Pre-Hospital Emergency Care Council

Governance Validation Framework

Site Assessment Report

Lindar Ambulance Services Ltd

March 2020

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

Pre-Hospital Emergency Care Council

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Executive Summary

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

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

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

The Licensed CPG Provider that is the subject of this report is Lindar Ambulance Services Ltd, a private provider of pre-hospital emergency care services based in Mayo. The on-site GVF assessment visits for this report were conducted during March 2020 by an assessment team drawn from a panel of subject matter experts selected and trained by PHECC to conduct the on-site assessments.

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

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

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

Overview of Licensed CPG Provider

Lindar Ambulance Services Ltd (Lindar) is based at Cloonkeen Cottage, Cloonkeen, Westport, Co Mayo. They provide a non-emergency ambulance service 24/7.

Overview of Licensed CPG Provider

Assessment Details:

Licensed CPG Provider	Lindar Ambulance Services Ltd
Type of Visit	Full GVF Assessment - GVFREP LIN 001_0320
Licensed CPG Provider Lead	GVFA7160
Date of Review	Practitioner Engagement - 10/03/2020 Site Assessment - 10/03/2020
Assessment Team	GVFA7106 - Team Lead GVFA4352 Onsite/Practitioner Engagement Assessor
Circumstances of this Site Assessment	Establishment of GVF programme - Transition to 3-year licensing cycle.
Relevant Recent Visits	Practitioner Engagement and On-site Assessment conducted March 2020.

Assessment Details (continued):

Licensed CPG Provider Participants

Managing Director
Medical Director (Medical Council Reg No 183073)
Clinical Lead/Advisor
Health and Safety Officer
Business Consultant
Administrator
EMT x 2

Onsite Feedback

Verbal feedback related to the GVF Assessment Team's initial findings was provided to the Executive Committee of Lindar Ambulance Services Ltd by the PHECC GVF Assessment Team Lead at the closing meeting. The GVF Assessment Team team acknowledged the low level of activity, which is attributable to a pending contract. It was identified that the absence of continuity and consistency in service provision contributes to an inability to fully embed systems but that this assessment and the resulting feedback should provide an opportunity to close existing gaps identified in the course of the on-site assessment.

A number of items were identified as areas of potential improvement. Specific reference made to medicines management and equipment checking and recording (Std 3.1.2 and Std. 3.1.3). There was agreement by all in attendance regarding the relevance and substance of the GVF Assessment Team's comments and indicative findings.

Judgement Framework

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

Theme 1

Person Centred
Care and Support

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

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

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

Lindar Ambulance Services Ltd is a private service provider with an established Executive Committee consisting of a Managing Director, Clinical Lead/Advisor, Administrator and Business Consultant. The consultant is contracted to provide advice on HR related activities and all health and safety matters. The ambulance base consists of a control/administration office, secure store, and a designated staff area that includes a communal meeting and staff room, with toilet and hand washing facilities.

1.1.1 The GVF Assessment Team observed that Lindar Ambulance Services Ltd provides a non-emergency ambulance service 24/7 with provision for one ambulance. The Provider maintains a pool of six emergency medical technicians (EMTs) who are rostered to ambulance duty. EMTs are recruited via a formal interviewing process, however there is no evidence of assessment of clinical competency in the hiring process or throughout their tenure, and there are limited performance management processes in place. Staff files were reviewed and same were filed meticulously to reflect the stages of recruitment and verification of mandatory training but with no evidence of clinical competency verification. An EMT handbook and employee safety handbook was available, however a deficit was identified in the absence of an operational handbook for EMTs to align the developed policies, procedures, protocols and guidelines to practice.

1.1.2 A policy exists for call taking, verification of address and dispatch. A 'booking form' is utilised to document pre-booked patient transfers and the retrospective 'booking forms' were available in the control office; same are audited monthly by the Clinical Lead.
A call taking protocol template was observed to identify minimum data requirements. Call details are then assigned verbally to the on-call Practitioner. A standardised approach to the call taking protocol after core office hours was not evidenced via the Practitioner Engagement as deviations exist.

There was some evidence of data collection and analysis related to the responsiveness of the Provider. Each dispatch is audited via a software system. This analysis captures delays in patient pick up and dispatch through live vehicle monitoring. Road safety is monitored via the speed tracking of the vehicle. In terms of fiscal efficiencies for the organisation, lost mileage is clearly identifiable. The outcome of the audit reports populated by the software system is disseminated verbally to the Practitioners involved.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.1.1 A comprehensive set of policies, protocols, procedures and guidelines has been developed by the Provider.

Areas for Improvement

1.1.1 The Provider should have redundancy measures in place for vehicle breakdown. The Provider confirmed that a contingency plan is facilitated by other local private Providers; an agreed memorandum of understanding would assist to formalise this contingency.

1.1.2 The Provider shall implement a competency verification process through clinical assessment at the outset of recruitment and shall embed on-going performance management systems to monitor on-going competency.
The Provider shall develop an operational handbook for EMTs to translate and align the developed policies, procedures, protocols and guidelines to operational practice.
The Provider shall develop a call taking orientation process where employees are trained and deemed competent. The Provider should consider the addition of information relating to infection status or special requirements when taking any calls in ensuring preparedness and readiness.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.2.1 Patient Consent: A policy on patient consent has been developed by the Provider. The consent procedure is listed as a mandatory audit subject annually.
Evidence of the application of the consent policy in practice was established anecdotally during the Practitioner Engagement and on-site assessment. However, Practitioner awareness of the consent policy was lacking and this identified the need for the Provider's policies, protocols, procedures and guidelines to be embedded more substantially in practice. The Provider's submitted self-assessment states that a patient identification/patient consent form is utilised, however a consent form was not identifiable on the site assessment, Practitioner Engagement or Executive Committee engagement. This finding aligns with the Provider's audit outcome of March 2019 that no consent form was used.

1.2.1 Patient Identification: Practitioners verbalised an awareness of the requirement to confirm the patient's identity. Staff stated they receive basic patient information via the booking and identify the patient on arrival at the facility's reception. Practitioners indicated that identification of the patient was reliant on the staff member within the facility leading them directly to the patient. The patient's name and date of birth are confirmed at handover. Practitioners stated that they verify the patient's capacity through their verbal interactions with staff in the handover process. No formal process for capacity assessment is instigated.

A blank Patient Care Report (PCR) was evidenced and the PCR is audited monthly by the Clinical Lead to include patient consent and identification. The monthly audit sheets were observed in a binder file in the control/administration office and the commentary regarding identified practice deficits was documented on the audit sheet in addition to the Practitioner's name and the date and content of the feedback given to the Practitioner. Recurrent deficits associated with the same Practitioner were noted on the audit sheet, which indicates the need for a formal process to address deficits in Practitioner practice.

1.2.2 The Provider reported the existence of a treatment refusal policy. This policy was not evident at assessment. Practitioners reported that refusal of transfer has not been experienced thus far.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.2.1 The GVF Assessment Team observed evidence of a culture of audit, which serves as a strong foundation to build on such processes and further enhance practice.

Areas for Improvement

1.2.1 The Provider should consider introducing an educational component at induction for Practitioners in the area of patient identification, patient consent and capacity assessment in line with the requirements of the Assisted Decision-Making (Capacity) Act 2015.
The Provider shall ensure the Practitioners confirm the patient's identity prior to transfer/dispatch, for example, verification of existing patient identifiers; patient arm band, patient name and patient date of birth.
The Provider should develop a formalised feedback mechanism to structure face-to-face feedback in addressing practice deficits appropriately with formalised quality improvement plans.

1.2.2 The Provider shall formalise refusal to treatment/transfer processes.

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

Pre-Hospital Emergency Care Council

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.3.1 The Provider clearly outlines the expectations and requirements of the Practitioners as reflected in two key policy documents; 'Ethics and Code of Behaviour' and 'Fitness to Practice'.

The Provider demonstrates organisational leadership in setting the example of expectation of Practitioners' conduct in the provision of the service and in modelling behaviours in how staff are treated. The GVF Assessment Team witnessed an explicit culture of respect towards staff that was evidenced by the interaction with Practitioners during the on-site assessment. The Provider's vision and mission statement were clearly displayed in the control/administration office.

1.3.2 Patient-centred care and respect for patients' wishes was identified as a clear value in the Practitioner Engagement. There was an expressed acknowledgement that the patient's wishes need to be upheld.

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

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

No specific observation noted by the GVF Assessment Team.

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

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

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

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

Assessment Panel Findings

1.4.1 The GVF Assessment Team evidenced the Provider's established patient satisfaction methodology in the form of the 'compliments/complaints feedback form'. There was no form available on the ambulance for use. A member of the public may submit feedback in three ways: phone, email or in writing. Practitioners were not acutely aware of this process.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.4.1 The Provider has a well-established organisational structure to shape the future of patient involvement in quality assurance; this could be enhanced further in practice by promoting feedback from patients and Practitioners.

Areas for Improvement

1.4.1 Patient feedback creates a strong platform to shape and improve future services. The Provider should consider a more formalised and embedded method for public feedback while been mindful that future patient satisfaction efforts will need to subscribe to GDPR legislation. The Provider should consider including the forms on the vehicle check-list.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

1.5.1 A suite of policy documents serve to address patient reported outcomes in the form of complaints: 'Quality and Governance Policy', 'Fitness to Practice Policy', 'Education and Training Policy' and 'Never Events Policy'.

The three stages of the Provider's complaints management process was evidenced in the self-assessment submission and verified by the Executive Committee during assessment. During Practitioner Engagement there was inconsistency noted in the Practitioners' approach regarding information on how to make a compliant. EMTs reported that if they encountered an issue resembling a complaint they would direct this to the Administrator. The incident reporting process was again facilitated via a verbal interaction with the Administrator as opposed to formal documentation via the completion of incident report forms. There was no documented evidence of any complaints received. It was reported that upon receipt of an incident or complaint the Administrator would respond formally within one week.

The Executive Committee described the cascade whereby incidents or complaints are discussed at their monthly meeting. The feedback loop to Practitioners is very ad hoc and requires a more structured formalised approach to aid continuous quality improvement and professional competency.

1.5.2 The Provider indicates that the staff induction programme provides direction on the complaints management process and expected actions. There was no evidence to support this.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

1.5.1 Crude systems exist for complaints management, which provides the foundation on which to shape and improve the service and the responsiveness of the Provider However, the link between the Provider's actual complaint management process and the Practitioners' actions requires strengthening; this is not embedded in practice.

Areas for Improvement

1.5.2 The Provider shall provide documented explicit direction to Practitioners on their operational responsibilities in the documentation and management of complaints and incidents during employee induction.
The Provider should develop planned educational sessions to update Practitioners on the expected processes around complaints and incidents management.
The Provider shall ensure on-going clinical competency through robust monitoring and assessment.

Theme 2

Effective Care and Support

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

The Provider considers only PHECC registered Practitioners for employment. The GVF Assessment Team evidenced an up to date register of Practitioners that is maintained in the control/administration office. The process of registration verification by Practitioners is managed manually and is a requirement of employment. The registration information is audited on an annual basis. The GVF Assessment Team evidenced the employee records, which were inclusive of all regulatory certifications required by Practitioners (CFR-A, manual handling, driving licence, immunisation records).

During Practitioner Engagement the equipment and medications required to implement CPG's at EMT level was assessed. Deficits in compliance were identified in respect of essential equipment in the ambulance. When queried, Practitioners stated they would notify the Administrator of any deficits post their equipment check at the start and end of their shift but no action was taken by the Practitioners to remove/replace.

Store room stock taking was managed by the Administrator. No checklist exists for the recording of stock quantities or expiry dates.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

A comprehensive set of policies, procedures, protocols and guidelines (PPPGs) are evident. These are emailed to staff for induction day. However, there is no verification process to ensure each Practitioner has read, understood and implemented same in line with individual Practitioner accountability. Additionally there is no identified cycle review established for the PPPGs as the evidence base alters in line with PHECC guidance and international best practice.

Areas for Improvement

The Provider should consider the introduction of clinical assessment in the hiring process and on-going throughout the employee's tenure to inform the training needs of Practitioners.
The Provider should consider planned Practitioner supervision in line with continuing professional development and to establish how practice is benchmarked against the policy/procedure/protocol and guideline content and required actions akin to a training needs analysis.
The Provider should consider advising Practitioners to reference the PHECC Field Guide App as they practice; this provides reassurance and verification for Practitioners and increased safety for service users.
The Provider shall involve the Medical Director in policy development and implementation (a gap exists in what is intended by the Provider and what actually happens in practice).
The Provider shall develop an equipment record log to reflect asset tracking and servicing.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.2.1 The Provider indicates the expected Standard in the handover of a patient in routine handover and in an unstable situation as evidenced by policy 'Handover of a Patient'. The formal PHECC developed handover process of IMIST-AMBO is supported by the Provider, however, observation by the GVF Assessment Team identified an unawareness of a formal handover process in practice.

The Provider uses the PHECC approved Patient Care Report (PCR) forms. The Practitioners confirmed use of same and the process is that the top copy is provided for the receiver, with the remaining copy returned to the Administrator. A PCR lock box was evident in the ambulance cabin. During Practitioner Engagement, the EMTs stated that the patient's transfer letter is opened and used to inform the PCR.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

2.2.1 The use of standardised handover system I.M.I.S.T. _ A.M.B.O is in line with best practice. Thus the Provider shall provide education on the standard handover protocol and audit its implementation.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.3.1 The vehicle 161 MO XXXX was available for inspection.
A current in-date insurance certificate and CVRT certificate were on display. There was no road tax certificate on display.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

2.3.1 The Provider shall display the road tax certificate as evidence that vehicle 161 MO XXXX is taxed in line with legislation.

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

Pre-Hospital Emergency Care Council

PHECC Statement	The Licensed CPG Provider provides an annual CPG report to the PHECC, which includes all the core components outlined in PHECC Council Rules POL003 (Section 23.1-23.10).
PHECC Requirements	2.4.1 The Licensed CPG Provider submits an Annual Medical Director report annually,* which informs the PHECC of clinical activities in the organisation and includes a CPG report (*Calendar year).

PHECC Statement	The Licensed CPG Provider undertakes an ongoing programme of clinical audit, as appropriate, which involves an appropriate combination of structure, process and outcome audits and implements the full audit cycle to support the quality improvement.
PHECC Requirements	2.4.2 The Licensed CPG Provider has a systematic programme of clinical audit in line with PHECC standards (STN019), which is used to monitor quality and outcomes and promote learning.

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

2.4.1 The Provider furnished an Annual Medical Director's Report.
The GVF Assessment Team interviewed the Medical Director who acknowledged that he recently transitioned into this new role having taken over from his predecessor. The Clinical Lead acknowledged also that with expansion of the organisation there would be more direct involvement of the Medical Director.

2.4.2 The Provider has established a clinical audit schedule. Audit is supported by a suite of policies to include the policy on clinical auditing including PCRs and the clinical and non-clinical audit plan.
A standard audit form is utilised outlining the expected process.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

2.4.2 The Provider has made significant efforts to structure their auditing approach. A related deficit is that the outputs of the audit are not cascaded to the Practitioners, thus leaving a gap in the application of policy to practice.

Areas for Improvement

2.4.1 The Provider should proactively aim to strengthen the medical governance through structured governance meetings with the Executive Committee informed by a planned structured agenda.
The Provider, in conjunction with the Medical Director, shall establish strong risk and incident management governance using a proactive risk and incident management approach.

2.4.2 The Provider, in partnership with the Medical Director, shall implement robust auditing practices that are planned or random in nature; this provides an opportunity to benchmark PHECC KPIs to practice.
The Provider shall cascade audit findings with planned dissemination of learning to Practitioners to close the existing gap.

Theme 3

Safe Care and Support

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

Pre-Hospital Emergency Care Council

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

3.1.1 Infection prevention and control (IPC): The GVF Assessment Team observed that Practitioners were not fully aware of the infection control policy and procedures. Vehicle inspection noted that the vehicle was clean and clutter free, however, the process for cleaning and decontamination was not aligned to the Provider's policy. As bookings are prearranged, ample opportunity exists for the crew to achieve appropriate levels of cleaning and decontamination. Practitioners were in uniform on the day. Daily cleaning schedule unknown to Practitioners and no evidence of a process to outline expected actions involved in a deep clean. The policy on 'single use and reusable equipment procedures' cites a monthly deep clean and directs one towards the 'deep cleaning policy' but no policy was identified during the GVF assessment. In the case of decontamination of the vehicle, it was reported that the vehicle is taken off the road to facilitate cleaning and single bookings safeguards against vehicle redundancy.

On inspection of the vehicle, the availability of personal protective equipment (PPE) was noted. The hand gel/sanitiser bottle was not secured within the cabin. There were minimal cleaning products on the ambulance and Practitioners were unaware of what products to use on specifics surfaces. Antibacterial wipes were in situ on the ambulance but an absence of disposable cloths for use with heavy soiling. Tissues were not available for patient use.
As there is no clinical waste facility at the Provider's base, clinical waste has being disposed of at facilities where patients were collected from or dispatched to. There is no memorandum of understanding relating to clinical waste or the disposal of sharps.

The Provider has a decontamination area but no surface to place contaminated items on for processing. The absence of a checklist for staff to follow protocols regarding decontamination process was noted.

3.1.2 Medicines Management: The Provider's 'Procurement of Medicines Policy' is not implemented effectively in practice. Storage, checking and replenishing/disposal of stocks was assessed with both Practitioners on the site assessment day.
The medication pouch remained sealed with the list on the outside reflecting medicines expiry dates. Upon opening the pouch, the GVF Assessment Team discovered two medication incidents;
• One anaphylactic medication was out of date – this medication is a time-critical medication (Expiry 11/19).
• Two anti-inflammatory medications were identified with two different strength presentations that increases the potential for medication error.

The Practitioners' awareness of Adverse Clinical Events (ACEs) relating to medication errors was poor and when asked to articulate the existing reporting structures for such events the Administrator was referenced as the solution to resolving identified issues with medicines or equipment.
In the absence of a checklist, the process of restocking consumables was ad-hoc.

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings Cont'd

3.1.3 Medical devices: The GVF Assessment Team verified the availability of service records for a selection of equipment. The Provider subcontracts out the servicing of medical devices and equipment. The Administrator confirmed that the medical devices were serviced but they were awaiting the service report from the contractor.

During Practitioner Engagement, it was observed that improvement was required in the testing of equipment and reporting of equipment failure, and the daily confirmation of equipment serviceability. Many items of equipment and processes were checked by the GVF Assessment Team. There were deficiencies observed regarding a number of items and processes related to equipment; these were itemised and reported to the Executive Committee.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

3.1.1 The GVF Assessment Team observed inadequate knowledge of the Provider's infection prevention control policy/procedures and recommend that the Provider increases vigilance and focus on improving the protection of patients and staff from healthcare associated infections. The Provider shall review its prevention strategies in relation to health care associated infections.
The Provider should develop a training module regarding infection prevention control to include routine and deep cleaning and decontamination.
The Provider shall compile a policy for deep clean/decontamination.
The Provider should introduce an agreed suite of suitable routine and deep cleaning products for cleaning, and an identified formulary of essential consumables.
The Provider should develop a clinical waste management strategy.

3.1.2 The GVF Assessment Team observed that medication management requires a much more stringent approach to ensure better control of process and best practice in medication management. The Provider shall review its medication management processes to include a daily checklist to record medication inspection.

3.1.3 The Provider shall establish a systematic process for scheduling equipment servicing.
The Provider shall orientate Practitioners on the familiarisation of equipment testing and usage.
A robust system should be established by the Provider to track all equipment and the maintenance records associated with them. The 'start of shift' inspection of the vehicle and equipment should be documented adequately thus identifying faulty equipment and/or expired stock.
The Provider shall implement an equipment servicing daily checklist.
The Provider shall make manufacturers' manuals available to staff.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

3.2.1 In discussion with the Executive Committee the GVF Assessment Team verified that the Provider has an identified incident reporting mechanism in place. However, a robust system of reporting adverse events and near misses was not evidenced. There is a process in place through the Executive Committee for prioritisation of an adverse incident and a cascade of investigation commences. T he feedback loop is incomplete with Practitioners reporting that they are not actively involved in ACE processes.

During Practitioner Engagement it was observed that EMTs are aware of the process of verbally reporting issues/adverse events to the Administrator, the only method of communication available, but lack an awareness of the formal procedures to report issues/ adverse events related to the ambulance, the staff or patients and in a responsive and timely manner.

3.2.2 The Provider furnished the GVF Assessment Team with an example of how the staff receive feedback regarding performance related issues, for example, staff are provided with verbal feedback on audit outcomes related to the PCR completion. ACEs are not communicated to staff in a formal way. Due to the low level of activity within the organisation it is difficult to establish if the patient safety process is effective. The Medical director is not currently involved in proactive risk assessment or risk management: this should be an area of strong consideration going forward.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

3.2.1 The Provider should develop more robust incident and risk management processes to include the expertise of the Medical Director.
The Provider shall provide staff training to increase awareness and knowledge of the expected process for incident reporting, complaints, and risk management, and establish staff training records to document the provision of training.

3.2.2 The Provider should consider the commencement of planned staff meetings for information distribution in line with CPG updates to enhance on-going competency and for the provision of feedback related to incidents/complaints/risks.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

3.3.1 The GVF Assessment Team were satisfied that the Provider has policies in place to prevent harm or abuse occurring: this was evidenced through review of employee records, which identified that relevant training had occurred to support Practitioners in this area.

During Practitioner Engagement, Practitioners demonstrated minimal awareness of their safeguarding responsibilities around vulnerable persons and child protection policy. Practitioners were unaware of the process for reporting to Tusla.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

3.3.1 The Provider shall ensure that all staff are familiar with the safeguarding policy and their statutory responsibilities around mandatory child protection.
The Provider shall provide training in the area of safeguarding of the adult and child in line with organisational guidance and statutory responsibilities.

Theme 4

Leadership, Governance and Management

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

Pre-Hospital Emergency Care Council

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

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

4.1.3 The CPG Provider is compliant with taxation laws.

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.1.1 The Provider identified the clinical governance within the organisation, which is through the Executive Committee and Medical Director. The Clinical Lead has delegated responsibility for clinical governance oversight. The Governance structure is commensurate with the needs and size of the organisation.
The GVF Assessment Team verified the Provider's structures for clinical governance, which encompass how the management team relate to the Medical Director. The Medical Director is newly appointed and during discussion showed awareness of the purpose of his role and of the contributions he can make to the clinical governance framework of the organisation going forward.

4.1.2 The GVF Assessment Team were satisfied that the Medical Director commits his on-going involvement in the organisation and plans to attend Clinical Governance meetings quarterly. The Medical Director is a practicing GP based in the local jurisdiction.

4.1.3 / 4.1.4 Evidence reviewed indicates the Provider is tax compliant and that relevant insurance is in situ.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

4.1.2 The Provider shall schedule regular clinical governance meetings with an identified agenda and recorded minutes to include the Medical Director.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.2.1 The GVF Assessment Team observed that the Provider has some systems and processes in place to support safety and quality improvement throughout the organisation. Applicability of identified processes to practice warrants improvement in terms of the formal reporting of safety incidents by Practitioners and the 360 degree feedback loop from management to Practitioners.

During inquiries the GVF Assessment Team observed evidence of audit in 20 areas of practice, with monthly audit of call taking and PCR use, and a manual system that supports Practitioner registration.

Due to the low level of operations, there are too few cases completed by the Provider to assess the quality and safety of the service provided.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

4.2.1 The Provider, in partnership with the Medical Provider, shall implement expanded auditing practices that are scheduled or random in nature; this provides an opportunity to benchmark PHECC KPIs to practice.
Robust incident and risk management processes contribute to continuous quality improvement: the Provider shall implement appropriate incident and risk management systems.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.3.1 The Provider has communicated compliance with statutory legislation through systems, processes and procedures. Evidence of compliance was observed through review of employee records, confirmation of insurance and tax compliance and evidenced by the suite of PPPGs that the Provider has developed to align practice against legislative requirements. The practical application of developed PPPGS to practice requires attention.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

4.3.1 The Provider should strengthen the risk management process with the development of a risk register to identify compliance gaps.
The Provider shall demonstrate enhanced commitment to the on-going competency of its workforce, supported by processes that ensure real time training records are available to management.
The Provider should establish a performance management system and a Practitioner supervisory programme to support the provision of safe and effective care.

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

Pre-Hospital Emergency Care Council

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

4.4.1 Due to the nature of the periodic work of the Practitioners with the Provider, a regular, planned staff briefing forum is not established. Thus communication channels with staff tend to be ad-hoc. The staff handbook is available in the staff communal area ,which is very much orientated to the vehicle. However, a deficit was identified in the absence of an operational handbook for EMTs to align the developed PPPGs to practice for the Practitioners. There is no formal process to communicate CPG amendments or updates. The notice board in the staff rest area facilitates circulation of updates and staff communication but there is no process in place to ensure staff has read and understood same.

4.4.2 The GVF Assessment Team were satisfied that the Provider has complied with the PHECC Governance Validation Framework and provided all material requested in this process.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

4.4.1 The Provider should consider the setup of regular face-to -face staff briefings to communicate practice related changes, updates and organisational feedback.
The Provider should consider alternative ways to communicate and adopt new recommendation and guidance issued by the PHECC and other regulatory bodies for example, a specific email address could be issued to employees to aid the flow of information and aid CPD. Consideration should be given to a staff newsletter.
The Provider should consider an audit trail to provide assurance that information disseminated is being received and understood by staff.

Theme 5

Workforce

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

Pre-Hospital Emergency Care Council

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

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

Assessment Panel Findings

5.1.1 The GVF Assessment Team strongly acknowledges the challenges that the Provider encounters in sustaining activity levels pending contracting, which is impacting its ability to deliver its longer-term strategic plan.
The Provider demonstrated a sufficient staff compliment to match activity levels.
In aligning resources to need, the Provider does not have a clinical assessment element to the hiring process and the on-going maintenance of professional competence.
With a longer-term strategic plan in mind, the Provider has succession planning at the forefront of their business continuity plans.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

The Provider has a pool of six EMTs who are rostered according to the demand for the services of the Provider in the pre-hospital environment.

Areas for Improvement

5.1.1 The Provider should adopt a robust recruitment process that focuses on all aspects of the qualities and competencies expected of a Practitioner, with patient safety at the forefront.
The Provider should introduce on-going clinical assessment/performance management for all employees.

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

Pre-Hospital Emergency Care Council

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.2.1 All Practitioners currently employed by the organisation have English as their first language.

5.2.2 The GVF Assessment Team was satisfied that the Provider has a recruitment process in situ to verify applicant's credentials. A manual system is in place that files, records and tracks all registrations and has a mechanism in place for Practitioners to annually confirm their PHECC registration status.

5.2.3 Employee records were verified by the GVF Assessment Team who confirm that the Provider has a system in place to confirm relevant qualifications and registrations of all employees reflecting Practitioner privilege status. A training record would be a worthwhile consideration.

5.2.4 Garda vetting is carried out by the Provider in accordance with the requirements of the National Vetting Bureau. The GVF Assessment Team verified the Provider's compliance in this area and reviewed the vetting records.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

The GVF Assessment Team were satisfied with the evidence presented of information governance in relation to Practitioner registration and training, and adherence with the current legislation related to vetting of staff.

Areas for Improvement

No specific observation noted by the GVF Assessment Team.

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

Pre-Hospital Emergency Care Council

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

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

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.3.1 A documented programme for the induction of employees is evidenced by the policy on 'Induction Day Programme'. The programme outlines employees' core responsibilities in relation to safety and quality of the service, however, there was clear evidence that Practitioners were unaware of certain key elements and processes relating to their responsibilities, for example, medical equipment checks, medication management and checking, cleaning and decontamination processes, infection prevention control procedures, call taking protocols and incident reporting.
Induction attendance records were not reviewed by the GVF Assessment Team.

Staff are required to adhere to a documented Code of Conduct.

5.3.2 It was noted that no formal process exists for the identification of training and developmental needs of staff.

5.3.3 Not Applicable to this Provider.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

5.3.1 The Provider should consider more comprehensive induction to incorporate the suite of PPPGs and seek staff verification of knowledge competence around same.

5.3.2 The Provider should develop a supervision platform to assess clinical competency and address competency gaps, this would support staff in identifying their continuing professional competency requirements.
The Provider should develop a training and development plan that details how the Provider will meet the on-going training and development needs of staff. A training record would be a worthwhile verifying tool.
Provision of mentorship and/or supervision for new recruits should be developed.
A formalised appraisal system with staff should be established to include personal development plans, which also supports staff to identify their continuing professional competency requirements.

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

Pre-Hospital Emergency Care Council

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

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

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

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

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

5.4.1 A Critical Incident Stress Management Programme is available via a consultancy firm and accessible to staff. The existence of this service was verified by Practitioners during the Practitioner Engagement and staff were aware of the process to access it. The Provider has no evaluation process to assess the effectiveness of CISM interventions with staff either formally or informally.

It was noted that the Executive Committee has a close relationship with staff, and management state that they would be made aware of any incident in order to follow up and support any welfare issues.

5.4.2 There are no active fitness to practice cases in the organisation currently.
Audit results were evident during the visit to the control/administration office. It was evident that recurrent variances in practice, for example in PCR completion, are verbally addressed with the Practitioner. However, no formal route was employed to address any recurrent practice deficits.

5.4.3 In the absence of an appraisal process, the Provider does not have a system for monitoring staff competence and appropriate CPG implementation. The Provider has not yet established a training schedule of CPD and the responsibility of up-skilling remains with the Practitioners. The Provider does have a patient feedback form with multiple methods of contact (paper, phone, email), this could potentially identify poor performance related to a complaint submission.

5.4.4 Practitioners reported that if they encountered an issue resembling a complaint/near miss/adverse event they would direct this to the Administrator. The incident reporting process was again facilitated via a verbal interaction with the Administrator as opposed to formal documentation via the completion of incident report forms. There was no documented evidence of any complaints received. It was reported that upon receipt of an incident or complaint the Administrator would respond formally within one week.

5.4.5 The Provider has a whistleblowing policy that protects disclosures in practice. Employees are aware of whom they report concerns to and Practitioners indicated that they can do so without fear of adverse consequences to themselves.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

No specific observation noted by the GVF Assessment Team.

Areas for Improvement

5.4.3 The Provider should introduce clinical scenarios or assessments as field learning facilitated by an appropriate person. Formal appraisal is an important pillar of the continuous quality improvement process and should be embedded into the practice of the organisation.

5.4.4 The Provider shall provide documented explicit direction to Practitioners on their operational responsibilities in the documentation and management of complaints and incidents during employee induction.

5.4.4 The Provider should develop planned educational sessions to update Practitioners on the expected processes around complaints, incidents and risks management.

5.4.5 The Provider should develop a 360 degree communication pathway to inform staff of audit results so as to align findings to competency gaps and/or compliance gaps and empower staff to flag areas of concern.

Theme 6

Use of Information

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

Pre-Hospital Emergency Care Council

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

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

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

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

Pre-Hospital Emergency Care Council

Assessment Panel Findings

6.1.1 The Provider demonstrated that systems, processes and procedures are in place to assure satisfactory implementation of information governance and the effective management of healthcare records. There was substantive evidence of compliance with GDRP in the security, management and storage of Patient Care Reports (PCRs). A lock box for the PCR exists in the ambulance cabin. Upon cessation of shift, PCRs are returned to the control/administration office for safe keeping, auditing and filing. Practitioners described how they manage the PCR; top copy to receiver, second copy retained for the Provider.

The Provider's clinical records management policy is in line with PHECC requirements and the Data Protection Act 2018. The GVF Assessment Team observed clinical PCRs and note that they are stored securely in the control/administration office.

6.1.2 The Provider's Clinical Lead has an established process in place to ensure clinical records auditing. Data captured from clinical records auditing is fed back to staff to improve quality.

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

Pre-Hospital Emergency Care Council

Areas of Best Practice

The Provider's Clinical Lead audits every PCR and provides commentary for the Practitioner in line with continuous quality improvement.

Areas for Improvement

6.1.1 The Provider should consider including data protection/GDPR/record management in the induction day programme with those topics being revisited periodically through on-going training.

6.1.2 The Provider shall introduce a formal process for addressing re-occurring documentation issues. The Provider shall provide feedback for Practitioners on the outcomes of audit example documentation audit of PCR.

Report Summary

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

Judgement Framework Level	External Assessment Assigned Level	Percentage
Not Applicable	1	2.3%
Not Met	2	4.6%
Minimally Met	10	23.3%
Moderately Met	10	23.3%
Substantively Met	6	14%
Fully Met	14	32.5%

GVF Site Assessment Summary -Lindar Ambulance Services ltd

	PHECC Requirement	Compliance level
Theme 1: Person-Centred Care and Support	**Standard 1.1 Patients have equitable access to healthcare services based on their assessed needs.**	
	1.1.1 The Licensed CPG Provider has systems, processes and procedures for the timely and clinically appropriate response to provide safe care and treatment to patient population they serve.	**Substantive**
	1.1.2 The Licensed CPG Provider has systems, processes and procedures in place for taking calls, verifying addresses and dispatch to call.	**Moderate**
	Standard 1.2 Patients' informed consent to care and treatment is obtained in accordance with legislation and best available evidence.	
	1.2.1 The Licensed CPG Provider has systems, processes and procedures, developed in line with best practice for patient consent and/or patient identification (which includes guidance for practitioners) in line with the PHECC Code of Professional Conduct & Ethics.	**Moderate**
	1.2.2 The Licensed CPG Provider has a policy/procedure in place in relation to the refusal of treatment and/or transport.	**Moderate**
	Standard 1.3 Patients' dignity, privacy and autonomy are respected and promoted.	
	1.3.1 The Licensed CPG Provider has arrangements in place to promote patients' privacy, dignity and autonomy.	**Fully Met**
	1.3.2 The Licensed CPG Provider demonstrates a commitment to develop a culture where volunteers, contractors and/or employees involve and treat people with compassion, kindness, dignity and respect.	**Fully Met**
	Standard 1.4 Licensed CPG Providers promote a culture of kindness, consideration and respect.	
	1.4.1 The Licensed CPG Provider undertakes Patient Satisfaction and/or Patient Experience Surveys to help shape and improve services and culture.	**Substantive**
	Standard 1.5 Patients' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	
	1.5.1 Patients' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	**Moderate**
	1.5.2 The Licensed CPG Provider provides training to all front-line volunteers, contractors and/or employees in handling a patient or family member's complaint or concern.	**Minimal**
Theme 2: Effective Care and Support	**Standard 2.1 Healthcare reflects national and international evidence of what is known to achieve best outcomes for patients.**	
	2.1.1 The Licensed CPG Provider has systems, processes and procedures in place to ensure Responders/Practitioners utilise the evidence-based CPG appropriate to their privledged status to deliver and ensure safe and appropriate care.	**Not Met**
	Standard 2.2 Patients receive integrated care, which is coordinated effectively within and between services.	
	2.2.1 The Licensed CPG Provider has a standardised handover process in place to ensure the safe, timely, and structured exchange of information during handover of patients.	**Minimal**
	Standard 2.3 Healthcare is provided in a physical environment, which supports the delivery of high-quality, safe, reliable care and protects the health and welfare of patients.	
	2.3.1 The Licensed CPG Provider has process, systems and procedures in place to ensure the road-worthiness of their patient transport vehicles in line with legislation.	**Minimal**
	Standard 2.4 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	
	2.4.1 The Licensed CPG Provider submits an Annual Medical Director Report annually,* which informs the PHECC of clinical activities in the organisation and includes a CPG report (*Calendar year).	**Fully Met**
	2.4.2 The Licensed CPG Provider has a systematic programme of clinical audit in line with the PHECC standards (STN019), which is used to monitor quality and outcomes and promote learning.	**Moderate**

Theme 3: Safe Care and Support	**Standard 3.1 Licensed CPG Providers protect patients from the risk of harm associated with the design and delivery of healthcare services.**	
	3.1.1 The Licensed CPG Provider has a reliable system in place to prevent and protect patients and staff from healthcare associated infections.	**Minimal**
	3.1.2 The Licensed CPG Provider ensures that there are systems, processes and procedures in place to ensure medicines availability, storage, stocking and disposal processes for the administration of pre-hospital emergency care.	**Minimal**
	3.1.3 The Licensed CPG Provider ensures that there are systems, processes and procedures in place to ensure equipment/medical device availability, storage, stocking and disposal for the administration of pre-hospital emergency care.	**Not Met**
	Standard 3.2 Licensed CPG Providers effectively identify, manage, respond to and report on patient-safety incidents.	
	3.2.1 The Licensed CPG Provider has structured incident reporting and investigation mechanisms, which support and encourage volunteers, contractors and/or employees to report adverse events, near-misses and no-harm events.	**Minimal**
	3.2.2 The Licensed CPG Provider has a process for the sharing of lessons learned from patient safety incidents (including adverse events, near misses and no-harm events) and complaints, which have occurred locally, nationally or internationally with employees, contractors and/or volunteers.	**Minimal**
	Standard 3.3 Licensed CPG Providers ensure all reasonable measures are taken to protect patients from abuse.	
	3.3.1 The Licensed CPG Provider has policies/procedures in place to prevent harm or abuse occurring and take action where concerns arise.	**Moderate**
Theme 4: Leadership, Governance and Management	**Standard 4.1 Licensed CPG Providers have clear accountability arrangements to achieve the delivery of high-quality, safe and reliable healthcare.**	
	4.1.1 The Licensed CPG Provider has an established reporting and accountability structure for clinical governance.	**Substantive**
	4.1.2 The Licensed CPG Provider has an identified Medical Director who is registered with the Medical Council and who is based in this jurisdiction and who oversees the service.	**Fully Met**
	4.1.3 The CPG Provider is compliant with taxation laws.	**Fully Met**
	4.1.4 The Licensed CPG Provider has documentary evidence of the required insurance policies.	**Fully Met**
	Standard 4.2 Licensed CPG Providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	
	4.2.1 The Licensed CPG Provider has systems, process and practices in place to utilise safety and quality information to highlight areas of improvement and improve the quality and safety of the service.	**Moderate**
	Standard 4.3 The conduct and provision of healthcare services are compliant with relevant Irish and European legislation.	
	4.3.1 The Licensed CPG Provider has systems, processes and procedures in place to ensure compliance with statutory legislation relating to the provision of safe and effective care.	**Substantive**
	Standard 4.4 Licensed CPG Providers act on standards and alerts and take into account recommendation(s) and guidance, as formally issued by relevant regulatory bodies as they apply to their service.	
	4.4.1 The Licensed CPG Provider has a process in place to ensure the appropriate communication and adoption of new recommendation(s) and guidance issued by the PHECC and other regulatory bodies.	**Moderate**
	4.4.2 The Licensed CPG Provider is compliant with the PHECC Governance Validation framework.	**Fully Met**

Theme 5: Workforce	**Standard 5.1 Licensed CPG Providers plan, organise and manage their workforce (volunteers, contractors and/or employees) to achieve the service objectives for high-quality, safe and reliable healthcare.**	
	5.1.1 The Licensed CPG Provider undertakes workforce planning to align resources to current workload and projected needs.	**Substantive**
	Standard 5.2 Licensed CPG Providers recruit/engage with practitioners with the required competencies to provide high-quality, safe and reliable healthcare.	
	5.2.1 The Licensed CPG Provider has a process in place to satisfy itself that the English language competence of its Responders and Practitioners, whose first language is not English, is appropriate to the clinical/ professional activities to be carried out by that person i.e. Responder or Practitioner levels.	**Fully Met**
	5.2.2 The Licensed CPG Provider has a process in place to check registration on appointment and on-going renewals of registration for volunteers, contractors and/or employees.	**Fully Met**
	5.2.3 The Licensed CPG Provider conducts checks to confirm that all employees, contractors and/or volunteers have the appropriate qualifications and registrations.	**Fully Met**
	5.2.4 The Licensed CPG Provider ensures that employees, contractors and/or volunteers are subject to Garda Vetting in line with the National Vetting Bureau (Children & Vulnerable Persons) Act 2012 prior to patient contact.	**Fully Met**
	Standard 5.3 Licensed CPG Providers ensure their workforce (volunteers, contractors and/or employees) have the competencies required to deliver high-quality, safe and reliable healthcare.	
	5.3.1 The Licensed CPG Provider has developed and implemented a comprehensive induction programme to ensure volunteers, contractors and/or employees understand their responsibilities in relation to the safety and quality of services.	**Moderate**
	5.3.2 The Licensed CPG Provider has a training and development programme in place to ensure volunteers, contractors and/or employees have the required competencies to undertake their duties in line with their registered status.	**Minimal**
	5.3.3 The Licensed CPG Provider has appropriate arrangement for the management, supervision and performance management of students (if applicable).	**Not Applicable**
	Standard 5.4 Licensed CPG Providers support their workforce (volunteers, contractors and/or employees) in delivering high-quality, safe and reliable healthcare.	
	5.4.1 The Licensed CPG Provider has a Critical Incident Stress Management process in place.	**Fully Met**
	5.4.2 The Licensed CPG Provider has a Fitness to Practice Policy/Procedure, which makes reference to the PHECC Fitness to Practice processes.	**Fully Met**
	5.4.3 The Licensed CPG Provider has processes for the identification of poor or variable staff performance.	**Minimal**
	5.4.4 The Licensed CPG Provider improves patient safety by encouraging and supporting employees, contractors and/or volunteers in the reporting and learning from patient safety incidents (including adverse incidents, near misses and no-harm events).	**Minimal**
	5.4.5 The Licensed CPG Provider creates opportunities for staff to feedback on the quality and safety of the service they work in.	**Substantive**
Theme 6: Use of Information	**Standard 6.1 Licensed CPG Providers have effective arrangements in place for clinical information governance.**	
	6.1.1 The Licensed CPG Provider implements the PHECC clinical information standards and associated patient reports.	**Fully Met**
	6.1.2 The Licensed CPG Provider has systems, processes and procedures in place to assure the data quality of healthcare records.	**Moderate**

Report Summary

Report Status

In accordance with the Council rules this GVF site-assessment does trigger a requirement for PHECC to issue an improvement notice regarding the Provider's service.
Council Rules for pre-hospital emergency care service providers who apply for recognition to implement Clinical Practice Guidelines (POL003 V6) outlines that, where appropriate, full recognition to implement CPGs will be awarded for a three (3) year period. This approval will apply from the last approval date.

Quality Improvement Plan

Lindar Ambulance Services Ltd are required to submit their quality improvement plan to PHECC. The quality improvement plan will encompass the findings outlined in this report and any other planned quality improvement or organisational development initiatives to be undertaken in the upcoming licensing period.

Pre-Hospital Emergency Care Council

Report Summary

Improvement Notice

This section highlights specific actions to be taken by Lindar Ambulance Services Ltd with immediate effect.

Be advised that all other recommendations, made in the body of the report, should also be observed and actioned in the follow up quality improvement plan.

Lindar Ambulance Services Ltd shall:

1. Increase focus on planned clinical supervision and seek to further involve the Medical Director in policy development and implementation, clinical governance and auditing, risk management (Std. 2.1.1 / 2.4.1).

2. Take steps to improve Practitioners' awareness and implementation of the Provider's infection prevention control and adverse clinical events (ACEs) policy/procedures (Std. 3.1.1).

3. Implement the policy for deep clean/decontamination (Std. 3.1.1).

4. Develop a clinical waste management strategy (Std. 3.1.1).

5. Increase focus on the implementation of the Medicines Management process and supervision related to storage, checking and replenishing/disposal of stock (Std. 3.1.2).

6. Improve the processes and procedures related to equipment checking, monitoring and maintenance, to also includes reporting, identification and correction of faults, monitoring and recording of servicing and other relevant matters (Std. 3.1.3).

7. Ensure that all staff are familiar with the safeguarding policy and their statutory responsibilities around mandatory child protection (Std. 3.3.1).

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