Governance Validation Framework

Assessment Report

St John Ambulance Ireland

August 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

Table of Contents

CONTENTS

1. Quality Assurance at The Pre-Hospital Emergency Care Council 04

2. Assessment Report Overview and Validation 05

3. Assessment Particpants 06

4. Initial Feedback Given 06

5. Rating Scale and Outcome Rating 06

6. Weighting Tolerance 07

7. Outcome Rating 07

8. Assessment Findings 07

   Standard 1: Person-Centred Care and Support 08

   Standard 2: Effective Integrated Care and Safe Enviroment 18

   Standard 3: Safe Care and Support 29

   Standard 4: Leadership and Governance 38

   Standard 5: Workforce Planning 45

   Standard 6: Use of information 55

9. Report Outcome and Rating Summary 59

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 (CPG) 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 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.

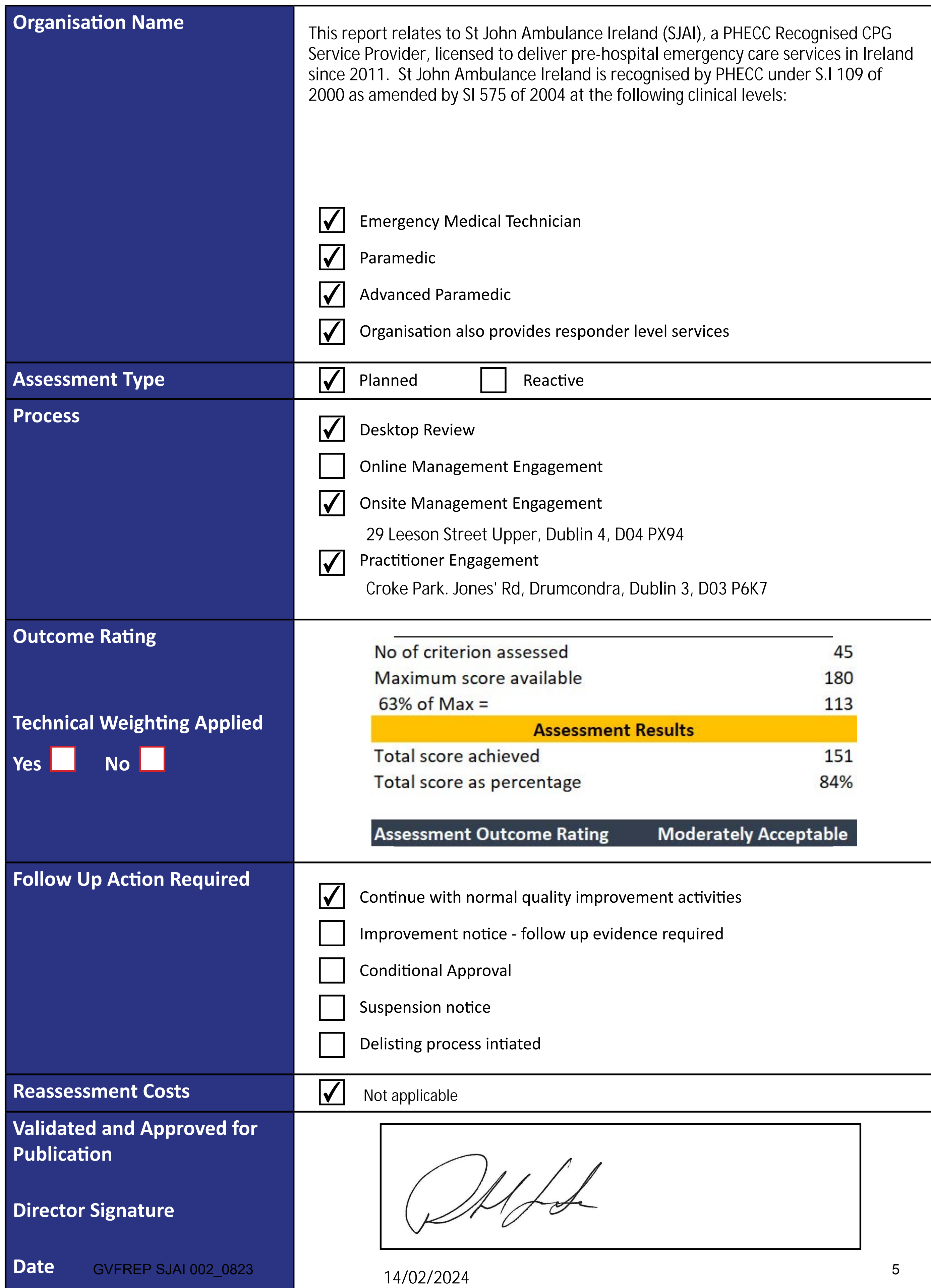
The GVF and the QRF relate to specific standards and identify the supporting components that PHECC recognised CPG service providers and approved organisations should have in place to ensure good governance and quality in delivery of education, pre-training, and operational hospital emergency care with 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 St John Ambulance Ireland (SJAI), a PHECC Recognised CPG Service Provider, licensed to deliver pre-hospital emergency care services in Ireland since 2011. St John Ambulance Ireland is 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 29 Leeson Street Upper, Dublin 4, D04 PX94 ☑ Practitioner Engagement Croke Park. Jones' Rd, Drumcondra, Dublin 3, D03 P6K7
Outcome Rating **Technical Weighting Applied** **Yes** ☐ **No** ☐	No of criterion assessed: 45 Maximum score available: 180 63% of Max = 113 **Assessment Results** Total score achieved: 151 Total score as percentage: 84% **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**	[signature]
Date	14/02/2024

3. Assessment Participants

Organisation	PHECC Assessment Team
Commissioner and Deputy Commissioner Communications Director	Team Lead
Head of Training, Development and Safeguarding Medical Director (Medical Council Reg No 182531)	Onsite Assessor
Director of Regions and Director of Operations Logistics Manager Leinster and Quality Manager	Practitioner Engagement Assessor
Operations and Medications EMT Programme Lead, Practitioners	

4. Initial Feedback Given

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

The following areas were identified as areas requiring improvement, or further potential for improvement areas: patient feedback mechanisms, introduction of the new complaints policy along with member education on making complaints, review of the organisation's audit programme and dissemination of results, continuing to recognise and record near-misses in terms of medication administration and equipment use, review of Patient Care Reports (PCR) storage and audit.

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.
**Not applicable criterion will not be considered in these calculations.*

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

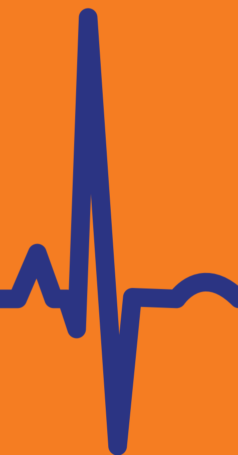
The following are points of note:

- 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

The terms staff, members and practitioners will be used interchangeably throughout this report.

The Provider has a comprehensive Event Management Policy and plan that involves engagement with event organisers. A detailed proforma information sheet and a risk assessment is completed by event organisers in conjunction with the Provider prior to booking of events, thus ensuring appropriate services are provided to match the identified needs of the event in question. An example of one such policy was reviewed by the Assessment Team.

The Provider has appointed an Events Manager to handle bookings at regional / divisional level and ensure they have adequate resources prior to committing cover at events.

The Provider has commenced data collection from recurring events e.g. patient type and numbers treated, to assist with future planning and more accurately determine the needs of such events and to ensure they are appropriately met.

Area(s) of Good Practice

The Provider utilises a comprehensive event management planning system and a forward-thinking approach with the introduction of event data collection to ensure provision of appropriate care at events.

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 Assessment Team reviewed the Provider's Equality and Diversity Policy.

During Practitioner Engagement staff were noted to have an inclusive approach when dealing with patients.

The Provider is currently developing a Vulnerable Adults Policy to sit alongside their Child Protection Policy. Development and training on this policy will be forthcoming to members.

Additionally, a new Welfare Lead role has been appointed, to consider the needs of both the Provider's members and the patients they treat.

Area(s) of Good Practice

The Assessment Team observed no evidence of discrimination and a proactive approach by the Provider on this issue. The development of both a Vulnerable Adult Policy and a Welfare Lead are positive steps to ensure these areas remain to the fore.

Area(s) for Improvement

The Provider should complete the development of the Vulnerable Adult Policy and its implementation.

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 detailed Radio Communications Policy in place.

The Provider uses Tetra and UHF radios depending on the event type and the Assessment Team observed knowledgeable use of these radios. Communication pathways were observed to be clear and accurate.

Procedures and training are reinforced prior to an event commencing at local level. Dispatch of practitioners at events is through the Event Medical Controller or the Co-ordinator depending on the size or complexity of the event.

Transfer Policy at an event will depend on skillset available and the presence or otherwise of other agencies.

Area(s) of Good Practice

HIgh quality use of the mobile radio system was observed to ensure the transmission of confidential information was streamlined during events.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

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

Patient Identification Policy was reviewed within the Provider's Ambulatory Care Report (ACR) and Patient Care Report (PCR) Document Completion Policy. Robust practices in relation to patient identification were observed during the Practitioner Engagement and there was high quality adherence to the organisational policies relating to patient identification and consent.

Area(s) of Good Practice

The Assessment Team observed good practice argarding patient identification.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

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

Policies in relation to informed consent were evidenced by the Assessment Team in the Provider's ACR and PCR Document Completion Policy as well as in the Duty Handbook.

Observations at the Practitioner Engagement revealed a high level of consistency in how members gained consent across multiple patient interactions.

Area(s) of Good Practice

A robust policy and training exists around informed consent.

Area(s) for Improvement

The Provider may benefit from having a standalone policy for informed consent.

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

As with patient identification, refusal to treat / transport is covered within the Provider's ACR and PCR Document Completion Policy.

Refusal of transport scenario was observed on several occasions at the Practitioner Engagement, and members adhered to the protocols in place by the Provider.

Good documentation surrounding refusal to transport was noted during the Practitioner Engagement.

Area(s) of Good Practice

Policies relating to both refusal to treat / transport were of a good standard and observed practice was evidence of adequate training in this area.

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

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

Assessment Findings

The area of compassion, respect and dignity is covered in the Provider's Equality and Diversity Policy.

A culture of compassion, respect and dignity was evident throughout the organisation and actively promoted by the Provider.

The Provider actively encourages members to raise any concerns they may have and there is a Whistleblower Policy that fully details this approach. There is a code of conduct included in the Provider's learner and on duty handbooks, which are available to each member.

Area(s) of Good Practice

There is an open approach to members raising concerns relating to issues regarding dignity, respect, and breaches in the code of conduct.

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

It appeared to the Assessment Team that seeking feedback was not a consistent feature within the Provider's organisation.

While there are mechanisms in place with an online feedback form, actively engaging with patients to seek feedback is not routinely undertaken, and members' understanding of this process appears to be lacking.

There has been a recent engagement with stakeholders to review this area with the hope of addressing the shortfall in a dynamic and progressive way. An example of using QR codes in the ambulance was being considered.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should take a proactive approach to gaining feedback, ensuring the process is visible, easily accessible, and importantly ensuring members are familiar with the policy and receive adequate training to support their patient interactions to gain feedback.

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

A Complaints Policy was reviewed by the Assessment Team including a recent infographic outlining the flowchart used. The policy sets out what appears to be a transparent process. No examples of real-life complaints were observed.

A timeframe after which a report must be submitted to the Commissioner was noted. There appears to be a process in place with a Complaints Lead and Team to whom the investigation may be appropriately assigned. An appeals process is in place.

It was noted complaints may come from a patient, a member of the public, or within the Provider's organisation itself.

Area(s) of Good Practice

The Provider is in the process of reviewing the complaints procedure and has a clear outline of what this process looks like with clear responsibilities and transparency.

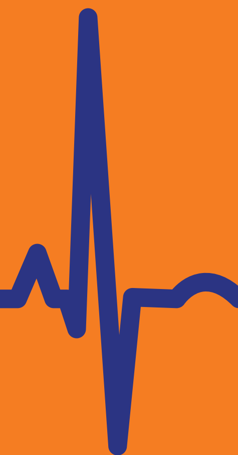
Area(s) for Improvement

The Provider should continue to focus on patient feedback mechanisms to further enhance the Provider's services and their approach to dealing with patients who may have had a negative interaction with the Provider.

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 Provider has completed CPG upskilling for all practitioners.

During Practitioner Engagement, a full range of available equipment and medications appropriate to practitioners' skill level was observed. Additional clinical support was also noted to be always available to members.

The Assessment Team reviewed individual Privileging Letters and Certificates of Training, which are recorded and stored online under a two-factor authentication process. Online records are managed by Divisional Administrators with a new system currently being rolled out online, with back up processes remaining in place in the interim.

Area(s) of Good Practice

The Provider has up to date training and recording of CPG status with observations on the ground matching the administrative records.

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 provides training to EMT on the IMIST-AMBO handover process. which was observed to be effective during the Practitioner Engagement, and identified good training and operational practice.

While there is no formal audit process on patient handover, a mentoring system exists with professional members within the Provider's organisation offering support and training locally and during hospital handovers, particularly when supporting the statutory ambulance services.

Area(s) of Good Practice

Effective patient handover process observed.

Area(s) for Improvement

The Provider would benefit from adding patient handover processes to their potential list of audit topics to identify any areas of improvement in this area.

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 Assessment Team discussed the vehicle checks with the Provider and noted these are completed every 6 months, with a yearly service report available online on a proprietary software system, including servicing dates. Pre-CVRT checks are complete on all vehicle in advance of the CVRT.

Road tax, insurance and CVRT dates were checked and in order during Practitioner Engagement.

The Assessment Team reviewed the Provider's policy for Ambulance equipment and medication checks to match each practitioner skill level. During Practitioner Engagement ambulances were noted to be well stocked with a system in place for checking equipment and medications prior to any duty.

A contractor provides annual checks of vehicles and equipment that requires engineering certification.
It was noted that ambulances turnover generally occurs after 15 years with most ambulances being re-purposed from the statutory ambulance services.

Area(s) of Good Practice

Policies and procedures are in place to ensure adequate monitoring of vehicles, equipment, and medications on a regular basis.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

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

The Assessment Team reviewed the Ambulance Driving Policy, which references the Emergency Services Driving Standard and the Road Safety Authority. There are two trained Road Safety Authority (RSA) instructors and there is a new policy under development that will include Blue Light Training.

Training includes Emergency Services Driving Standard Levels 1 – 3 and ranges from competent to drive an ambulance up to Level 3, Blue Light.

Online records in relation to driver training are maintained.

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 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

This is covered by the Provider under their Ambulance Driving Policy and clearly references the RSA drivers' guide in relation to Blue Light driving.

During Practitioner Engagement related queries indicated that members' understanding of the Blue Light Policy was not universal.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should ensure all members are aware of and have received appropriate training in the use of emergency lights and sirens.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider has a Divisional Premises Risk Assessment Policy that outlines an annual requirement to conduct a risk assessment of all premises used by the members.

There is a risk assessment form available for use within each division and these forms are submitted for review and action. Risk assessment training has been recently completed to facilitate members to improve the individual premises annual review process, and identification of other organisational risks.

The Assessment Team viewed a newly compiled risk management list, to identify and mitigate risk through training and resourcing.

Risk assessment also forms an important part of the Provider's event venue risk assessment, particularly for those venues where the Provider is regularly contracted to provide cover. It was noted on Practitioner Engagement that the risk assessment for this site was thorough with staff well trained and familiar with the site.

Area(s) of Good Practice

Risk assessments, including physical and fire safety plans, are regularly updated both at the Provider's venues and event venues.

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

The Assessment Team viewed a comprehensive new strategic plan for the Provider and a presentation was provided during the onsite engagement. This plan comprehensively addresses future business continuity in a very inclusive and transparent way.

The Commissioner and Medical Director are current leads for Strategic Planning and the Clinical Advisory Group. There is an Operational and Divisional restructure planned to address inconsistencies and ensure viability of smaller units, with focus on compliance, membership, and finance. All events are managed through headquarters, which can facilitate regions in providing better support to divisions, depending on their needs.

National Headquarters staff now includes a Business Manager and IT support staff to support the transition to online systems, and improve the modernisation and robustness of the Provider. Risk mitigation during the online transition is to include more secure, less cumbersome IT systems that are cloud based.

Area(s) of Good Practice

The Assessment Team recognises that the Provider is amid a period of transition and compliments that they have prioritised business continuity and taken steps to restructure and support regions and divisions.

Area(s) for Improvement

The Assessment Team encourages the Provider to continue and follow through on the steps noted in findings above.

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

The Assessment Team notes that major incident planning is covered in the Provider's Event Management Policy. The Provider has a clearly defined hierarchical structure, known by all members, which lends itself to efficient management of resources and ability to efficiently react to situations.

The Provider works regularly at events with multi-agency service Providers and has robust communications in place with the various national bodies in the event of major incident planning or mobilisation being necessary.

Area(s) of Good Practice

Robust systems for multi-agency communications are in place, alongside the Provider's own plans for major incidents at events.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

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

Discussion took place between the Assessment Team and the Provider's Management Team around their audit programme. To date, audits have focused primarily on the logistical and administrative aspects of the Provider's organisation with less focus on clinical audit.

Audits to date have included PCR/ACR review, with a sense from members on the ground that knowledge surrounding audit and dissemination of any findings has not been well coordinated or communicated. However, it was encouraging to hear and view plans for future audit programmes that stems from the re-structuring of the Provider's organisation and audit has its own heading in the area of compliance for each division.

A new audit team is being developed to centrally coordinate and review the audit programme, with an audit lead and training of members to form compliance teams. A novel score card system for compliance with audit will be introduced in divisions to assist with monitoring.

The audit lead will report to the Clinical Advisory Group who will in turn formulate the audit programme. The Clinical Advisory Group will dictate clinical audit topics to include both clinical and operational audits. Audit findings will be fed from the Clinical Advisory Group to the Medical Directorate, following which findings and actions will be disseminated to members, using online IT solutions.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should include clinical audit topics in their audit programme, which may be determined by the reporting of adverse events and/or complaints, and highlights the importance of dissemination of findings and actions arising out of the audit process to their members.

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 the Annual Report ,which was evidenced and reviewed by the Assessment Team. The process surrounding the writing of the report appears to be transparent with various teams feeding in relevant information to the Medical Director.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

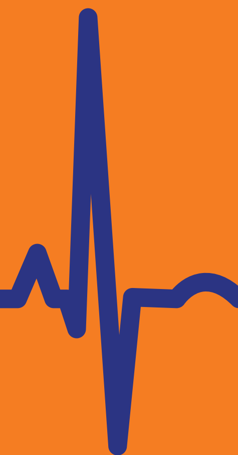
Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 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

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

Assessment Findings

The Assessment Team were satisfied that a comprehensive Infection Prevention and Control Policy is in place. There are plans to appoint an Infection Prevention and Control Lead with a nursing or medical background to review organisational policies and practices.

Training is incorporated into all practitioner levels and there was positive feedback from the Practitioner Engagement, remarking on the standard of cleanliness of the vehicles. The Provider was noted to use the statutory ambulance services step by step cleaning guidelines, which were deemed positive, with disinfection wipes and appropriate cleaning material being used.

During Practitioner Engagement, practitioners were noted to be wearing gloves when managing patients, and hand gel 70% alcohol based is provided for all members use. However, It was noted that hand washing post clinical contact was poor.

Area(s) of Good Practice

Infection Prevention and Control Policy and procedures appear robust.

Area(s) for Improvement

The Provider should raise awareness of hand hygiene protocols, particularly post patient contact. The Provider should consider an observational audit at events, relating to hand washing.

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

There are local arrangements in place at divisional level for the disposal of clinical waste, but this is not standardised and there is no formal policy relating to healthcare risk waste disposal. It is however mentioned briefly as part of the Infection Prevention and Control Policy.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should ensure there is a policy and formalised process in place nationally for correct disposal and traceability of healthcare risk waste generated by the Provider. An educational module should also be developed and delivered to all members.

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 Provider has a comprehensive Medication Management Policy, which covers aspects such as supply and return of medications, responsibilities, storage, adverse events, administration errors and reference to the relative legislation.

There appears to be thorough paperwork to match the policies in terms of recording the ordering and disposal of medications.

The Controlled Drug Policy is currently being updated with their local pharmacy and in line with HPRA guidelines.

Medications are stored at three locations nationally until required and then delivered to relevant regions. They are transported in a locked safe in a locked press and locked vehicle.

At the onsite engagement, the Assessment Team inspected the controlled medications stock and the documentation that supports storage and supply. All stock levels were correct and their robust security and processes in place was observed, including a surveillance camera at headquarters.

Area(s) of Good Practice

There are robust security measures in place for the storage of controlled medications.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

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

Training on the Provider's medication policy and practices forms part of the EMT Programme. Reports from the Practitioner Engagement indicated a high level of knowledge and competency around administration of medications and medication management.

Systems are in place to identify and replace expired medications, with checks in place before each duty and an app in use to report what has been used.

A central regional system for medication bags is in place, with tagging, expiry date sheets and checking before each duty being paramount in ensuring the correct stock and in-date stock is available.
This system involves a blue tag / red tag system with blue indicating the bag is ready for duty and being replaced by a red tag once the bag is opened and a sheet to record details surrounding the use of the bag, why it was opened and what was used.
Penthrox is stored in a locked safe in ambulance, with the bottle being disposed of in a yellow bin when expired.
Advanced Paramedic medications are held in three locations, with three further paramedic medication sites.

Escalation of concerns regarding near-misses or adverse events is in place and up to Medical Director level if required.
While there was no formal inclusion of lessons learned or audit outcomes resulting from medication errors, the management team discussed two incidents where change had occurred as a result of near-misses.
The first example was the introduction of the use of stickers on the Ibuprofen tablets to identify 200mg strength. The second example included the removal of oral Paracetamol suspension (age 6+) to ensure correct Paediatric doses were administered.
No adverse incidents were reported or recorded.

Area(s) of Good Practice

A comprehensive medication management and training programme is in place with competent practitioners.
A responsive approach to near-misses has been taken in the past with direct action and initiative shown.

Area(s) for Improvement

The Provider should ensure adequate training of staff in the recognition and recording of near-misses and adverse events, which in turn will influence audit topics and initiate positive change around the area of medication.

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

Comprehensive ambulance equipment checklists, and audit tools were reviewed by the Assessment Team. Members appear adept and knowledgeable in both checking and reordering stock for ambulances and kit bags.

Divisional teams report to the regional teams when equipment is required, and quarterly ambulance stock checks occur.

The Management Team are considering introducing a barcode system for stock control.

Area(s) of Good Practice

The Provider utilises comprehensive ambulance equipment checklists.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

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 Management Team were knowledgeable on training and the requirement to disseminate updates or safety notices received from PHECC, HIQA, HPRA. Members reported a thorough Induction Programme relating to the use of equipment and adequate training.

During Practitioner Engagement members were deemed competent and confident with the use of relevant equipment. Previously the main modality to disseminate information was via email and this was without a 'read receipt' notification. The Provider is now embracing IT solutions, and their online learning platform is commonly used to update members on equipment, policies, and training. Members can confirm they have 'read' the update. Video information can be viewed, and certificates can be generated once training modules have been completed. This allows the Provider to track who has completed training.

An online system has just been rolled out to members and includes an area for all notifications, policies, CPG, event briefings with a member alert section, and a 'read receipt' can be generated. Additionally, IT systems and proprietary software will also be utilised.

Area(s) of Good Practice

The Provider uses IT solutions to improve training and dissemination of updates to include confirmation that information has been read and training completed.

Area(s) for Improvement

The Provider should continue to improve its training-related systems and structures.

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 Assessment Team acknowledges the significant challenges faced by the Provider in recent years as a consequence of historical events. As a result, the Provider has reviewed safeguarding policies, both in relation to children and vulnerable adults, and the resultant policies and practical changes appears to have resulted in robust and transparent processes.
The Assessment Team confirmed that the current process of volunteer application involves 6 stages:
1. Local interview / application process at divisional level
2. Child First raining (TUSLA)
3. Safeguarding training (bespoke to the Provider)
4. Garda Vetting
5. Induction Process
6. ID card / email address. Expiry date on ID card, to match when first cert is due renewal.

The Provider is currently introducing a Vulnerable Adult Policy and training to all existing members, as well as being added to the member recruitment stages above.
The Assessment Team were informed that IT systems, using a spread sheet, currently tracks each applicant's progress through the six stages.
Each member's ID card will have a QR code that will link back to proprietary software with the aim of being able to check each member's status prior to a duty by scanning the code and checking the date of their various certificates. There are plans to add privileging status to this QR code as well. Currently three trials of this system are underway.

Day to day, there are internal reporting systems in place on the day of an event. National safeguarding officers are to be actioned and trained on immediate risk management with notification to Garda when necessary.
Of note on Practitioner Engagement, members reported a general lack of knowledge concerning mandated persons reporting responsibilities for incidents relating to safeguarding of children and vulnerable adults.

Area(s) of Good Practice

The Provider is to be commended on their review and actions taken in relation to safeguarding of children and vulnerable adults. Robust systems, embracing IT solutions, are under development to ensure the highest standard of safeguarding is adhered to. The six-stage process for applicants is thorough.

Area(s) for Improvement

The Provider must ensure information regarding safeguarding policies, particularly for members on the ground, is incorporated into training at all levels and including existing members.

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 Assessment Team acknowledges the priority for the Provider since the last GVF process has been their response to the historical issues. It is evident from the outline in standard 3.7 that an immense amount of work has been completed here and the response is appropriate.

With regards to clinical audit, 3.5 outlines two examples of change and follow-up actions relating to medication issues. In relation to the Paediatric dosage issue, it was further identified from PCR audit that the Provider was treating a higher-than-expected number of under 18-year olds, and this combination of events led to the production of a training video highlighting the pitfalls of Paediatric dosing, encouraging the use of the PHECC field guide, and use of partner to cross check medications.
While these did not solely arise as a direct result of an audit process, it allowed the Assessment Team to observe a proactive approach from the Provider and a prompt response.

Area(s) of Good Practice

The Assessment Team was impressed with the response to the Paediatric dosage issue with both the removal of the oral Paracetamol suspension (age 6+) but also an innovative video training module to consolidate and inform members about the change in practice.

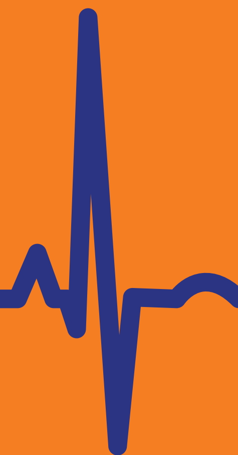
Area(s) for Improvement

The Provider should look closely at areas of clinical practice and feed into their Clinical Advisory Group. This can help inform clinical audit topics and improve organisational learning.

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

Considerable time was spent on the morning of the onsite assessment discussing recent changes relating to this standard, which are currently underway at the Provider's organisation, and many strands of this change are mentioned throughout this report The primary outcomes of the project are improvement in governance and compliance, and strengthening of divisional performance.

The first point to note is the extensive degree of consultation with members of the Provider. Management ensured they had a thorough understanding of the challenges from every level within the organisation.
A high-level overview of the planned changes, as related to the Assessment Team, include the setting up of six national regions, a new management structure with a regional centre for each region, the merging of smaller divisions, a new finance model to improve and simplify processes, implementation of performance management and tracking key metrics for divisions relating to governance and performance.

Each division shall focus on three elements:
1. Compliance: Audits, garda vetting, CPT
2. Membership: Divisional training plan, members attendance
3. Finance: Adherence to budget

The Provider's Management Team delivered a comprehensive presentation to the Assessment Team detailing the new organisation structure with roles and responsibilities defined for each level.
The Interview with the Medical Director confirmed their involvement and alignment with the governance strategy and their role in the clinical aspect of this strategy.
A Clinical Advisory Group has been introduced that reports to the Medical Directorate and provides a reporting source for all clinical issues, along with oversight of clinical audit.

Area(s) of Good Practice

Regarding the organisational development work that has been carried out by the management of the Provider, the Provider is ambitious in its approach to change, and one of their strengths is the consultation process ensuring buy-in from all levels within their organisation. Good leadership has been demonstrated by the Management Team and, they have undertaken not only to improve the corporate and clinical governance of the Provider but to create an entire cultural shift.

Area(s) for Improvement

The Provider should ensure that the considerable administrative and IT support required for such changes has been thoroughly scoped out.

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 Provider has an active Medical Director who is supported by a Medical Directorate to oversee clinical matters within the organisation. The Medical Director oversees the privileging process and the Medical Director's Annual Report. They are broadly aware of responsibilities of their role in relation to the PHECC standard, which was evidenced by the Assessment Team.

Area(s) of Good Practice

There is an active medical directorate in place with regular scheduled meetings to oversee the clinical governance within the Provider.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

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 Medical Director is registered on the Specialist Register of the Irish Medical Council and has the appropriate competencies and experience to fulfil this role. The Medical Director sits on the Clinical Advisory Group and Medical Directorate.

The Assessment Team's engagement with the Medical Director was positive. The Medical Director confirmed their commitment to the Provider, and oversight given to the clinical governance aspect.

Area(s) of Good Practice

The Medical Director is providing appropriate oversight and clinical governance. There appears to be appropriate reporting structures within the Provider's organisation with the Medical Directorate and Clinical Advisory Group.

Area(s) for Improvement

The Provider would benefit from reviewing the Medical Director's current job specification to ensure it complies with the PHECC Medical Director Standard (STN032), which identifies the expected Role and Responsibilities.

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 Assessment Team noted the Provider's submission for the GVF assessment to be efficient and well organised in terms of accessing and reading policies, which were consistently presented. Recognition is given that many of these policies are new. The Assessment Team further recognises that the Provider is currently developing and rolling out IT systems to ensure policies are available to members using online systems, and electronic platforms.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should ensure policies and documents are easily accessible to members.

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

As noted previously under medication / equipment alerts and updates under Standard 3, the Provider is currently rolling out improvements in the dissemination of new recommendations, including those from PHECC and other regulatory bodies.
The new improvements proposed will include 'read' receipts and the generation of certificates of completion where appropriate.

Area(s) of Good Practice

The Provider has recognised previous systems of sharing information were inconsistent and are taking steps to address this with IT solutions.

Area(s) for Improvement

The Provider should develop a system that ensures confirmation that information has been received and read by member. If an action is required by the member(s), then a document denoting proof of completion should be generated.

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

Submitted documents from the Provider offer an insight into their approach to risk management. Policies exist on Divisional Premises Risk Assessment, Health and Safety Policy and the Provider's Risk Management policy.

Event management policies reviewed by the Assessment Team and the observation carried out during Practitioner Engagement both indicate that the Provider has robust plans in place for risk management at both management and member level.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

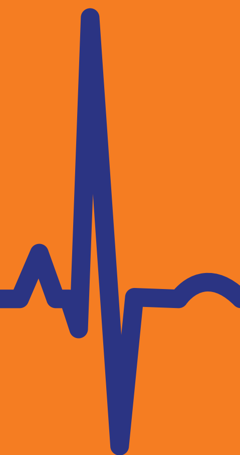
Area(s) for Improvement

No specific observation noted by the Assessment Team.

Standard 5

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 Assessment Team observed event planning forms that require completion by the event organiser before a duty is accepted, which aims to ensure the appropriate skill level is available for that duty. The commencement of data collection at every event for future planning is a progressive step to assist in this.

The Provider has some contractual arrangements at static events, which it fulfils first before committing to any other duties, thus ensuring adequate numbers are available of the appropriate skill level for each event. This is coordinated centrally and given the Provider is a volunteer service, their system appears robust.

Specific training around events is also be arranged should the need arise, for example, heat stroke in marathon runners.

Area(s) of Good Practice

The Assessment Team observed robust staffing structures, particularly considering the volunteer nature of the service.

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 Assessment Team observed evidence of the Provider's management system in relation to practitioner licensing, credentialing, and privileging. Files were reviewed and involvement of the Medical Director noted.

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

5.3 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's English Language Policy was reviewed and discussions with the Management Team indicate this policy requires a review to lower the entry level as it is deemed to be too high.

The Provider confirmed applicants applying for certification are self-funded and the process is carried out by the National Vetting Officer and at divisional interview process. Applicants can appeal decisions through the training department.

Area(s) of Good Practice

The Provider has an English Language policy in place.

Area(s) for Improvement

The Provider should review their English Language policy regarding entry level requirements.

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

As discussed previously, Health and Safety, and Risk Assessment is a priority for the Provider. There is an internal Health and Safety Statement and Risk Assessment Policy.

Within the plans for the new management structure, to further enhance safety and quality knowledge at regional and divisional levels, will be training to supervisor management, QQI level 6, for Regional and Divisional Trainers as well as Health and Safety Officers at divisional level on the Compliance Team.

Training records in relation to Manual Handling were reviewed by the Assessment Team along with the online Course Management System updates and the refresher course.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should implement developed plans to enhance safety and quality of services by providing training at divisional levels.

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 Assessment Team reviewed evidence of practitioner Continuous Professional Competency (CPC) folders that are completed every year to include training, duties, patient contacts, and which are in line with PHECC standards.

During Practitioner Engagement practitioners described training sessions they had attended and those planned throughout the year.

There is a Memorandum of Understanding (MOU) in place with a major Emergency Department to facilitate placements to fulfil CPC requirements for members. Training schedules are formulated locally and based on member requirements in consultation with their unit officers.

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

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

Rating

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

Assessment Findings

The Provider has links with the statutory ambulance service to facilitate EMT students gain experience.

A MOU is in place with an Emergency Department within the Dublin catchment area where EMT training is provided for two 12-hour shifts. A similar process is also undertaken in a Southern Hospital, however a formal MOU has yet to be completed.

The Provider acknowledges they have an ongoing piece of work to be completed on the arrangement with the statutory ambulance service and the training needs and expectations of EMT students.

Area(s) of Good Practice

The Provider has appropriate arrangements in place for EMT training.

Area(s) for Improvement

The Provider should continue efforts to complete the formal MOU arrangements with Emergency Departments and the statutory ambulance service in terms of supporting achievement of key learning objectives for students.

Standard 5

Criterion

5.7 The Provider has systems in place to promote and protect the wellbeing, health, and safety of employees, volunteers and/or contractors.

Rating

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

Assessment Findings

The Assessment Team noted a policy on Critical Incident Stress Management (CISM) and Pregnancy related risk. The Management Team and members confirmed support was provided as necessary with regular debriefs after incidents and activism of CISM and referral to counsellors when required.

The Provider has recently developed a new role within the organisation as Welfare Lead. Engagement has already commenced with members and a working group has been set up.

Area(s) of Good Practice

CISM policy in place, expansion of support services through a new Lead Welfare role and positive reports from staff regarding feeling supported.

Area(s) for Improvement

No specific observation noted by the Assessment Team.

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 area of performance management was addressed in the presentation of the structural review of the organisation, with the implementation of performance management of new roles due to be introduced. With the Provider undertaking such change, it is encouraging that performance management of the new roles will be undertaken.

The structural review also mentions the tracking of metrics for divisions on governance and performance. It is not clear if performance relates to individuals or more wider issues, however, management spoke about performance management being undertaken at divisional level with divisions then being assessed regionally, with progression to a higher level, if deemed necessary.

The Medical Director was questioned on performance management and indicated there had not been any issues that had risen to his level, but he would support as necessary should the need arise.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should continue the development and implementation of processes for the performance management of employees, volunteers, and/or contractors.

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 Assessment Team notes the extensive engagement undertaken by the management team in recent years to obtain feedback from members as they developed their new strategy.

A member survey was recently undertaken along with a survey on communications. It appears that the Provider has identified the benefit of engaging with its members and plans are underway to seek member feedback at training sessions.

Area(s) of Good Practice

Positive Provider engagement with regular opportunities for members to give their views.

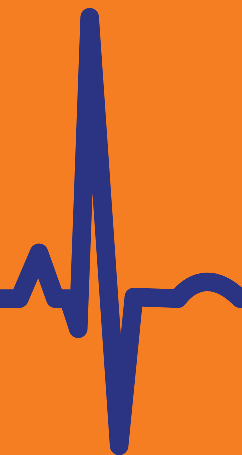
Area(s) for Improvement

No specific observation noted by the Assessment Team.

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 Assessment Team reviewed the Provider's Clinical Record Management Policy. Within this policy is the need for all PCR/ACR to be returned to headquarters within 72 hours. Management admit that ensuring all documents are returned within 72 hours is challenging, generally due to logistics.
Printed envelopes are available within each division to allow postage, however, many are left to be returned in person at the next available opportunity.

Training on record management is provided on the EMT course.

There was no consistent answer as to how those documents are stored while waiting to be returned and it was conceded that on occasion PCR may not be treated or stored in accordance with the stated policy. This represents as a risk to the Provider.
The Provider indicated several plans that might rectify this situation, including a 'drop-in' box to be available at each of the regional centres. They are also considering if a proprietary system would offer an IT solution.

The most recent audit of PCR/ACR was in 2021. The Provider reports they are due to undertake a further audit later this year. Approximately 30 PCR are audited in this process.
The 2021 review of PCRs highlighted a higher than anticipated number of Paediatric and Adolescent PCR, as a result of the types of events covered, e.g. underage sports events, discos. This was a further influencing factor that led to their paediatric training module.

Observed practices during Practitioner Engagement were positive with all PCR and ACR being completed accurately.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider shall address the issue of PCR storage while awaiting return to headquarters.
The Provider should audit their PCR more regularly and use such audits to determine further audit needs.

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 Assessment Team reviewed comprehensive data protection polices.
The Provider has an assigned Data Protection Officer.

The Assessment Team were informed that GDPR training is planned on an online training system in the near future to update members on these procedures.

The issue noted regarding storage of PCR?ACR has the potential to jeopardise the Provider's data protection procedures.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider shall ensure correct storage of PCR to ensure compliance with data protections regulations.

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 Assessment Team discussed the audit of PCR/ACR with the Provider and note this does not occur as frequently as it might. Approximately 30 PCR were reviewed in 2021. The Assessment Team are not aware of how many PCR are returned annually but the recommendation would be that 10% of all records should be audited.

It was also noted by the Assessment Team that some PCR would be handed over to another CPG Service Provider at the time of patient transfer to another ambulance provider, making it impossible to review some PCR.

Area(s) of Good Practice

No specific observation noted by the Assessment Team.

Area(s) for Improvement

The Provider should improve the frequency and number of PCR/ACR included in their audit to improve quality checks of healthcare records. It is recommended that a minimum of 10% of all records should be audited.

9. Report Outcome and Rating Summary

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

COMBINED STANDARD SCORE

Std 1	Std 2	Std 3	Std 4	Std 5	Std 6	TOTAL
32	35	25	21	31	7	**151**

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	45
Maximum score available	180
63% of Max =	113
Assessment Results	
Total score achieved	151
Total score as percentage	84%
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 St John Ambulance Ireland in accordance with Council Policy for Recognition to Implement Clinical Practice Guidelines (POL003) is unaffected.

St John Ambulance Ireland should continue to develop their Quality Assurance (QA) systems and are required to develop and submit a Quality Improvement Plan (QIP) to gvf@phecc.ie. The 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 St John Ambulance Ireland in the upcoming licensing period.

St John Ambulance Ireland

Pre-Hospital Emergency Care Council

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.	3
1.3	The Provider ensures information from calls / activation is recorded accurately and dispatched according to priority.	4
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.	3

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.	4
2.5	The Provider has a policy on the use of emergency lights and sirens.	3
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.	2
2.8	The Provider ensures plans are in place to deal with major incidents.	4
2.9	The Provider has a 3-year programme of clinical and environmental audits in line with the services provided.	2
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.	2
3.3	The Provider ensures that medications are administered in accordance with the relevant laws and regulation.	4
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.	3
3.5	The Provider ensures that there are systems in place to ensure the availability of medical devices and consumables.	4
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.	3
4.2	The Provider has a documented structure and accountability for clinical governance.	4
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.	4
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.	3
4.6	The Provider develops a risk management plan that includes a reporting system and a process for identifying potential risks.	4

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.	3
5.4	The Provider ensures employees volunteers, and/or contractors understand their responsibilities in relation to the safety and quality of services.	3
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.	4
5.6	The Provider has appropriate arrangements for the management and supervision of students (if applicable).	3
5.7	The Provider has systems in place to promote and protect the wellbeing, health, and safety of employees, volunteers and/or contractors.	4
5.8	The Provider has processes for the performance management of employees, volunteers, and/or contractors.	2
5.9	The Provider creates opportunities for employees, volunteers and/or contractors to feedback on all aspects of the service.	4
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.	3
6.3	The Provider has systems in place to measure the quality of healthcare records.	2

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