. Safe use of these medications in an acute setting will require a significant knowledge of medications that patients take for chronic conditions.

Note 4: Medications not currently on the 7th Schedule are denoted by *. These medications are under the process of submission to the Department of Health and Children for addition to the 7th Schedule.

Note 5: Medication routes not currently on the 7th Schedule are denoted by **. These medications are under the process of submission to the Department of Health and Children for amendment on the 7th Schedule.

Note 6: Medication indications not currently on the 7th Schedule are denoted by ***. These medications are under the process of submission to the Department of Health and Children for amendment on the 7th Schedule.

Medications	Route (7th Schedule)	Conditions of administration (SI no 155 of 2020, 7th Schedule)
Cardiovascular		
Adenosine	IV	SVT
Amiodarone	IV	Cardiac Arrest/Tachyarrhythmia
Aspirin	PO	Acute Cardiac Syndrome
Atropine	IV	Cardiac Arrest/Bradycardia/Poisoning
Clopidogrel	PO	Acute Coronary Syndrome
GTN	SL	Cardiac chest pain/Congestive heart failure
Magnesium Sulphate	IV	Cardiac Arrest/Tachyarrhythmia
Sodium Bicarbonate Injection BP	IV	Cardiac Arrest
Ticagrelor	PO	Acute Coronary Syndrome
Diabetes		
Dextrose 5%	IV	Dilutant for medications
Dextrose 10%	IV	Hypoglycaemia
Glucagon	IM	Hypoglycaemia
Glucose gel	BUCCAL	Hypoglycaemia (not on schedule)
Allergies		
Adrenaline (1:1,000) auto injector	IM	Anaphylaxis
Adrenaline (1:1,000)	IM	Anaphylaxis
Cetirizine*	PO	Allergic reactions
Chlorphenamine	PO	Allergic reactions
Chlorphenamine	IM/IV	Anaphylaxis
Hydrocortisone	IM/IV	Bronchospasm/Anaphylaxis
Respiratory		
Adrenaline (1:1,000)	NEB	Croup
Dexamethasone	PO	Croup
Furosemide	PO**	Congestive heart failure
Furosemide	IM/IV	Pulmonary oedema
Hydrocortisone	IM/IV	Bronchospasm
Ipratropium Bromide	NEB	Bronchospasm
Magnesium Sulphate	IV	Bronchospasm
Prednisolone*	PO	Anti-inflammatory/Allergic conditions/ Acute asthma/COPD exacerbation management***
Salbutamol Aerosol	INH	Acute asthma/COPD exacerbation management
Salbutamol nebule	INH	Acute asthma/COPD exacerbation management

Analgesics		
Co-codamol*	PO	Pain
Ibuprofen	PO	Pain
Ibuprofen	PR	Pain
Instillagel*	Topical	
Hydromorphone hydrochloride	SC	Pain
Hydromorphone hydrochloride	PO	Pain
Ketamine	IM/IV	
LatGel*	Topical	
Methoxyflurane	INH	Pain
Morphine	PO	Pain
Morphine	IM/IV	Pain
Nitrous Oxide and Oxygen (Entonox®)	INH	Pain
Oxycodone	PO	Pain
Oxycodone	SC	Pain
Paracetamol	PO	Pain
Paracetamol	PR	Pain
Paracetamol	IV	Pain
Lidocaine Hydrochloride spray	Topical	Local anaesthetic
Lidocaine	IV/SC/Top	Local anaesthetic
Lidocaine Gel	Topical	Local anaesthetic
Tetracaine Gel 4%	Topical	Anaesthesia prior to IV
Pyrexia		
Paracetamol	PO	Pyrexia
Paracetamol	PR	Pyrexia
Paracetamol	IV	Pyrexia
Poisons		
Activated Charcoal	PO	Poisoning
Naloxone	IN	Respiratory depression secondary to known or suspected narcotic overdose
Naloxone	SC/IM/IV	Respiratory depression secondary to known or suspected narcotic overdose
Sodium Bicarbonate Injection BP	IV	Poisoning
Nausea/Vomiting/Diarrhoea/Constipation		
Cyclizine	PO**	To prevent or treat opiate induced nausea and vomiting, anti-emetic
Cyclizine	IM/IV	To prevent or treat opiate induced nausea and vomiting, anti-emetic

Haloperidol PO	PO	Nausea and vomiting
Lactulose	PO	Constipation
Loperamide*	PO	Diarrhoea
Metoclopramide Solution IM/IV	IM/IV	To prevent or treat opiate induced nausea and vomiting/anti-emetic
Sodium Citrate/Sodium Lauryl Sulphacetate*	PR	Constipation
Macrogol*	PO	Constipation
Ondansetron PO	PO	Nausea/Vomiting
Ondansetron IM/IV	IM/IV	To prevent or treat opiate induced nausea and vomiting/anti-emetic
Senna	PO	Constipation
Antibiotics		
Amoxicillin*	PO	Infection
Azithromycin*	PO	Infection
Benzlpenicillin	IM/IV	Infection
Cefalexin*	PO	Infection
Cefotaxime	IM/IV	Suspected or confirmed sepsis
Ceftriaxone	IM/IV	Suspected or confirmed sepsis Infection
Ciprofloxacin*	PO	Infection
Clarithromycin*	PO	Infection
Clindamycin Lotion*	Topical	Infection
Clotrimazole Cream*	Topical	Infection
Co-amoxiclav*	PO	Infection
Doxycycline*	PO	Infection
Famciclovir*	PO	Infection
Flucloxacillin*	PO	Infection
Fosfomycin*	PO	Infection
Fusidic Acid 1% drops*	Topical	Infection
Metronidazole*	PO	Infection
Nitrofurantoin*	PO	Infection
Phenoxymethylpenicillin*	PO	Infection
Sodium Fusidate Cream/ ointment*	Topical	Infection
Trimethoprim*	PO	Infection
Palliative Care		
Glycopyrronium Bromide	SC	Oropharyngeal secretions
Haloperidol	PO	Delirium/Agitation

Haloperidol	SC	Delirium/Agitation
Hyoscine Butylbromide	SC	Abdominal colic/Oropharyngeal secretions
Midazolam	BUCCAL	Sedation/Agitation***
Midazolam	SC	Seizures/Agitation
Adrenal Insufficiency		
Hydrocortisone	IM	Addison's disease
Hydrocortisone	IV	Addison's disease
Seizures		
Diazepam	PR	Seizures
Diazepam	IM/IV	Seizures
Magnesium Sulphate	IV	Pre-eclampsia
Midazolam	IN/IM	Seizures
Midazolam	BUCCAL	Seizures
Sedation		
Lorazepam	PO	Sedation
Midazolam	IN/IM/IV	Sedation
Fentanyl	IN/IV	Sedation
Ketamine	IM/IV	Sedation
Maternal Emergencies		
Oxytocin	IM	Post-partum haemorrhage
Trauma		
Tranexamic Acid	IV	Haemorrhagic shock
Mental Health		
Diazepam	PO**	Sedative
Vaccination		
Influenza vaccine	IM	Prophylaxis for Influenza Infection
Diphtheria Tetanus Pertussis Vaccine*	IM	Active/re-immunisation against tetanus and diphtheria
General		
Fluorescein*	Drops	Eye injuries
Oral rehydration salts*	PO	Dehydration
Oxygen	INH	Hypoxia
Sodium Chloride 0.9% IV	IV	Multiple Indications

8.3 Clinical Practice Guidance for Medication Administration

Heretofore, condition- and circumstance-specific clinical practice guideline algorithms have facilitated medication administration by Paramedics and Advanced Paramedics in emergency situations. The scope of practice of the Specialist Paramedic – Community Care is considerably broader that these other PHECC grades and at individual Specialist Paramedic – Community Care level will be determined by local context.

The future framework for direct medication administration by the Specialist Paramedic – Community Care beyond the existing arrangements for Paramedics and Advanced Paramedics remains to be developed and will be contingent on legal advice received. However, it is envisaged that the PHECC clinical practice guideline framework that facilitates medication administration by Specialist Paramedics – Community Care should be high-level and overarching rather than condition-specific.

It is also envisaged that this overarching guidance framework will articulate with more specific and detailed local level guidance that is generated by health services that provide Community Paramedicine services. This will require Specialist Paramedics – Community Care, Clinical/Medical Directors of Licensed CPG Service Providers, in collaboration with a registered pharmacist, to be actively involved in the generation of local level guidance for medication administration. An example of a possible PHECC overarching Specialist Paramedic – Community Care medication clinical practice guideline is shown below for illustrative purposes.

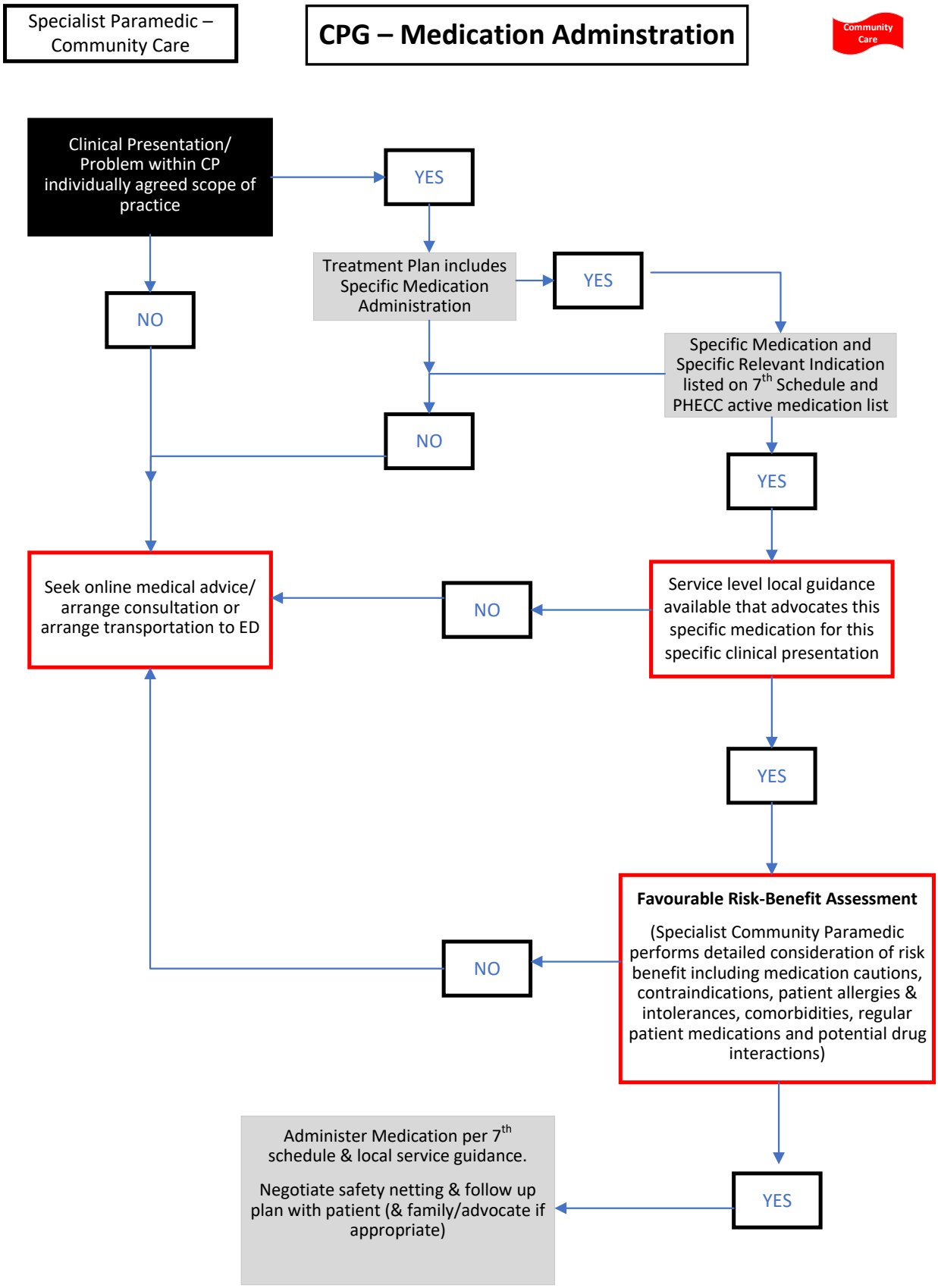

Figure 5: Illustrative Medication Administration Framework CPG

9 CLINICAL GOVERNANCE

Pre-Hospital Emergency Care Council

9 CLINICAL GOVERNANCE

9.1 Overview

Clinical governance is the system through which healthcare teams are accountable for the quality, safety and experience of patients in the care they have delivered (HSE Clinical Governance). Clinical governance is an essential facilitator of Community Paramedicine and is the shared responsibility of health services and the Specialist Paramedics – Community Care they employ. Clinical governance structures and arrangements ensure that all involved in delivery of care are aware of their personal responsibilities and accountability, with the core aim to improve patient outcomes. Clinical and corporate governance structures are interdependent across service provision and patient care. Governance structures are an essential component in the delivery of high-quality, safe, and reliable healthcare.[11, 12]

9.2 Clinical Governance Underpinning Requirements

The HSE Quality, Safety and Risk Framework identifies the essential underpinning requirements that must be in place to ensure safe and effective care. Licenced CPG Service Providers at the level of Specialist Paramedic – Community Care will have embedded these requirements:[14]

(a) Communication and consultation with key stakeholders

(b) Clear accountability arrangements

(c) Adequate capacity and capability

(d) Standardised policies, procedures, protocols, and guidelines (PPPG)

(e) Robust monitoring, reporting and review arrangements

(f) Assurance arrangements

9.3 Organisational Structures

Along with leadership and accountability, clinical governance requires that the right structures are in place to achieve the quality and safety of services.12

Clinical governance structures provide a framework through which care provision teams are accountable for the quality, safety and satisfaction of patients being cared for. Health services that provide Community Paramedicine services should devise a clinical governance model that demonstrates partnership between corporate management and a Clinical Directorate (Clinical or Medical Director and profession leads as appropriate). This model must enable a culture and commitment to deliver agreed service levels and quality of care.

A clinical governance model should clearly outline lines of accountability at individual, team and service levels so that all involved are aware of their responsibilities. When a service is located or provided on more than one site the model structure should clearly identify accountability and responsibility for quality and safety of services provided throughout all sites.2 This latter point may have specific relevance where Specialist Paramedics – Community Care provide clinical care across traditional service boundaries.

A Licensed CPG Service Provider for Community Paramedicine must have the capacity and capability to implement and monitor effective quality, safety and risk management systems.3 While service providers may differ in size and complexity, all organisations should have transparent and effective structures to facilitate clinical governance. For larger organisations, there must be alignment of local, regional and national accountability.

Competency assurance for Specialist Paramedics – Community Care is an essential component of clinical governance and should be incorporated as a routine component of clinical care activity.

9.4 The Clinical Director

Within a Community Paramedicine health service provider, a Clinical Director has a key role in developing and implementing clinical governance systems. The Clinical Director is a clearly identifiable individual whose clinical expertise reflects the scope of practice of the Specialist Paramedic – Community Care. The clinical director should:[13]

- have overall clinical accountability, responsibility and authority for the delivery of high-quality, safe and reliable services
- participate in regular governance meetings to ensure systematic monitoring and evaluation of service
- review and guide the organisation's Clinical Governance Policy
- monitor clinical risk, key performance indicators and quality improvement
- review and guide policies, including those pertinent to adverse clinical events, serious reportable events (SRE), near-miss incidents and complaints
- oversee how learning is shared with practitioners
- review and ensure compliance with statutory requirements
- oversee and monitor a system of operational clinical support for Specialist Paramedics – Community Care.

9.5 Communication and Consultation with Key Stakeholders

Structures and strategies should be in place across stakeholders to ensure effective communication and consultation to support best integrated clinical practice. Service user involvement and community engagement should be incorporated and include feedback from individual care episodes, service planning, education, and quality review/improvement.[14]

9.6 Policies, Procedures, Protocols and Guidelines (PPPG)

The Health Service Provider delivering Community Paramedicine services should have systems in place to develop standardised Policies, Procedures, Protocols and Guidelines (PPPG) to support practice. PPPG will include the purpose, aims and objectives of a given service. PPPG will facilitate transparency, accountability and ensure that delivery of services is within the scope of what can be achieved safely, effectively and sustainably. All staff should be supported in implementing PPPG.

9.7 Incident Management

PPPG should include an Incident Management Framework that considers overall accountability for the management of incidents and incorporates materials that outline clear roles and responsibilities for staff at all levels. This incident management framework will be informed by the incident management guidance provided by the HSE and incorporate the following principles:[15]

- Person-centred
- Fair and just
- Open and transparent
- Responsive

- Improvement-focused
- Learning

9.8 Shift Leader/Manager Role and Responsibilities

A clinical governance model must include transparent operational governance, i.e., reporting relationships during operational shifts. The reporting relationships into and out of the operational leader/manager must be explicit, with clear guidance on their role, both in the day-to-day running of a clinical service and in incident management.

9.9 Legislation Supporting Clinical Governance

In Ireland, specific legislation enables PHECC to recognise pre-hospital emergency care providers (Licensed CPG Service Providers) who undertake to implement PHECC Clinical Practice Guidelines (SI 575 of 2004). Healthcare services who provide PHECC-recognised Community Paramedicine services must incorporate a Licensed CPG Service Provider and are thus subject to performance requirements under the PHECC Governance Validation Framework.

This Governance Validation Framework gives weight to the need for assurance of effectiveness of systems in place for quality, risk and safety management. It is recognised that these existing mechanisms restrict the settings in which Specialist Paramedics – Community Care can be employed to those that incorporate Licensed CPG Service Providers.

It is likely that as the Irish Healthcare system evolves the skillset of Specialist Paramedics – Community Care may have relevance beyond traditional Licensed CPG Service Provider settings. PHECC will need to consider how best to address this issue in the future.

10 MONITORING OF PERFORMANCE METRICS AND CLINICAL INDICATORS

Pre-Hospital Emergency Care Council

10 MONITORING OF PERFORMANCE METRICS AND CLINICAL INDICATORS

The effectiveness of an individual Community Paramedicine service needs to be measured to identify benefits and any deficits that can lead to quality improvement. It is thus important to define and measure performance metrics to determine benefits and deficits. In conjunction with a robust clinical governance model, measurement of performance metrics and clinical indicators will provide information on the effectiveness and outcomes of any Community Paramedicine model.

It is the role of PHECC to establish domains for performance metrics for Community Paramedicine. These domains should incorporate measurement of Patient Safety, Patient Outcomes, Patient Experience, Practitioner experience and System Performance. PHECC should develop these domains in consultation with health service providers delivering Community Paramedicine services. Beyond the domains defined by PHECC it will be a matter for the Licensed CPG Service Provider to determine the specific metrics they will measure (to reflect said domain) to reflect what is most appropriate for their service and organisation. Ultimately, these domains and metrics will be reviewed as a component of the PHECC Governance Validation Framework process.

11 CLINICAL SUPERVISION AND SUPPORT

Pre-Hospital Emergency Care Council

11 CLINICAL SUPERVISION AND SUPPORT

11.1 Clinical Supervision

Clinical supervision provides the environment and culture to reflect, evaluate, evolve, and refine the approach to clinical practice.14 It is a key element of patient safety and the development of safe and competent practitioners. Provision of clinical supervision is necessary to support the transition to primary care from traditional EMS roles.17 Evidence suggests though that there is a lack of standardisation in supervision models in Community Paramedicine systems and this may impact on the realisation of their full potential.[2]

Clinical supervision is a necessary facilitator of the role of Specialist Paramedic – Community Care and of Community Paramedicine services. Although the provision of a system of clinical supervision is the primary responsibility of the health service provider (most particularly Licensed CPG Service Provider), Specialist Paramedics – Community Care also share responsibility for ensuring that models of clinical supervision are appropriately and effectively implemented.

Clinical services that employ Specialist Paramedics – Community Care should develop models of supervision appropriate to local requirements in collaboration with Specialist Paramedics – Community Care. Clinical Supervisors may be drawn from the Licensed CPG Service Provider or a linked General Practice. Supervisors may be experienced Specialist Paramedics – Community Care who have completed their consolidation phase of clinical practice, be a GP or another doctor employed by the Service Provider. A given model of supervision should be transparent and subject to regular review. The role of clinical supervisor should include supporting ongoing practitioner educational needs, practice development, the enablement of peer-to-peer support and clinical practice review. A clinical supervisor should have clinical knowledge and expertise in the field of Community Paramedicine and be able to bring innovation to the role of supervision. Ultimately, a supervisor can assist a practitioner in building their capabilities and enhancing their critical thinking and clinical reasoning in an ongoing fashion. Clinical services must ensure that supervisors are adequately supported in their role, and supervisors in turn must understand their role in the provision of support for Specialist Paramedics – Community Care.

Clinical supervision models should enable and encourage:

- patient safety
- open communication
- protected time for practitioner professional development
- the maintenance of continuous professional competence
- support for the best health and well-being for practitioners.

11.2 Clinical Support

Clinical support includes the provision of access for practitioners to an experienced healthcare professional to support decision-making in real time in the clinical environment. Support resources will be context-dependent but might include GPs, Emergency Department doctors, members of a multi-disciplinary team and Specialist Paramedic – Community Care colleagues. Clinical services that employ Specialist Paramedics – Community Care should develop appropriate local mechanisms for the prevision of online clinical support as necessary. These mechanisms should be transparent and be incorporated in Policies, Procedures, Protocols and Guidelines (PPPG).

Modern telecommunications technology can be a notable facilitator of clinical support structures and should be harnessed to this end. Clinical support involving medical practitioners may have specific relevance where medication administration forms a component of an individual patient's treatment plan (beyond circumstances that allow autonomous medication administration by a Specialist Paramedics – Community Care). In such circumstances, a Specialist Paramedic – Community Care can fulfil a physician extender role and facilitate a remote consultation with a medical practitioner that can result in an appropriate prescription for required medication.

Clinical support also includes local service-level policies, procedures, protocols, and guidelines that are developed and continually updated to support Specialist Paramedics – Community Care. Health services/Licensed CPG Service Providers who employ Specialist Paramedics – Community Care should have transparent systems in place to develop these materials, and Specialist Paramedics – Community Care should be actively involved in this development. Local level policy and procedures should ensure that service delivery falls within the scope of what can be achieved safely, effectively and sustainably. Consideration should be given to the production of a Governance Manual outlining roles, scope of practice, policies and procedures and documented agreement on the operation of a given Specialist Paramedic – Community Care service.

12 CONTINUING PROFESSIONAL COMPETENCE AND DEVELOPMENT

Pre-Hospital Emergency Care Council

12 CONTINUING PROFESSIONAL COMPETENCE AND DEVELOPMENT

12.1 Introduction

Continuous professional development (CPD) is a key characteristic of effective practitioners who are well positioned to deliver safe, high-quality patient care and services. CORU defines CPD as the means by which health and social care professions maintain and improve their knowledge, skills and competence, and develop the professional qualities required throughout their professional life.18

12.2 Continuing Professional Competence and Development for Specialist Paramedics – Community Care

Pending the development of a formal PHECC continuing professional competence/development system, Specialist Paramedics – Community Care should maintain a personal portfolio of activities based on their own developmental needs and guided by the following principles.

The continuing professional competence and development (CPCD) portfolio

1. Each registered Specialist Paramedic – Community Care should maintain a portfolio for annual review by the regulator or appointee.
2. The portfolio should comprise a record of obligatory and optional learning and self-development activities.
3. The pillars of advanced practice should be represented across the portfolio.
4. The portfolio will incorporate certification kept up to date for courses such as Moving and Handling, BLS, GDPR, Children First, Hand Hygiene and all other organisational mandatory training courses.
5. A varied suite of formal and informal self-development activities from within the practitioner's recognised institution and from external sources can be included, e.g., attending conferences, seminars, and workshops.
6. Activities to keep appraised of up-to-date research evidence should be included, e.g., attendance at and contributing to journal clubs.
7. Evidence of writing up/discussing case studies, self-reflection and presenting to peers is classed as a component of CPCD and should be included.
8. A suggested minimum of 50 credits (hours) of CPCD should be recorded each year.
9. *These 50 credits should incorporate external, internal and audit/quality improvement activities.*

Review of CPCD portfolio

10. Portfolios should be reviewed from time to time by a regulator-appointed practitioner or independent observer.
11. PHECC should put a process in place for cases of disagreement, disparity or non-adherence.

PHECC should move to develop a formal, comprehensive system of CPCD for Specialist Paramedics – Community Care as a priority. Practitioners that are Specialist Paramedics – Community Care should be involved in the design of this future formal system.

12.3 Primary Care and Continuous Professional Competence and Development

During training, Specialist Paramedics – Community Care should have extensive exposure to primary care settings including General Practice. Beyond this initial training, ongoing rotational experience in primary care is viewed as an essential facilitator of specialist Community Paramedicine, both in terms of further development and in the maintenance of competency in clinical practice in primary care. PHECC recommend that, in general, Specialist Paramedics – Community Care spend a minimum of 0.2 FTE contributing to care in a direct primary care setting. The scope of practice of an individual CP may vary somewhat depending on competency acquisition and maintenance, as well as operational area. Clinical governance for Specialist Paramedics – Community Care should include access to clinical supervision in primary care, incorporating regular case review and audit.

13 CONTINUING PROFESSIONAL COMPETENCE AND DEVELOPMENT

Pre-Hospital Emergency Care Council

13 RESEARCH, AUDIT AND QUALITY IMPROVEMENT

13.1 Introduction

'Research is designed and conducted to generate new generalizable or transferable knowledge. It includes both quantitative and qualitative studies that aim to generate new hypotheses as well as studies that aim to test existing or new hypotheses.'19

'Clinical audit is a clinically-led quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and acting to improve care when standards are not met. The process involves the selection of aspects of the structure, processes and outcomes of care which are then systematically evaluated against explicit criteria. If required, improvements should be implemented at an individual, team or organisation level and then the care re-evaluated to confirm improvements.'19

'Quality improvement (QI) is the combined and unceasing efforts of everyone – healthcare professionals, patients and their families, researchers, commissioners, providers, and educators – to make the changes that will lead to better patient outcomes, better experience of care, continued development and supporting of staff in delivering quality care.'19

Research, audit and quality improvement represent core components of Specialist Paramedic – Community Care practice and should be facilitated at all levels

13.2 Research

As new models of healthcare delivery emerge, it is essential that research is carried out into areas such as safety, effectiveness, and value for money. As a novel model of healthcare delivery, the introduction of Community Paramedicine to Ireland creates significant opportunities for research. It is important that Specialist Paramedics – Community Care and other stakeholders, including healthcare delivery organisations and the Pre-Hospital Emergency Care Council, support and engage in research considering the delivery of Community Paramedicine.

To this end, important facilitators that should be considered by all stakeholders include:

1. Ongoing research training and development activities
2. Dedicated funding for research activities
3. Protected time to engage in/support research
4. Collaborations involving third-level institutions, Specialist Paramedics – Community Care and service providers
5. Research champions
6. Dedicated clinician-academic posts for Specialist Paramedics – Community Care.

13.3 Audit

Clinical audit involves the systematic review of care against explicit criteria and acts to improve care when standards are not met. Clinical audit is an essential component of quality assurance and service improvement, and it is expected that service providers and Specialist Paramedics – Community Care collaborate in clinical audit on an ongoing basis. Community Paramedicine must be open to audit and be able to critically appraise audit outcomes. Practice must be underpinned by continuous improvement, including that gleaned from audit results. Specialist Paramedics – Community Care should be able to evaluate and audit their own and others' clinical practice. They should be able to

choose and apply valid, reliable methods and act on the findings. Audit findings should also feed back into education to enable continuous development and quality improvement of Community Paramedicine training and education.

13.4 Quality Improvement

Specialist Paramedics – Community Care and their health service employers will be committed to continuous quality improvement. To this end, the HSE 'Framework for Improving Quality in our Health Service' can serve as a useful framework to support quality improvement initiatives in Community Paramedicine.20 The framework considers the following six drivers for improving quality:

1. Leadership for Quality Family Engagement
2. Staff Engagement
3. Use of Improvement Methods
4. Measurement for Quality
5. Governance for Quality

It is notable that Community Paramedicine will interface with a wider range of stakeholders than conventional paramedicine. Key concepts will include service user engagement along with early engagement and regular interactions with other health services to enhance multi-disciplinary team working and better, safer patient care. There is evidence to support the concept that patient experience feedback can shape services to better meet patient needs.19 Patient engagement and involvement should be integral to service design, development, and evaluation. This is essential to ensure a service that is truly patient-focused and regards the service user at its centre. This is in keeping with government policy, a key element of which is the empowerment and participation of service users.[21]

Patient experience data should be considered alongside safety and clinical effectiveness data and the associations between them made explicit.14 It is important that Specialist Paramedics – Community Care are engaged in both the design of patient feedback mechanisms and the analysis. This will enable sustainable improvements in systems.

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Pre-Hospital Emergency Care Council

14 REFERENCES

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15 ACKNOWLEDGEMENTS

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The implementation of Community Paramedicine aims to bring the right care to the right patient in the right place and is aligned with the aims of Sláintecare in this regard. This Community Paramedicine Framework is intended to underpin developments and practice of Community Paramedicine in Ireland.

The Pre-Hospital Emergency Care Council are grateful to all those who contributed to the development of this Community Paramedicine Framework.

We wish to acknowledge the members of the PHECC MAC sub-committees and their contributions to the development of both the introductory report and final framework.

The work undertaken by the EU-funded Co-operation and Working Together (CAWT) Health and Social Care Partnership Community and National Ambulance Service (NAS) pilot projects provided valuable learning towards the development of this framework, and our gratitude goes to all involved in those projects.

The work of the team at Monash University, under the leadership of Brendan Shannon, who researched and produced two key documents on scope of practice and current literature for Community Paramedicine, was invaluable in providing context and identifying the positives and negatives from international systems as well as identifying challenges to the introduction of a robust Community Paramedicine model.

We wish to acknowledge and thank those who presented at the Community Paramedic Seminar, Ms Bridget Clarke, NAS Project Lead; Dr Seamus Clarke, General Practitioner; Ms Ann McDermott, NAS Community Paramedic; Ms Georgette Eaton, Clinical Practice Development Manager – Advanced Paramedic Practitioners (Urgent Care), London Ambulance Service, and those who joined our expert panel for discussion, Mr Robert Morton, Director of the National Ambulance Service; Prof. Andy Newton, Chairman of Health Practices Associates Council and J. D. Heffern, Chief Paramedic, Indigenous Services Canada. The seminar was chaired and moderated by Dr Alan Batt, Adj. Assoc. Prof. of Paramedic Science and we welcome his input.

To those stakeholders who contributed to our development workshop, we are grateful. Both Irish and international collaborators were generous with their time and advice:

D/O Martin O'Reilly	Dublin Fire Brigade EMS Support Officer
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Ms Elaine Barrett	HSE Public Health Nurse
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Engagements took place with Georgette Eaton, Clinical Practice Development Manager – Advanced Paramedic Practitioners (Urgent Care), London Ambulance Service, and Gemma Nosworthy, Primary Care Manager, Betsi Cadwaladr University Health Board, Wales, and Bryn Thomas, Consultant Paramedic, Welsh Ambulance Service Trust. Both engagements were very helpful, and we appreciate the time taken by all to provide an overview of their Community Paramedicine models.

The conduct of a stakeholder and expert workshop by the Grant Thornton team, led by Sharon Scanlan, provided valuable input into this framework.

APPENDIX 1

Appendix 1: Recommendations from 'The Introduction of Community Paramedicine into Ireland' Report (Collins H. & Power B. 2020)

Recommendation 1:

PHECC to engage with the Sláintecare office to ensure an integration of the Community Paramedicine programme with other Sláintecare projects.

- The role of Community Paramedic should have a focus on shifting care from acute hospital to community care.

Recommendation 2:

It will be essential that the Community Paramedicine practitioner would have the word 'paramedic' in the title.

- Consider utilising the title of 'Community Paramedic Specialist' or 'Primary Care Paramedic' to describe the Community Paramedicine practitioner.

Recommendation 3:

PHECC to facilitate the mainstreaming of Community Paramedicine into Ireland and engage with the wider stakeholders to achieve this aim.

Recommendation 4:

PHECC to set standards and educational outcomes for the Community Paramedicine Practitioners going forward.

- International models and the NAS experience could help with the setting of these standards and educational outcomes

Recommendation 5:

PHECC to explore the integration of Community Paramedicine with Primary and Acute Care.

Recommendation 6:

As there is limited experience of Community Paramedicine in Ireland the experience of the role resides with those stakeholders involved in the CAWT funded pilot project and other existing community-based pilot project participants. PHECC to engage with them when deliberating on Community Paramedicine, taking cognisance of the evaluation of the CAWT Project which will be completed in Q4, 2020 following cessation of the CAWT Project on 31st August 2020.

Recommendation 7:

PHECC to establish a sub-group under MAC to set clinical standards for the Community Paramedicine programme.

- The sub-group may include representative(s) from ICGP, ccommunity paramedics qualified in Glasgow Caledonian University (GCU) as part of the CAWT Project, paramedics who have completed the Irish Community Paramedicine programme, a primary care/ general practitioner academic, a representative from the NAS Medical Directorate, a patient representative, other existing community-based pilot project participants and other persons determined by MAC.

Recommendation 8:

Robust clinical governance structures, on the part of Licensed CPG Service Providers, including supervision, mentoring and clinical audit are required.

Recommendation 9:

Urgent legislation change is required to accommodate Community Paramedicine training, qualification awards and registration.

- Change is also required to facilitate prescription only medication administration by Specialist Paramedic – Community Care practitioners.

Recommendation 10:

Legislation change is required to enable Community Paramedicine Practitioners prescribe medications as autonomous practitioners.

Recommendation 11:

An appointment of clinical facilitator(s) with appropriate education skills and Community Paramedicine practice experience is required to support the programme.

Recommendation 12:

That the PHECC Education and Standards Committee develop the educational requirements to support the roll out of Community Paramedic Practitioners.

Recommendation 13:

Core competencies required of a Community Paramedicine practitioner include: autonomy in clinical practice, decision-making, expert practice, professional and clinical leadership, research, teamwork, communication skills, population health & health promotion.

- To accomplish these the education to be set at level 9 on the National Qualifications Framework.


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