Pre-Hospital Emergency Care Council

Governance Validation Framework

Assessment Report

Emergency Services Training Institute Ltd

September 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

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

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

- The Governance Validation Framework (GVF), in place since 2018, monitors the 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.

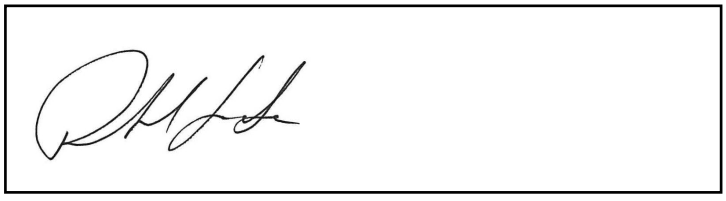
The GVF and the QRF relate to specific standards and identify the supporting components that PHECC recognised CPG service providers and approved organisations should have in place to ensure good governance and quality in delivery of education, pre-training, and operational hospital emergency care with 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 Emergency Services Training Institute Ltd, a PHECC Recognised CPG Service Provider, licensed to deliver pre-hospital emergency care services in Ireland since 2017. Emergency Services Training Institute Ltd 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 C7 The Exchange, Calmount Park, Ballymount, D12 VW20 ☑ Practitioner Engagement Diageo, James's Gate, James's St, Dublin 8.
Outcome Rating **Technical Weighting Applied** **Yes** ☐ **No** ☑	No of criterion assessed: 42 Maximum score available: 168 63% of Max = 106 **Assessment Results** Total score achieved: 106 Total score as percentage: 63% **Assessment Outcome Rating: Moderately Acceptable**
Follow Up Action Required	☑ Continue with normal quality improvement activities ☐ Improvement notice - follow up evidence required ☐ Conditional Approval ☐ Suspension notice ☐ Delisting process intiated
Reassessment Costs	☑ Not applicable
Validated and Approved for Publication **Director Signature** **Date**	 31/01/2024

3. Assessment Participants

Organisation	PHECC Assessment Team
Director x 2	Lead Assessor
Medical Director (Medical Council Reg No 409301)	Onsite Assessor
Station Officer (EMT)	Practitioner Engagement Assessor
Station Sub Officer (EMT)	

4. Initial Feedback Given

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

The following areas were identified as areas requiring improvement, or further potential for improvement areas:
Safe care and support, which fell short of expectations; clinical audits were an area of particular concern in light of the low call volume; Corporate and Clinical Governance requires strengthening; clarity is required around staff wellbeing.

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 assessment team were informed that the Provider also delivers care in other clinical situations and communication processes are varied dependent on the situation.

Within the Provider's contracted industrial site an internal telephone number is used to report emergency incidents. This is answered by the duty practitioner and entered in the logbook provided. If the practitioners are tasked with an incident the phone is transferred to the security control who will log the incident and task the practitioners.

If on a film set, the practitioners use radio and a dedicated phone for contact purposes.

If attending a cycle race, the practitioners use personal phones to communicate with race officials should they be required to respond to an incident.

However, there is no written procedure for any of the communication processes described above.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall develop a written process and protocols for the communication and tasking processes.

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

Staff training in respecting the wishes of the patient includes the recording of treatment refusal. Evidence submitted by the Provider indicates that practitioners are supervised, and Patient Care Reports (PCR) are inspected. While there is 100% inspection of PCR there is little evidence of any supervised practice.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider would benefit from introducing periodic supervision of practice.

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

Not applicable as the call volume is extremely low.

Area(s) of Good Practice

Area(s) for Improvement

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

PCR are utilised, which contains name and date of birth for each patient encountered. 100% of completed PCR are reviewed.

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 1

Criterion

1.5 The Provider has a policy for informed consent.

Rating

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

Assessment Findings

The Patient Guidance Policy was submitted in evidence. There is no reference to informed consent within the policy.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall update the policy to include a section on 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

The Patient Guidance Policy was presented in evidence. This has three sections, one of which is 'Refusal of Transport'. While it is acknowledged in the policy that the patient has an absolute right to refusal of treatment and/or transport the policy categorically states that the Provider does not provide patient transport and makes no further reference to refusal of treatment. The policy outlines the process on how the refusals would be managed if they were to introduce transports. Capacity would be recorded in accordance with the PCR questions.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should update the Patient Guidance Policy to include a section on informed consent in relation to treatment and/or transport.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Ethics Policy was presented in evidence and is designed to protect the Provider's organisation and not its patients/clients. A verbal acknowledgment of a culture of dignity and respect was offered by the Provider.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should revise the Ethics Policy with an emphasis on patient protection, emphasise this culture through the rewritten policy and ensure it is distributed to all staff.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Patient Guidance Policy was presented in evidence. The policy has three sections, one of which refers to 'patient satisfaction surveys'.

A QR code for patient feedback is available at the film location, however, it is rarely if ever used. Verbal feedback has been received from the film company in relation to satisfaction of service.

No processes exist for feedback at the Provider's contracted industrial site or cycling sites.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should be less passive and more proactive in acquiring feedback from their three main activity locations.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider has a Complaints Policy and aims to formally respond within a defined timeline. The Complaints Policy presented to the assessment team outlines that the 'appropriate director' is responsible for managing complaints. It does not specify how the appropriate director is identified.

The policy also refers to the Office Manager, a title that does not appear on the organisational chart and is defunct. The policy does not refer to training of staff in relation to complaint handling. No evidence of training occurring was presented.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should review and update the complaint policy, ensuring all titles referenced are correct and identify which Director is responsible for complaints within the policy.

The Provider should ensure that staff receive training in handling and receiving complaints.

Standard 2

Effective Integrated Care and Safe Environment

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

Standard 2

Criterion

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

Rating

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

Assessment Findings

The assessment team were advised that all EMT have been up-skilled to 2021 CPG. However, all practitioners who are classified as paramedics are not up-skilled. Paramedics that have not up-skilled have had their privileging withdrawn. Discussion revealed that there was no clarity in relation to privileging to practice for the Provider.

The small number, and minor nature of most of the clinical caseload managed on the Provider's contracted industrial site raises the problem of retention of skills. In the past this was mitigated by occasional placements with another CPG Service Provider. This has not occurred since before COVID-19 pandemic.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should ensure a privileging letter is issued to each staff member outlining their scope of practice in relation to PHECC CPG, medications, core and non-core skills.

The Provider should identify ways to mitigate the loss of core skills (e.g. CPR) among staff on the Provider's contracted industrial site.

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 Patient Guidance Policy was presented in evidence. This has three sections, one of which refers to patient handover procedure: IMIST-AMBO process has been adopted.

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

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

Rating

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

Assessment Findings

The Provider's contracted industrial site has the use of a hired van while waiting for a new replacement vehicle. This response van had a large unsecured box on the floor with clinical equipment in it. Unsecured equipment represents a hazard in a moving vehicle.

At cycling events a response car is utilised.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall ensure all equipment is safely secured in its vehicles.

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 Provider reports that it does not transport patients.
The Provider provider services in several different situations - see Assessment Findings - criterion 2.3 & 2.5.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should consider ESDS training for drivers at the appropriate level(s).

With specific reference to the contracted industrial site, the Provider should consider the possibility of having to transport patients to the medical center and the suitability of the current transport vehicle.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider reports that it does not transport patients. They do however, have a response vehicle for covering cycle races, which is fitted with blue lights. The Provider's Risk Management Policy makes no reference to the use of emergency lights and sirens or driving under emergency conditions. However, the Provider's EMT and Paramedic Job Descriptions do make reference to the 'principles of safe emergency vehicle operation' without specifying any details.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall update the Risk Management policy to provide clarity on their policy for the use of lights and sirens and the principles of safe emergency vehicle operation.

The Provider should consider ESDS training for drivers at the appropriate level(s).

Standard 2

Criterion

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

Rating

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

Assessment Findings

The assessment team considered the Provider's planning and arrangements regarding Fire safety to be adequate.

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

2.7 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 Provider is a very small organisation with a contract for three specific areas of operation. The Provider's contracted industrial site is managed on a day-to-day basis by a facilities and services management company and all the EMT employed there are employed by services management company.

The film and cycle race services are planned up to six months in advanced using a mixture of full time and part time staff.

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

2.8 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 Provider is a small non-transporting service and would not be engaged to provide support at a major incident.

Area(s) of Good Practice

Area(s) for Improvement

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Clinical Audit Policy was presented in evidence. There is no reference to audit types, structure, process or outcome. The audits presented were poor, primarily due to low numbers involved. The Provider utilised PHECC Key Performance Indicators (KPI) as the basis for the audit (pain management, response time and chest pain).

It was apparent to the assessment team that there was no great understanding of the audit process within the Provider's organisation. Response times were within the Provider's contracted industrial site and only three patients presented with chest pain.
The Medical Director's report for 2021 (and in discussion during assessment) referenced three audits. All the subjects chosen for audit were based on PHECC KPI even though these were not appropriate for the Provider's activities. This resulted in:
(i) a pain management audit, which included only one patient with a pain score >7
(ii) an audit of treatment of chest pain with only one patient fulfilling inclusion criteria
(iii) an audit of response times when every case had a response time of less than 5 minutes.

There was no evidence shown of using the audit cycle.
The impression of the Assessment Team is that audit is viewed as a task to be completed to satisfy the Regulator and not as a tool to assist improvement of quality or safety.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

Clinical audit should be meaningful for an organisation. For the Provider this will require care in choosing what to audit. With the low numbers involved, broad categories should be targeted for inclusion in the audit. The correct choice of subject to audit will reveal areas for improvement that can assist in developing a meaningful Quality Improvement Plan (QIP) that will improve both quality and safety of the services provided.

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 did not submit the Provider's Annual Report using the correct format. The submitted Medical Director's report includes a reference to attached documents, however, these documents were not presented for review. Three clinical audits were presented during the site visit.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should ensure submission of Annual Report to PHECC is completed using the correct format.

Standard 3

Safe Care and Support

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

Standard 3

Criterion

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

Rating

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

Assessment Findings

Infection Prevention and Control Policy was presented in evidence. Glove type not specified. The Provider takes no responsibility for Hepatitis B vaccination of staff, reference to 'should have vaccine' and 'contact their doctor to arrange vaccine' identified within the policy.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall update their Infection Prevention and Control Policy specifying glove type for use, and more definite Hepatitis B vaccine requirements. The Provider shall ensure that the full range of nitrile gloves are available for staff and provide advice on appropriate glove use during patient contact in accordance with the World Health Organisation.

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 was no differentiation between household waste and clinical waste at the Provider's contracted industrial site. One clinical waste bin was utilised for both.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall educate their staff in the management and segregation of waste types and provide a solution to ensure avoidance of inappropriate waste disposal in the clinical waste bags.

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 Medications and Equipment Management Policy was presented in evidence.

Staff at the Provider's contracted industrial site was informed informally during upskilling that Activated Charcoal would not be utilised within their service. The assessment team confirmed that no policy or written instruction was issued to Practitioners to verify this decision.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should differentiate between training and operations to ensure that staff have clarity on privileging of specific medications and skills.

Decisions affecting the availability of CPG listed medications to Practitioners should be documented by the Provider, formally ratified by the Provider's Medical Director, and circulated to all Practitioners.

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

At the Provider's contracted industrial site the medication bag is stored in the response van and is not available in the Treatment Room should the van be responding to another incident. All medications relevant to their practice were available in the van and in date.

Medications were inspected at the Provider's head office. A locked medication press is utilised to store the Midazolam for paramedic use. The paramedic medication bag contained a medication for sea sickness prevention, which is not included in the PHECC practitioner medication formulary.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should ensure that Practitioners' medication bags are only be stocked with medications from the PHECC medication formulary.
The Provider should issue clear instruction that they are legally restricted to administering only CPG listed medications on the Provider's behalf.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider's contracted industrial site's response van has a response bag that was equipped for resuscitation and trauma. The response bag had a manual suction device, it was observed that there was no spare collection vessel available should it be required.

The advanced airway pack did not contain a catheter mount. An AED with Lead II ECG monitoring was available. The model utilised by the Provider cannot print out the ECG rhythm, which may limit the diagnostic aspects of practice. A medication bag and available equipment was inspected. A maternity pack was located in a bag that was incorrectly labelled.

The equipment in the Treatment Room at the Provider's contracted industrial site was inspected, as with the response van, there was no spare container for the suction device. No electric suction unit was available in either the response van or the Treatment Room. No ECG monitor available in the Treatment Room. A static treatment/examination couch was available for patient examinations and first aid equipment for the treatment of minor injuries was present.

The Treatment Room has been recently re-located to a basement area and access to this area is very poor. There are two entry points, one from the front of the building, through several security doors and a second from the rear of the building, no lift available. Steep external stone steps are used as the means of removing patients to an ambulance should this be required. During discussion it emerged that there was no consultation with the Provider or the staff in relation to the location of the Treatment Room. Staff confirmed that they had not raised any concerns. Also, during discussion, it became obvious that it had not occurred to the staff that a patient may walk in and require equipment such as an ECG monitor or medications. There were no records available of any service being carried out on the equipment.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

As a patient safety measure the response van and Treatment Room at the Provider's contracted industrial site shall be equipped as standalone units.
The Provider shall review the arrangements for equipment availability in the treatment room.
The Provider shall ensure the testing of diagnostic and transport equipment, and maintain records of serviceability.
The Provider shall ensure the availability of effective suction units.
The Provider shall consider alternative options for the location of the Treatment Room to enable safe access and egress to this area for patients and practitioners.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider is responsible for the standard of emergency care delivered at their contracted industrial site. An AED with Lead II ECG monitoring was in place. During the Practitioner Engagement it was apparent that certain staff lacked the knowledge and skills related to ECG monitoring.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall conduct a training needs analysis to ensure that all their practitioners are familiar with and can operate the therapeutic equipment within their site of operations.

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

A Child Protection Policy was presented in evidence. This policy, however, refers to Children First – National Guidance for the Protection and Welfare of Children 2011 as their standard. Despite the policy being reviewed in 2021, the policy makes no reference to the Children First Act 2015. No child safeguarding statement was presented in evidence. Also, no reference is made to mandated persons to report suspected child abuse within the policy. There are no children permitted onto the Provider's contracted industrial site, however, children are regularly encountered on film sets and potentially during cycle races.

Garda vetting could not be verified for all listed practitioners.

During the practitioner engagement at the Provider's contracted industrial site there was confusion as to the role of the 'designated person' regarding who should be given access to original Garda vetting bureau results. During the visit to the Provider's premises, it was confirmed that three people within the Provider's staff have access to the Garda vetting bureau result form.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall update the Child Protection policy and include reference to the Children First Act 2015, mandated reporting, and a child safeguarding statement.
The Provider should develop a policy that specifies how their contracted industrial site and the Provider's staff are to be Garda vetted.
The Provider shall produce a policy and process to manage vetting requests and the categories of reports generated by them. This should specify a 'designated person' to receive and manage any vetting results information .
The Provider should consider the data protection implications related to their current processes.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider expressed a desire to be compliant in this area, however, the QIP presented was just the GVF framework. There was no attempt to highlight specific areas for improvement – probably because there were no signals in the form of complaints, satisfaction data, adverse events/near misses.

The Medical Director stated that he did not provide input into the QIP process.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall initiate a process to improve and increase audit and monitoring at the Provider's various operations.

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

The organisational chart is not fit for purpose and does not give clear indication in relation to clinical governance. The staff at the Provider's contracted industrial site are employed directly by the services management company and the Provider appears to be providing CPG practice cover to them.

The Provider's Director contacts the Provider's contracted industrial site every Thursday and if Ambulatory Care Reports (ACR)/PCR have been completed he collects them on Friday.
A Station Officer is responsible for the management of emergency care at the Provider's contracted industrial site. The Station Officer is named on the Provider's organisational chart as the Provider's contracted industrial site liaison officer, however, no other line or functional management role is assigned to him. He is assisted by one Sub Officer. The Sub Officer covers duty when the Station Officer is off, otherwise he is part of the two-person crew on duty. Eight First Response Officers, one of which is out on long term sick, are also employed at the site. There is no policy on who takes clinical lead at an incident, however, the person with the longest service, through custom and practice, is assumed to be the clinical lead.

A memorandum of understanding (MoU) between the Provider and the services management company, which was signed on behalf of the industrial site by the Station Officer who is employed by the services management company, brings into question the legitimacy of the MoU. The MoU relates to training services and has no reference to clinical practice and clinical governance.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall improve corporate governance within their organisation.

The Provider shall redraft the memorandum of understanding between the Provider and the services management company outlining the clinical service provision and the clinical governance to be agreed and signed by a senior manager from the services management company.

The Provider shall redraft the organisational chart to accurately reflect the organisation's relationships.

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 services management company staff report that no feedback has ever been received from the Provider on clinical practice. The clinical governance relationship between the service management company's staff and the Provider appears to be a cursory one.

During discussion at the on-site visit, it was reported by the Provider that in practice a call is made to the supervisor and the staff member concerned if an issue emerges. It was unclear how often this action had been taken and no evidence was presented.

The staff at the Provider's contracted industrial site were unaware of who the Medical Director is and report that he has never visited the site. Discussion with the Provider confirmed that, in his 4-5 years in the role, the Medical Director has not visited any of the three clinical areas where the Provider provides services. The Medical Director confirmed that he was unaware of the Provider's contracted industrial site's treatment room deficits.

During discussions it became apparent that the Medical Director has an indirect role within the Provider's clinical service provision.

The assessment team established that there is no formal time allocation attached to the Medical Director's role as head of clinical governance. The Provider's Director decides if and when to consult with the Medical Director and that no formal or recorded meetings occur between the Provider's Directors and the Medical Director. The Medical Director is not immersed in the overall clinical governance in accordance with the requirements outlined in the PHECC Medical Director Standard (Role and Responsibilities) (STN032).

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall improve clinical governance within their organisation and ensure that the Medical Director undertakes a more proactive role in accordance with the roles and responsibilities outlined in the PHECC Medical Director Standard (Role and Responsibilities) (STN032).

The Provider shall strengthen the clinical governance relationship between the services management company and the Provider's organisation, and update the MoU between them.

The Provider shall develop a clinical feedback process to ensure staff are made aware of both positive and negative clinical practice issues.

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 Provider's Medical Director is registered with the Medical Council on the specialist register (Emergency Medicine).

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 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

All policy documents from the Provider and the services management company were available to staff at the Provider's contracted industrial site. There is, however, no sign off process to ensure and verify that staff have read these policies.

It was also noted that most, if not all, policies had a review date that was 6-7 years after the policy was written. Policy details appeared to be amended when it was thought to be necessary, but no overall review was planned until the seven-year period had elapsed.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should introduce a sign-off process for staff in relation to policies and procedures.

The Provider should review arrangements to ensure policies continue to be appropriate, helpful to staff, and remain current.

PHECC advise that the Provider review the best practices regarding length a policy should be in existence before a formal review is undertaken and review their practices accordingly.

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

PHECC updates are posted on the notice board at the Provider's contracted industrial site. However, it was reported that as staff are communicated to directly by PHECC when updates are introduced there is no process in place to ensure that staff are aware of these updates.

During discussion it was acknowledged that there was no process for dissemination of updates directly to staff.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

To ensure all Provider's staff are fully informed, the Provider shall develop a process to ensure that its communication responsibilities are met, and that new recommendations issued by PHECC, other regulatory bodies, and public health alerts are disseminated directly to staff.

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

A Risk Management Policy was presented in evidence. This document is very theoretical in nature and is written from a perspective of definitions etc. There is no specific reporting system and/or process for identifying potential risks.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should update the Risk Management Policy to include a reference to management and staff reporting and identifying potential risks.

Risk Management Processes should also be put in place.

Standard 5

Workforce Planning

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

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider has three areas of operations with little if any variation of the requirements at each site. During on-site discussion it emerged that employment is stable with full time staff at the Provider's contracted industrial site and part time or casual staff involved in their other clinical activities.

The film and cycle activities are planned five to six months in advance permitting planning for adequate cover for events. No event plans were furnished as part of the assessment.

Area(s) of Good Practice

The assessment team formed an opinion that the Provider knows their staff well, on a personal level, and are very diligent during the recruitment process. The Provider is well placed to use their training resources to aid retention and acquisition of skills.

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

A random sampling of practitioners' records identified incorrect registration details for two practitioners. Their provided Personal Identification Numbers (PIN) were incorrect. This suggests that the reliability of checks require improvement.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should improve their Privileging process to ensure the correct PIN of all practitioners are on file and match their registration details.

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 English Language policy meets the current PHECC requirements.

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

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

Rating

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

Assessment Findings

The appendix to the training plan included the induction programme, which outlines the responsibilities of staff.

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

5.5 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 required refresher training takes place on an annual basis. There is, however, no monitoring of Continuous Professional Competency (CPC) for the services management staff, despite this being specified in the Provider's policy on CPC. The Station Officer was unaware of who is the Provider's Facilitator.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should align policy and practice to ensure CPC and other development processes are in place.

The Provider shall complete a training needs analysis for staff at the Provider's contracted industrial site. (Ref: criterion 3.6)

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider is also a PHECC Recognised Institution (RI), however as a Recognised CPG Service provider they report that they do not place students within their clinical practice provision.
This area is deemed not applicable.

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

5.7 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 Critical Incident Stress Management Policy (CISM) was presented in evidence. Following a review of the policy, of specific concern is the indication of a cut and paste practice whilst developing this policy, as the policy states it claims to apply to "accident and emergency staff". Of serious concern is that the policy is grossly out of date and lists a deceased Practitioner as the provider of CISM services to practitioners. However, during the on-site management engagement, it transpired that the Provider has established a contract with a new company to provide CISM services.

During practitioner engagement, discussion with practitioners identified that they had no knowledge of the Provider's counselling services. The Station Officer advised that he would inform the Provider's Director should an issue emerge. There is no peer support worker trained within the Provider's staff. The industrial site notice board has contact details for the contracted industrial site management company's counselling service.

A discussion related to Fitness to Practice (FTP) and the policy identified a number of inaccurate statements, it was recognised that an update is required to ensure clarity.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall:

- update their CISM policy with accurate details as a matter of urgency,
- clearly differentiate the CISM process for services management company staff and the Provider's staff (at the Provider's contracted industrial site), and
- incorporate responsibility for CISM in the updated MoU between the services management company and the Provider.

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 Fitness to Practice Acceptance Policy was presented in evidence. Following a review of the policy, of concern is the unenforceable nature of some statements within. During discussions with the Provider it was recognised that an update is required to increase accuracy and ensure clarity.

The Provider reports that 100% of the PCR are audited to comply with this requirement, however, there is no process on how this audit is conducted to ensure competency of performance.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should update the Fitness to Practice Acceptance Policy to increase accuracy and ensure clarity.

The Provider should develop a process for audit of PCR to ensure competency of performance of the practitioners.

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 Near Miss and Adverse Incident policy was presented in evidence. During discussions it transpired that there was no clear understanding of 'near miss' and how it could be utilised for quality improvement. Adverse events appeared to be synonymous with medication errors. Also, it was not clear from the policy that it was the responsibility of staff to report adverse incidents.

Reference to both Irish and UK legislation is identified within the policy, which suggests fundamental misunderstanding of the relevant statutes that may apply to the Provider. The Policy also communicates confusion about the role of PHECC, as it implies PHECC is responsible to ensure that 'medicines, healthcare products and medical equipment meet appropriate standards of safety, quality, performance and effectiveness, and are used safely'.

There was no knowledge of this reporting mechanism among the staff at the Provider's contracted industrial site. The 'non-punitive reporting' section is not explicit in that it only outlines exceptions that may result in disciplinary action.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider shall update and amend their Near Miss and Adverse Incident policy to remove reference to UK regulations/legislation, insert appropriate Irish references, amend in relation to PHECC's responsibility, ensure a clear and complete definition of adverse event/no-harm/near miss is included, make it explicit in relation to non-punitive reporting for staff, highlight staff's responsibility to report adverse incidents, and ensure updated policy is disseminated to all staff.
The Provider shall develop a QIP focused on areas that data and feedback from staff signal as requiring change and improvement, and monitor what it is doing well and not-so-well.

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 Clinical Records Management policy was presented in evidence. Once collected the ACR/PCR are filed by month and year and stored in a securely lock cabinet within the Provider's main office. The cabinet was accessible by both of the Provider's Directors and the Administrative Support Officer.

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 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

No process was identified to ensure security/confidentiality of documentation from completion of the ACR/PCR until they are stored in the secure storage area. The ACR/PCR completed by the service management company staff are stored in a locked box and collected weekly. Once collected ACR/PCR are filed by month and year and stored in a securely lock cabinet within the Provider's main office. The cabinet was accessible by both of the Provider's Directors and the Administrative Support Officer.

Area(s) of Good Practice

No specific observation noted by the assessment team.

Area(s) for Improvement

The Provider should update the policy to ensure security/confidentiality of documentation from completion of the ACR/PCR until they are stored in the secure storage area.

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 Clinical Records Management policy was presented in evidence. All PCR are reviewed weekly by the Provider's 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.

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
25	23	12	13	22	11	106

STANDARD ACCEPTABLE/NOT ACCEPTABLE

Std 1	Std 2	Std 3	Std 4	Std 5	Std 6
Acceptable	Acceptable	Not 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	42
Maximum score available	168
63% of Max =	106
Assessment Results	
Total score achieved	106
Total score as percentage	63%
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 Emergency Services Training Institute Ltd in accordance with Council Policy for Recognition to Implement Clinical Practice Guidelines (POL003) is unaffected.

PHECC will now engage with Emergency Services Training Institute Ltd regarding required improvement actions related to specific assessment findings that present specific risks.

Emergency Services Training Institute Ltd 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 Emergency Services Training Institute Ltd in the upcoming licensing period.

Emergency Services Training Institution Ltd

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.	3
1.2	Access to pre-hospital emergency care is not affected by discrimination.	4
1.3	The Provider ensures information from calls / activation is recorded accurately and dispatched according to priority.	N/A
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.	2
1.6	The Provider has a policy in place in relation to the patient's refusal of treatment and/or transport.	3
1.7	The Provider ensures all patients are treated with compassion, respect, and dignity.	3
1.8	The Provider seeks feedback from patients and carers to improve services.	3
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.	2
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.	2
2.4	Training is provided for staff to transport patients safely, including during emergency situations.	1
2.5	The Provider has a policy on the use of emergency lights and sirens.	1
2.6	The Provider has a fire safety plan for any physical environments owned or used by their organisation.	4
2.7	The Provider ensures there is a business continuity plan for their organisation.	4
2.8	The Provider ensures plans are in place to deal with major incidents.	N/A
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).	3

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.	1
3.2	The Provider segregates and manages waste according to hazard level and disposes of same, according to best practice.	0
3.3	The Provider ensures that medications are administered in accordance with the relevant laws and regulation.	3
3.4	The Provider has systems and processes to ensure safe medication practices including, but not limited to, availability, storage, administration, expiration, disposal and recall alert.	1
3.5	The Provider ensures that there are systems in place to ensure the availability of medical devices and consumables.	1
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.	2
3.7	The Provider has a safeguarding policy to deal with children and vulnerable adults.	2
3.8	The Provider can demonstrate follow-up and actions taken as a result of audit and monitoring findings.	2
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.	1
4.2	The Provider has a documented structure and accountability for clinical governance.	2
4.3	The Provider has a Medical Director, who is registered with the Medical Council, with general or specialist registration who provides oversight and support for Clinical Governance.	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.	2
4.6	The Provider develops a risk management plan that includes a reporting system and a process for identifying potential risks.	1

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.	3
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.	4
5.4	The Provider ensures employees volunteers, and/or contractors understand their responsibilities in relation to the safety and quality of services.	4
5.5	The Provider has an ongoing training and development programme in place to ensure employees, volunteers, and/or contractors have the required competencies to undertake their duties in line with their scope of practice.	3
5.6	The Provider has appropriate arrangements for the management and supervision of students (if applicable).	N/A
5.7	The Provider has systems in place to promote and protect the wellbeing, health, and safety of employees, volunteers and/or contractors.	1
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.	1
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.	4
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.	4

Pre-Hospital Emergency Care Council

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

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