Pre-Hospital Emergency Care Council

Governance Validation Framework

Assessment Report

Blue Screen Medics Ltd

July 2023

Pre-Hospital Emergency Care Council

Mission Statement

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

QUALITY ASSURANCE PROGRAMME

Governance Validation Framework
Quality Review Framework

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

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

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

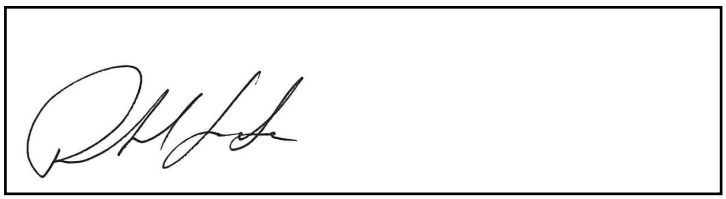
- The Governance Validation Framework (GVF), in place since 2018, monitors the Licensed CPG Service Providers that PHECC recognise to deliver pre-hospital emergency care in the community. Providers are required to be compliant with the GVF Standard (STN034) and its related criteria.
- The Quality Review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

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

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

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

2. Assessment Report Overview and Validation

Organisation Name	This report relates to Blue Screen Medics Ltd, a PHECC Recognised CPG Service Provider, licensed to deliver pre-hospital emergency care services in Ireland since 2019. Organisation are recognised by PHECC under S.I 109 of 2000 as amended by SI 575 of 2004 at the following clinical levels: ☑ Emergency Medical Technician ☑ Paramedic ☐ Advanced Paramedic ☑ Organisation also provides responder level services
Assessment type	☑ Planned ☐ Reactive
Process	☑ Desktop Review ☐ Online Management Engagement ☑ Onsite Management Engagement Sika Cottage, Little Newtown, Enniskerry, Co Wicklow, A98Y1TD ☑ Practitioner Engagement Kilternan, Co Dublin
Outcome rating **Technical weighting applied** **Yes** ☐ **No** ☑	No of criterion assessed 44 Maximum score available 176 63% of Max = 111 **Assessment Results** Total score achieved 131 Total score as percentage 74% **Assessment Outcome Rating** **Moderately Acceptable**
Follow up action required	☑ Continue with normal quality improvement activities ☐ Improvement notice - follow up evidence required ☐ Conditional Approval ☐ Suspension notice ☐ Delisting process intiated
Reassessment costs	☑ Not applicable
Validated and approved for publication. **Director Signature** **Date**	 09/01/2024

3. Assessment Participants

Organisation	PHECC Assessment Team
Managing Director	GVFA7460 Team Lead
Compliance Lead	GVFA4532– Onsite Assessor
Medical Director (Medical Council Reg No 414131)	GVFA3572 – Practitioner Engagement Assessor
Paramedic x 1 EMT x 1	

4. Initial Feedback Given

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

The following areas were identified as areas requiring improvement, or further potential for improvement areas: equipment, medications, governance, staff training, driving, transporting of compressed gas, risk compliance and GDPR compliance.

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

5. Rating Scale and Outcome Rating

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

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

6. Weighting Tolerance

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

7. Outcome Rating

The outcome rating is determined by the rating scores applied by the Assessment Team to each criterion and includes the application of any associated technical weighting that may apply. An outcome rating is created using a rating matrix that brings the components of the assessment rating system together and calculates the assessment outcome rating based upon the combined rating achieved in the criteria and Standards, expressed as a percentage of the maximum available (100%).* An outcome rating is applied and the follow up and impact of the achieved rating on the organisation's recognition status is determined accordingly.

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

8. Assessment Findings

The following are points of note:

- During assessment a risk assessment and escalation procedure is utilised by the Assessment Team.
- It is recognised that not every criterion may be relevant or apply to each Provider. The judgement of the Assessment Team, in consultation with PHECC executive, will determine if a criterion should be considered applicable. If not , the rating system adjusts to accommodate.

- A criterion may be rated as fully met and yet attract an opportunity for improvement comment where a minor adjustment may yield further improvement.

- It should be noted that regardless of the Provider's outcome rating an improvement notice may be issued by PHECC related to the Assessment Team findings with regards to specific criterion that fall below the expected standard; particularly ones that may present a specific risk or pose a detrimental impact to safety.

Standard 1

Person-Centred Care and Support

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

Standard 1

Criterion

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

Rating

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

Assessment Findings

In submitted documentation, and during on-site assessment the Provider outlined the model of their service provision: a provider of pre-hospital personnel to the film production industry and event organisers.

Patients access care in accordance with pre-planned arrangements agreed in advance between the production company/event organiser and the Provider. The Assessment Team verified that safety and medical plans created by the film production company and/or event organisers are in place, and these include a risk rated overview of the anticipated needs of the crew and staff for pre-hospital provided cover for a specific period of time/event.

The Provider's privileged practitioners provide initial care and, where necessary, can escalate care to a higher level where the patient's clinical presentation falls outside the scope of agreed level of medical cover or scope of practice of the on-site practitioner. Practitioners operate mainly as solo responders whilst on duty.

During Practitioner Engagement (PE) the Assessor observed a run sheet for the day's planned activity and verified that the Provider ensures care is provided based on the identified needs of the personnel involved and within the practitioner's scope of practice.

Practitioners reported no issues with sick leave or dropping cover.

Area(s) of Good Practice

The Provider liaises closely with the production company/event organiser to ensure appropriate level of pre-hospital cover depending on the activities scheduled to occur on a given day.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider verified that all services are available to all persons working on behalf of the client and in line with the Equality Act 2010.

A formal process for communication is agreed by the Provider and client as part of the safety and medical plan. Radios are generally provided on-site by the contractor. Patients often self-present to a triage station at an event/workplace and practitioners may attend calls when notified by radio transmission where or when they are required.

Area(s) of Good Practice

There is good communications, rapport and visibility of Practitioners at sites and events. The Provider ensures that all patients requiring pre-hospital care on-site can access the service using reliable methods of communication.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider has a process in place for activating and responding promptly to calls. The details regarding call activation are agreed in advance with the client at the safety and medical planning stage. Practitioners generally use their own mobile phones on-site but in addition radios are often issued as per the agreed plan.

Practitioners complete a report form for each patient encounter, along with an ACR/PCR. The report forms are reviewed at end of each day by Operations Manager/Managing Director and information gathered forms part of an activation log.

Following a review of the evidence, the Assessment Team raised possible General Data Protection Regulation (GDPR) issues, which may arise from gathering additional patient sensitive information. The Provider acknowledged that this process would be reviewed and amended immediately.

Area(s) of Good Practice

The Provider ensures that there is a robust process for call activation and a pre-hospital practitioner is accessible and in close proximity for patients to self-present or be brought to a designated treatment area.

Area(s) for Improvement

The Provider shall redesign the process for recording call activation and responses to ensure compliance with GDPR requirements.

Standard 1

Criterion

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

Rating

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

Assessment Findings

During on-site assessment and Practitioner Engagement it was established that given the nature of services provided by the Provider, and low level and frequency of calls, that patient identification is a simple process.
The Provider uses name and date of birth as a good discriminator on the ACR/PCR for patient identification.

Area(s) of Good Practice

The Provider uses a simple but effective approach to patient identification.

Area(s) for Improvement

In the event that the Provider's organisation expands, with an increase in patient numbers, the Provider may need to consider developing a system capable of generating a unique incident number for each patient encounter.

Standard 1

Criterion

1.5 The Provider has a policy for informed consent.

Rating

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

Assessment Findings

The assessment team evidenced that the Provider has a policy for informed consent in place.
The PE Assessor observed staff identify themselves and gain consent from all patients seeking clinical care.

The Assessment Team verified that, at induction stage, training related to informed the consent policy had taken place.

Area(s) of Good Practice

Practitioners are training in informed consent.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Assessment Team verified that the Provider has a refusal of treatment/transport policy in place. Staff training records were viewed and verified during the assessment.

The PE Assessor established that the practitioner was aware of the policy and had training in the implementation of the policy during induction.

Due to the small number of patients requiring treatment/transport the Provider cannot generate an audit related to this standard.

Area(s) of Good Practice

The Provider is compliant with this standard.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Assessment Team were satisfied that during the assessment it was evident that there is a culture of respect and caring amongst practitioners and throughout the Provider's organisation.

There is an attitude of respect, compassion and dignity espoused by the Provider

Area(s) of Good Practice

There is an attitude of respect, compassion and dignity espoused by the Provider

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Assessment Team did not evidence a formal process whereby feedback is collected, collated and shared with staff. In discussion with the Assessment Team, the Provider described how their organisation actively but informally seeks feedback when engaging with the commissioning client at the end of a contracted period of service. One-to-one communication initiated by the Managing Director with the client is the Provider's main method of receiving feedback, which does include secondary feedback from patients treated on behalf of the client.

The Assessment Team evidenced that regular compliments were being received by the Provider regarding the treatment and standard of care provided by practitioners, however ,this information is not collated into a specific report.

Area(s) of Good Practice

The Provider actively seeks feedback from the services commissioner to improve patient services.

Area(s) for Improvement

The Provider should implement a formal process that gathers feedback from patients, and share it with staff to improve quality of services.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Assessment Team evidenced that the Provider has a complaints policy in place. The Provider actively manages all complaints within an agreed timeframe and there is an external adjudicator identified to ensure the openness and transparency of the process.

During the PE staff demonstrated good awareness of the complaints policy and had knowledge of the process as per the policy.

Area(s) of Good Practice

Within the Provider's organisation, all staff have good awareness of the complaints procedure and how to implement it.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Effective Integrated Care and Safe Environment

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

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Assessment Team were satisfied that there is good governance and oversight processes in place to ensure that practitioners utilise PHECC CPG appropriate to their scope of practice.

Induction and training records are maintained and were evidenced by the Assessment Team during the on-site engagement.

Area(s) of Good Practice

The Provider has an effective process for maintaining essential records for each practitioner.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider has a standardised policy for IMIST-AMBO handover when conducting patient handovers.

During the PE the Assessor verified that practitioners had training in handover procedure/policy during induction, however, the requirement for handover is minimal due to the nature and volume of calls handled by the Provider at present.

Area(s) of Good Practice

The Provider has a standardised policy in place.

Area(s) for Improvement

The Provider may consider including IMIST-AMBO handover in future staff training plans to maintain fluency in the handover process.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider has a vehicle management policy in place. The Assessment Team were satisfied that the Provider had standardised the layout and improved the general quality of their vehicle sin use since the last GVF assessment.

The Provider has developed a paper-based vehicle inspection check list, which aims to improve the organisation's system regarding the gathering of vehicle safety information.

The team evidenced that all required documentation is in place.

Area(s) of Good Practice

The Provider upgraded their vehicles since the last GVF assessment.
The Provider developed a vehicle inspection process to improve vehicle safety.

Area(s) for Improvement

The Provider shall expand their vehicle management policy to include a defined maintenance vehicle and equipment schedule.

Standard 2

Criterion

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

Rating

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

Assessment Findings

In discussion with the Assessment Team, the Provider explained that the nature of the service provided by practitioners rarely requires the transport of seriously ill or injured patients. Where there was potential for this requirement, the statutory agencies would be alerted to transport patients to a higher level of care in the nearest emergency facility.

The Provider has a fully equipped ambulance that can provide on-scene support at events, and only experienced staff with appropriate licence are granted permission to drive the vehicle by the Managing Director. Specific audit and monitoring of safe driving standards are ad-hoc.

Area(s) of Good Practice

The Provider has a procedure in place that ensures the safe transport of patients.

Area(s) for Improvement

The Provider's should consider ESDS training for its ambulance drivers at the appropriate level for the services activity. (RSA ESDS Level 1, 2 or 3, as appropriate).

The Provider should consider a process for the audit of safe driving.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider has a Vehicle Management Policy in place, however, the policy does not specifically reference the use of emergency light and sirens.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider shall develop a policy to provide clarity to its staff regarding conduction of emergency driving.

The Provider's should consider ESDS training for its ambulance drivers at the appropriate level for the services activity (RSA ESDS Level 1, 2 or 3, as appropriate).

Standard 2

Criterion

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

Rating

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

Assessment Findings

In discussion with the Assessment Team, the Provider outlined how the contractor carries out health and safety assessments (which includes fire safety) for the location of the film set. These plans are shared with the Provider in advance of the scheduled date for the pre-hospital service.

Newly appointed practitioners have a mentored period on site prior to being rostered as solo responders.

Area(s) of Good Practice

There is good communication between the Provider and contractor in relation to site safety.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

In discussion with the Assessment Team, the Provider described the nature of the business and how the level of service provision is negotiated based on the budget constraints of the contractor.

Where the level of practitioner cover required increases unexpectedly at short notice, the Provider has the ability to respond utilising the services of other PHECC Recognised CPG Service Providers.

Area(s) of Good Practice

The Provider has a contingency plan to ensure business continuity for their organisation.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

Planning for incidents is driven by the production company, risk assessments are regularly carried out. The assessment team discussed potential scenarios related to incidents, however due to the small size and nature of service provision of the providers operations, to date a formal major incident plan has not been developed.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider shall develop a major incident plan to formalise its approach to the first minutes of a major incident should one occur.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Assessment Team verified that the Provider has a Clinical Audit Policy in place. In discussion with the Assessment Team, the Provider described the current clinical audit process, which involves the review of every ACR/PCR on a quarterly basis.

The Medical Director, Managing Director and Compliance Lead collaborate on the implementation of the clinical audit cycle, however, due to small numbers of patients treated annually the Provider has set out a plan that will capture three specific clinical presentations. The Provider cited two clinical scenarios that were captured as a result of audit, both had a direct influence on the outcome of patient care and in turn provided opportunity for feedback to staff on improving documentation and clinical practice.

Area(s) of Good Practice

The Provider has a robust clinical audit process in place.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider submitted an Annual Report for the year ending 2022. The report comprises an overview of the size and nature of the business activities of the Provider.

The Assessment Team noted that overall clinical audit revealed small numbers of patient encounters, yet, compliance with audit standards appears to fall below the accepted levels in a range of areas.
In discussion with the Assessment Team, the Managing Director and Compliance Lead both agreed that audit results would imply that there is room for improvement and that with the recent appointment of a new Medical Director that training and continuous professional development (CPD) can be designed to improve practice across a range of clinical activities.

Area(s) of Good Practice

The Provider is compliant with this standard.

Area(s) for Improvement

The Provider would benefit from collaboration with the Medical Director to drive improvements in quality, and these plans should be included in their quality improvement plan (QIP).

Standard 3

Safe Care and Support

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

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider has in place an Infection Prevention and Control Policy (IP&C), which requires some modification as it references infection control material that is no longer in use. The Assessment Team did not evidence the results of an IPC audit programme, however, the Managing Director stated that he carries out unannounced site visits and hand hygiene spot checks while practitioners are on duty.

During the PE, practitioners reported that they had received training in infection prevention and control and that alcohol-based hand gel is provided. The PE Assessor observed adequate hand washing facilities available in on-site toilet cabins and also in the production office building.

Area(s) of Good Practice

The Provider has good IP&C processes in place.

Area(s) for Improvement

The Provider should consider implementing an IP&C Audit Programme to further demonstrate compliance of the organisation in good IP&C practices.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider has a process outlined in the Infection Prevention & Control Policy on the management of clinical waste according to hazard level. The Managing Director holds overall responsibility for the collection and safe disposal of all clinical waste generated by the Provider's organisation.

During on-site assessment, the Assessment Team observed the clinical waste bin, which was appropriately located and locked, and evidenced supporting documentation verifying that a licensed clinical waste company are contracted to dispose of waste as and when required.

The PE Assessor noted that staff were knowledgeable about the procedures for managing clinical and hazardous waste. Practitioners also reported that due to the nature of the work carried out there is minimal production of hazardous waste. However, the Assessor noted that while there was a sharps bin available in the first aid kit bag there was no evidence of clinical waste /yellow bags being available.

Area(s) of Good Practice

The Provider has a process for waste management that is appropriate to the size and nature of the business.

Area(s) for Improvement

The Provider shall ensure that clinical waste /yellow bags are available at all times.

The Provider would benefit from implementing a tagging system to improve tracking of large clinical waste bags if volumes of waste increase commensurate with the size of their organisation.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Assessment Team verified that the Provider has a Medications Management Policy in place. The Managing Director holds responsibility for overall medication management processes with support from the Medical Director in terms of training, audit, and compliance with relevant laws and regulation.

The team verified good process for the checking of medication bags and a checklist is available.

Area(s) of Good Practice

The Provider has good medication management procedures in place.

Area(s) for Improvement

The Provider shall ensure that HPRA are notified of specific medication use required under current regulations.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Managing Director has overall responsibility for managing stock levels and restocking of medications and a local pharmacy provides medications as required.

Overall, the Assessment Team were satisfied that there are robust processes in place for the management, stocking and checking of medications. Medication bags are stocked and sealed with the closest medication expiry date as the check date and medication bags are checked by the practitioner prior to going on duty.

There are processes in place for the disposal of out-of-date medicines and there is a check list which records all medications which have been administered and medicines which have expired and require appropriate disposal.

During practitioner engagement, the assessor randomly checked a medication bag and discovered an out-of-date medication, the medication was removed and disposed of.

The Provider has a procedure in place to notify practitioners of alerts and recall of medications.

Area(s) of Good Practice

The Provider notifies practitioners regarding alerts and recalls of medications.

Area(s) for Improvement

The Provider shall improve their medication management to ensure that all medications required for administration under CPG are in date and available to Practitioners at all times.

The Provider should include medication management as part of a scheduled training plan for all staff.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider has an Equipment Management Policy in place. During on-site assessment the Provider stated that there are regular meetings relating to equipment and medication management, and the Assessment Team were unable to verify records of such meetings during the site visit.

The Assessment Team noted that there were some deficits in the provision of equipment required by practitioners to fully enact PHECC Clinical Practice Guidelines (CPGs), such as limb splits and access to an automated external defibrillator (AED) with monitoring capability.

The onsite Assessment Team evidenced an equipment and vehicle check list book which has been recently introduced by the company to improve their processes around fault reporting and servicing of vehicles and equipment.

Area(s) of Good Practice

The Provider has an equipment and vehicle checklist in place.

Area(s) for Improvement

The Provider shall address the shortfall in the provision of equipment to ensure practitioners can effectively enact PHECC CPG.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider does not have a formal induction training programme but schedules all new employees to undergo an induction process. Following successful completion of the induction period, which is recorded on an Employee Induction Form, the Provider places the completed form on the employee's personnel file. The Assessment Team evidenced a sample of a completed induction form from a current employee's file.

New practitioners are mentored for their first tour of duty to familiarise them with the type and nature of the business. During PE, practitioners reported that training needs are evaluated regularly, and organised training events are carried out in-house as required. Practitioners also reported that ongoing CPC is offered by the Provider.

Area(s) of Good Practice

The Provider facilitates opportunities for staff to maintain competencies and to undertake CPD.

Area(s) for Improvement

The Provider should develop a formal and a more structure induction training programme for new employees.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider has a Child Protection and Welfare Policy in place, however, the current version does not reference vulnerable adults.

The Assessment Team reviewed a random sample of staff records verifying that staff had undertaken Children First training.

The PE Assessor noted that practitioners are familiar with regard to the Provider's policy for safeguarding of children and practitioners verified that management facilitated access to the online mandatory training programme.

Area(s) of Good Practice

The Provider ensures all employees undergo Children First Training.

Area(s) for Improvement

The Provider shall update the current safeguarding policy to include vulnerable adults and communicate the new policy to practitioners.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider has a Clinical Audit Policy in place. In discussion with the Assessment Team, the Managing Director and Compliance Lead shared the results of monitoring of all Ambulatory Care Reports (ACR). As the number of patient encounters are low, the Provider can review all documentation related to patient care in a short timeframe, and follow up on issues with individual practitioners.

However, it was noted that practitioners were not aware that audit was been carried out or of specific audit results or findings.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should incorporate the findings of clinical audit into scheduled staff training days.

Standard 4

Leadership and Goverance

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

Standard 4

Criterion

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

Rating

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

Assessment Findings

During on-site assessment the Provider described the corporate governance structures which are in place within the organisation and informed that meetings are held regularly with all relevant stakeholders. A new Medical Director has been appointed.

The Assessment Team were unable to verify evidence of meeting agenda and minutes related to corporate governance, decision making and risk management processes.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should develop and implement a Corporate Governance Policy to reflect the organisation's corporate governance structure and develop a robust mechanism to record meeting agenda, minutes, and action lists in line with best practice.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Clinical Governance Policy is out of date as the named Medical Director is no longer the post holder.

The Managing Director currently holds overall accountability for clinical governance, however, the appointment of a new Medical Director is noted.

The Assessment Team were unable to verify evidence of meeting agenda and minutes related to clinical governance, quality and patient safety.

The Assessment Team viewed privileging letters for each practitioner employed within the organisation.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should revise the current Clinical Governance Policy to reflect the organisation's new stakeholder and revised clinical governance arrangements.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Assessment Team verified that the Medical Director(MD) is registered with the Irish Medical Council and has the requisite competencies and experience to fulfil the role.

The MD is a new appointment to the organisation and following discussion with the MD the Assessment Team were satisfied that the MD is aware of the role and responsibilities attached to the post. However, the role profile and job description submitted by the Provider does not comply with the listed requirements of PHECC Medical Directors Role and Responsibilities Standard STN032.

The Provider outlined a plan for monthly governance meetings with the MD and a schedule for staff training, clinical audit and oversight as part of the future clinical governance structure.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should develop the job description and role profile for the Medical Director in line with PHECC Medical Directors Role and Responsibilities Standard STN032.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Provider has a structured approach to the development of policies and procedures. The Compliance Lead develops the content material with input from the Managing Director and Medical Director (where appropriate). The Compliance Lead discussed plans for updating the system for policy development, document formatting, and document control with the Assessment Team.

Area(s) of Good Practice

The Provider has a designated lead for policy development.

Area(s) for Improvement

The Provider should continue to improve the standard of written documents in a consistent and uniform way.

All Policies and procedure documents should be reviewed to ensure that they up to date and reflect current practice and PHECC Standards.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Provider has a mechanism for circulating important information issued by PHECC and other regulatory bodies.

The PE Assessor verified that practitioners agreed that all new recommendations and alerts are communicated to staff directly by email. The Provider receives a read receipt as confirmation that the practitioner has received the email.

The Assessment Team reviewed a sample of emails that were sent to staff and also reviewed online group messages that included all employees of the Provider's organisation.

Area(s) of Good Practice

Due to the small cohort of practitioners the Provider has good processes in place for efficiently circulating important information to everyone.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 4

Criterion

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

Rating

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

Assessment Findings

During onsite assessment the Provider described and evidenced a risk management plan which is developed by the contractor for every event/film location where pre-hospital services are required. The plan(s) include environmental and health & safety risk assessment and contingency plans to mitigate against those potential risks.

The Provider has not developed a process for identifying potential risks for organisation itself and had no risk register available for review by the Assessment Team.

The Provider has an Adverse Incident Policy in place, however, this requires revision to separate out the policy on near misses.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should develop an approach to risk management and risk mitigation relevant to the size, scope, and organisational capacity.

Standard 5

Workforce Planning

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

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider describes the size and nature of their organisation as not requiring complex planning in relation to staffing, workforce planning, and skill mix. All practitioners are employed on bank contracts and have been working with the Provider for a considerable period of time.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider has a robust process in place to ensure that practitioners are licensed by PHECC and are privileged to deliver pre-hospital care on behalf of the Provider.

The Provider ensures that credentialing of practitioners is in place, including CFRA, Children First and manual handling certification.

The Assessment Team verified that each employee had the required documentation and certification to practice and that mandatory regulatory requirements are monitored. Privileging letters for each practitioner were also reviewed and deemed to comply with PHECC standard STN033.

Area(s) of Good Practice

The Provider has a robust mechanism in place to ensure compliance with this standard.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider outlined the approach to English language competency assessment and currently has no staff that are not native English speakers. However, there is no formal English language competency policy in place.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider shall formally document a policy for English language competency to facilitate the assessment of an application for employment, should this situation arise.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider ensures that induction training includes incident reporting, orientation on the Provider's health and safety statement, and identification of the health and safety representative.

Area(s) of Good Practice

The Provider includes all health and safety information and requirements as part of the induction process.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider has not carried out a formal assessment of training needs for their organisation. Currently training is provided or accessed based on practitioner requests or recommendations.

The Assessment Team verified that CPG upskilling is delivered by a recognised RI and training certs formed part of each employee's training record.

The Provider stated that with the appointment of the new Medical Director that there will be a complete review of practitioner training needs and that a training and development plan will be developed to include in-house training and external programmes for the purposes of practitioner CPC.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider shall develop a training and development programme based on the result of clinical audit and projected growth of the organisation.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Assessment Team determined that this criterion is not applicable for this Provider.

Area(s) of Good Practice

Area(s) for Improvement

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider liaises with the contractor on each production prior to determine the day's requirements for clinical cover. A call sheet is developed detailing the activities on set and the number of personnel involved. This information provides the Management team with insight into the facilities available for practitioners such as toilets, catering, terrain, weather clothing requirements.

During on site assessment and in discussion with the Managing Director safety concerns were raised by the Assessment Team in relation to a practitioner transporting cylinders of oxygen.

The Provider has a CISM Policy in place and practitioners are familiar with how to access the programme.

During practitioner engagement the practitioner on duty reported that they had received CISM peer support training within another organisation and advised that they were the peer support contact person for this Provider too.

The Provider also has arranged access to a confidential external counselling service should an employee wish to avail of such a service.

Area(s) of Good Practice

The Provider demonstrates consideration for the wellbeing of their employees.

Area(s) for Improvement

The Provider shall implement a process for safe transporting of pressurised cylinders in all situations.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider does not have a performance management system in place.

There is an opportunity during induction training for the Provider to identify areas where the practitioner requires additional training and development, however, there is no formal process to review or follow through on the continuing needs and performance of individual staff.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider shall consider developing a performance management system.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider does not currently have a formal process for employees or contractors to feedback on aspects of their service.

The Provider identified several examples of how feedback is received from contractors and where cards and compliments are regularly received from contractors and service users. The Provider stated that there were plans to develop a web-based feedback link on their website.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should develop a formal mechanism for the capture of employee and contractor feedback.

Standard 6

Use of Information

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

Standard 6

Criterion

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

Rating

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

Assessment Findings

The Provider has a Clinical Records Management Policy in place.

During the practitioner engagement it was noted that information was recorded accurately on an Ambulatory Care Report by Practitioners onscene. It is noted that some information was also emailed directly to the Provider to satisfy an insurance requirement of the comissioner of care.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider shall review all processes related to the documentation of patient care to ensure compliance with PHECC Clinical information Standards and General Data Protection Requirements.

Standard 6

Criterion

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

Rating

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

Assessment Findings

The Provider has a Clinical Record Management Policy in place.

The PE Assessor observed that the ACR were being stored inappropriately.

The Assessment Team addressed the issue with the Provider who agreed to remediate the practice immediately.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider shall review all processes related to how patient confidentiality and patient data is protected.

Standard 6

Criterion

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

Rating

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

Assessment Findings

The Provider has a process for audit of all PCR/ACR. The results of audit are reviewed by the Compliance Lead and Managing Director and, where appropriate, fed back to staff.

The Assessment Team could not verify evidence of staff feedback or review following a deficit in an individual's performance. However, the Assessment Team were satisfied that, with the appointment of the new Medical Director, the Provider will develop a training and development programme that will address deficits identified in the quality review of healthcare records.

Area(s) of Good Practice

The Provider has a mechanism in place to audit every patient encounter.

Area(s) for Improvement

The Provider should develop an element within a staff training and education programme to ensure staff awareness of their responsibilities related to good record keeping, patient confidentiality, and data protection.

9. Report Outcome and Rating Summary

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

COMBINED STANDARD SCORE

Std 1	Std 2	Std 3	Std 4	Std 5	Std 6	TOTAL
33	33	22	16	21	6	131

STANDARD ACCEPTABLE/NOT ACCEPTABLE

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

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

No of criterion assessed	44
Maximum score available	176
63% of Max =	111
Assessment Results	
Total score achieved	131
Total score as percentage	74%
Assessment Outcome Rating	**Moderately Acceptable**

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

PHECC will now engage with Blue Screen Medics regarding required improvement actions related to specific assessment findings that present specific risks.

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

Blue Screen Medics Ltd

Assessment Outcome Rating

Moderately Acceptable

Standard 1: Person-Centred Care and Support

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

	Criteria	Rating Score
1.1	Patients have access to pre-hospital emergency care based on their identified needs and the Provider's scope of services.	4
1.2	Access to pre-hospital emergency care is not affected by discrimination.	4
1.3	The Provider ensures information from calls / activation is recorded accurately and dispatched according to priority.	3
1.4	The Provider develops and implements a process to ensure best practice for patient identification.	4
1.5	The Provider has a policy for informed consent.	4
1.6	The Provider has a policy in place in relation to the patient's refusal of treatment and/or transport.	4
1.7	The Provider ensures all patients are treated with compassion, respect, and dignity.	4
1.8	The Provider seeks feedback from patients and carers to improve services.	2
1.9	Patients' complaints and concerns are responded to within an agreed timeframe and openly with clear support provided throughout this process.	4

Standard 2: Effective Integrated Care and Safe Environment

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

	Criteria	Rating Score
2.1	The Provider has systems in place to ensure Practitioners utilise the PHECC CPG (Clinical Practice Guidelines) appropriate to their scope of practice.	4
2.2	The Provider has a standardised handover process in place to ensure the safe, timely, and structured exchange of information during handover of patients.	4
2.3	The Provider has a system in place to ensure the safety of their vehicles in line with legislation.	4
2.4	Training is provided for staff to transport patients safely, including during emergency situations.	2
2.5	The Provider has a policy on the use of emergency lights and sirens.	1
2.6	The Provider has a fire safety plan for any physical environments owned or used by their organisation.	4
2.7	The Provider ensures there is a business continuity plan for their organisation.	4
2.8	The Provider ensures plans are in place to deal with major incidents.	2
2.9	The Provider has a 3-year programme of clinical and environmental audits in line with the services provided.	4
2.10	The Provider submits a CPG Service Provider Annual Report,* which informs PHECC of clinical and other activities in their organisation. (*Calendar year).	4

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

Standard 5: Workforce Planning		
Statement – The intent here is to ensure staff are registered and trained to provide care appropriate to their role. Staff need to be trained on safety issues at the onset of employment and at regular intervals during their employment. Orientation, both organisational and role specific, should be provided to all new staff. Staff learning and professional development needs, specific to pre-hospital emergency care should be identified, documented, and addressed. A health and safety programme is concerned with protecting the wellbeing, health, and safety of people employed by the Provider.		
Criteria		**Rating Score**
5.1	There is a staffing structure developed for the Provider that identifies the number, types, and required qualifications of staff required to provide the service.	4
5.2	The Provider ensures that Practitioners are Licensed by PHECC, Credentialed, and Privileged prior to delivering pre-hospital care.	4
5.3	The Provider has a process in place to satisfy itself of the Practitioner's English language competency where English is not the Practitioner's first language.	2
5.4	The Provider ensures employees volunteers, and/or contractors understand their responsibilities in relation to the safety and quality of services.	4
5.5	The Provider has an ongoing training and development programme in place to ensure employees, volunteers, and/or contractors have the required competencies to undertake their duties in line with their scope of practice.	3
5.6	The Provider has appropriate arrangements for the management and supervision of students (if applicable).	N/A
5.7	The Provider has systems in place to promote and protect the wellbeing, health, and safety of employees, volunteers and/or contractors.	2
5.8	The Provider has processes for the performance management of employees, volunteers, and/or contractors.	0
5.9	The Provider creates opportunities for employees, volunteers and/or contractors to feedback on all aspects of the service.	2
Standard 6: Use of Information		
Statement – The intent here is to ensure that there are information management policies in place to support the Provider providing best practice patient care. All episodes of patient care should be documented, and these records audited to measure compliance.		
Criteria		**Rating Score**
6.1	The Provider ensures appropriate documentation is maintained for all patient care in accordance with the current PHECC Clinical Information Standards.	2
6.2	The Provider ensures confidentiality and security of data is protected.	1
6.3	The Provider has systems in place to measure the quality of healthcare records.	3

Pre-Hospital
Emergency Care
Council

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

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