Pre-Hospital Emergency Care Council

Governance Validation Framework

Assessment Report

Medicall Ambulance Ltd

March 2026

Pre-Hospital Emergency Care Council

Mission Statement

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

QUALITY ASSURANCE PROGRAMME

Governance Validation Framework
Quality Review Framework

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

The Pre-Hospital Emergency Care Council (PHECC) is an independent statutory body who set the standards for education and training for pre-hospital emergency care in Ireland. The Council publish clinical practice guidelines (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.

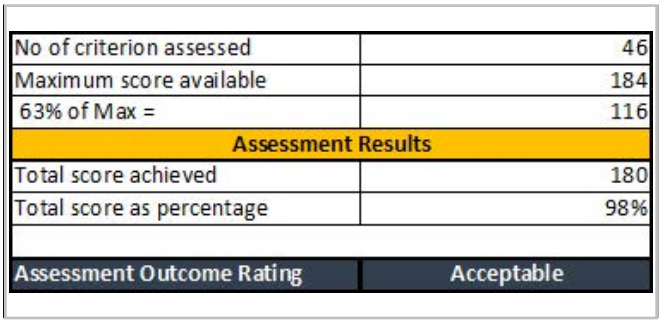
The GVF and the QRF relate to specific standards and identify the supporting components that PHECC recognised CPG service providers and approved organisations should have in place to ensure good governance and quality in delivery of education, pre-training, and operational hospital emergency care with 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 Medicall Ambulance Limited a PHECC Recognised CPG Service Provider, licensed to deliver pre-hospital emergency care services in Ireland since 2009. Medicall Ambulance Limited is recognised by PHECC under S.I. No. 109 of 2000 as amended by SI. No. 575 of 2004 at the following clinical levels: ☑ Emergency Medical Technician ☑ Paramedic ☑ Advanced Paramedic ☐ Organisation also provides responder level services
Assessment Type	☑ Planned ☐ Unscheduled
Process	☑ Desktop Review ☐ Online Management Engagement ☑ Onsite Management Engagement IDA Business & Technology Park, Clonshaugh, dUBLIN 17 ☑ Practitioner Engagement IDA Business & Technology Park, Clonshaugh, dUBLIN 17
Outcome Rating **Technical Weighting Applied** **Yes** ☐ **No** ☑	
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**	 28 August 2026

No of criterion assessed	46
Maximum score available	184
63% of Max =	116
Assessment Results	
Total score achieved	180
Total score as percentage	98%
Assessment Outcome Rating	**Acceptable**

3. Assessment Participants

Organisation	PHECC Assessment Team
Director of Service Delivery Medical Director (Medical Council Reg No 22936)	Lead Assessor
Resource Compliance Manager Operations Compliance Manager	Onsite Assessor x 2
Operations Manager, HR & Special Projects Manager, Finance Manager, Staff Development Manager	Practitioner Engagement Assessor
Senior Project Manager, Dispatch Supervisor, Practitioners	

4. Initial Feedback Given

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

The following areas were identified as areas requiring improvement, or further potential for improvement areas: ESDS driver training, revise Infection Prevention and Control Policy and Child Safeguarding Policy, and source EAP service provider.

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
Minimally Acceptable	**Outcome rating of ≥ 38% <63% of max available** Outcome score is within the weighted tolerance	• May be placed on Conditional Approval or *suspended while development work is completed * Risk assessment dependent
Conditionally Acceptable	**Outcome rating of ≥ 25% <38% of max available** *Outcome score is outside the weighted tolerance = Technically Conditionally Acceptable	• Will be placed on Conditional Approval, or *suspended while development work is completed *Risk assessment dependent
Unacceptable	**Outcome rating of < 25% of max available**	· Removal of PHECC recognition status

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

Based on the Provider's submission and engagement during the assessment process the Assessment Team verified that the Provider's service delivery plan is robust and fully integrated into daily operations. Accountability for patient access is clearly defined and monitored through a clinical governance system. Access to pre-hospital emergency care is based on patient need as evidenced in the Dispatch Induction Manual and training course content. The Provider operates a safe call taking process that includes a process for assessment of request and escalation to a higher level of care as necessary.

The Dispatch and Communications system was reviewed by the Assessment Team, and the relevant Manager provided overview and commentary on the call taking process and the allocation of ambulance and crew based upon patient needs. The Provider operates its service in accordance with PHECC's Inter Facility Patient Transfer Standard and the Provider's Call Screening, Resource Allocation and Crew Communications Policy. Out of hours phone calls are directed to a dedicated Provider mobile phone and are dealt with by the crew on duty. The Provider also utilises a backup call taking service who pass relevant details to the crew. No patient details are taken by the call answering service.

Area(s) of Good Practice

The Provider operates an effective call answering system, which ensures patients have access to timely and appropriate pre-hospital emergency care based on their clinical needs.

Area(s) for Improvement

No specific observations 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

During Practitioner Engagement (PE) the Assessor witnessed care being given to all patients in a safe, caring and equitable manner with no evidence of poor practice related to equity or discrimination. The Provider has an Equality, Inclusion and Diversity Policy is in place and all necessary information to determine patient need and priority is obtained prior to call dispatch.

Area(s) of Good Practice

Observation and engagement with Practitioners revealed evidence of a positive and caring culture being in place within the Provider's organisation.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Assessment Team note that the Provider uses a standardised form on an online system to document all calls. Calls are dispatched according to the crew via a digital management platform that the Provider licences for use, data is securely transmitted to the crew. The PHECC's Inter Facility Patient Transfer Standard and the Provider's Call Screening, Resource Allocation and Crew Communications Policy guide the call activation system. Training on dispatch is delivered during induction, and the training lesson content was reviewed. From a governance perspective a dispatch quality audit review was undertaken in January 2026 with very good compliance scores reflected, scores ranged between 92 and 100% compliance. Management utilise a range of digitally created information to review quality aspects of service delivery.

Area(s) of Good Practice

The Provider's system is supported with data collection and review by management of response times and unit hour utilisation. Overall governance is strong.

Area(s) for Improvement

No specific observations 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

The Provider has a defined policy in place to confirm a minimum of 2 patient identifiers including Name, Date of Birth, and Medical Record Number. In practice staff looked for three identifiers. In the call room, staff also take a patient address as a fourth method of patient identification. Identification of patients is documented and communicated in induction training materials. The Provider has a Clinical Audit Policy in place, and the Assessment Team verified that the Provider monitors this process and has conducted clinical audits related to confirmation of patient identification. Practitioners reported receipt of feedback related to this and other topics.

Area(s) of Good Practice

The Provider's advice and system for confirming patient identification is considered to be robust.

Area(s) for Improvement

No specific observations 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 Provider has a policy on Consent, Capacity and Refusal of Treatment/Transport which was reviewed by the Assessment Team and this policy is in operation. During PE the Assessor witnessed consent to care delivery being gathered by Practitioners. Consent was also sought from patients to perform different diagnostic skills. The Provider has developed mandatory educational modules online that detail patient consent, capacity and refusal of care.

Area(s) of Good Practice

A Patient Care Record (PCR) audit was conducted in October 2025 and re audited in February 2026, which covered the area of informed consent.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider has a policy in place for patient refusal of treatment and/or transport. The Assessment Team discussed refusal of care with the Provider's Representatives who confirmed that, whilst it is a rare occurrence in a private ambulance service, all instances of patient refusal of care are documented on the PCR, and Practitioners are instructed to mark these for audit and notify their Supervisor of the occurrence. Practitioners are supported in this area by online educational modules, which they must complete on patient consent, capacity and refusal of care.

Area(s) of Good Practice

Practitioners are required to take 2 sets of vital signs from the patient when there is a refusal of treatment and transport.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 1

Criterion

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

Rating

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

Assessment Findings

The Provider ensures Practitioner applicants are assessed during their employment interview process for kindness, caring and critical thinking skills. The Provider has specified behaviours and expectations from Practitioner both in HR related policies and employee handbooks, which were reviewed by the Assessment Team. This topic was discussed with Representatives, and the Assessment Team note that the Provider has established a caring culture. During PE, the Assessor noted that the Provider's Practitioners treated all patients with empathy, respect, and dignity.

Area(s) of Good Practice

Patient feedback is generally very positive towards staff members.

Area(s) for Improvement

No specific observations 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

Patient feedback is sought after every journey, all patients transferred are given a feedback form. During the PE, feedback was observed being sought using a patient feedback card that allows several methodologies to be employed: by scanning a QR code on the card and giving feedback on a digital form; an option of a contact number on the card to make a call to give feedback; the reverse side of the card allows the person to make a written suggestion of a change for improvement, and it also utilises the happy faces method.
Evidence of patient feedback gained was provided and reviewed by the Assessment Team. All feedback is reviewed, monitored and fed back to Practitioners ad-hoc, or during staff appraisals. Any negative feedback is investigated, and the Assessment Team explored the managements process and specific activity and actions taken in response to a case of poor feedback on foot of below standard care, which did not meet the Provider's expectations.

Area(s) of Good Practice

The Provider's feedback system is robust; the patient and their carers have a multitude of feedback routes made available to them by the Provider.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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 Feedback and Complaints Policy in place. During PE, the crew were able to relate relative details and confirmed that this topic is covered during induction. The crew related they would direct a patient or carer to the Resource Compliance Manager if they wanted to make a complaint.

Complaints can be accepted through a variety of routes, and if the complaint is regarded as serious this will be elevated to management level. The Assessment Team discussed an example of a complaint with Representatives. Once a complaint is received via the Provider's feedback section on its website it is automatically sent to the Management Team. The complaint is investigated by the Resource Compliance Officer. The Provider has a dedicated timescale for responses and investigation, and the policy states it aims to resolve complaints within 30 days. If the complainant is unhappy with the result, they can appeal the investigation, in this case, which Representatives stated has not yet happened, they will engage a suitably qualified independent investigator. The Provider updates the complainant throughout the process, especially if any delays are envisioned.

The Assessment Team noted that the Provider's analysis of complaints revealed that they are generally related to uncomfortable vehicle journeys or excessive noise in the back of the vehicle. The Provider, on foot of this analysis, has begun the process of fleet replacement with a different vehicle model and internal design which seeks elimination of these issues to improve patient comfort and Practitioner ergonomics.

Area(s) of Good Practice

The Provider carries out analysis of complaints received to identify any trends and then engages in action to eliminate these issues.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 2

Effective Integrated Care and Safe Environment

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

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider has a robust Clinical Governance System overseen by the Medical Director. There is a system for privileging Practitioners to deliver PHECC Clinical Practice Guidelines (CPG), which involves credentialing of the Practitioners, completion and passing of induction and a system of mentoring. The Provider provides induction training; supernumerary staff work with an experienced Practitioner on a shift where their clinical skills are assessed. The Provider has Mentors in place to monitor and guide staff in clinical matters.

Area(s) of Good Practice

The Provider has developed an internal system for privileging for upcoming implementation, which will require Practitioners to attain a specific number of Continuous Professional Development (CPD) points to maintain their privileging.

Area(s) for Improvement

No specific observations 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 ensures that a comprehensive handover process is universally applied, ensuring relevant and timely information exchange. The process is fully integrated with the PCR, and Practitioners demonstrated awareness of the handover models specified.
The Provider has a standardised model in place for both interfacility and Emergency Department transfers of patients. For handover of patients during interfacility transfers an internally devised handover process that incorporates the relevant elements of the IMIST-AMBO handover is used. The Provider's Handover Policy documentation specifies that the standardised model of IMIST-AMBO is to be utilised when delivering a patient to the Emergency Department, which is less frequently than interfacility transfers. There is training available to support patient handover and recording of same.

Area(s) of Good Practice

Monitoring of handover is part of the induction/mentoring process and is documented on the Provider's monitoring forms.

Area(s) for Improvement

No specific observations 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 Assessment Team observed that a vehicle safety system is in operation, which seeks to ensure compliance with commercial vehicle regulations, which the Assessment Team consider to be robust in nature. The Provider's vehicle pre shift and inspection are supported by a Digital App that logs issues and crew are mandated to notify the base who must decide on the next appropriate steps e.g. vehicle is roadworthy or its use is forbidden. The Operations Team are automatically notified of the issue. The safety checks are based upon the Road Safety Authority's standards, with additional Provider specific requirements.

The Assessment Team witnessed one ambulance in the depot awaiting replacement of a fire extinguisher prior to becoming operational, which evidenced the safety systems in operation.

All vehicles observed had in-date insurance, tax and commercial vehicle roadworthiness test (CVRT). All equipment on board had in-date service tags attached. A QR code is used by crew to record the changing of O2 cylinders on the Digital App.

Area(s) of Good Practice

A positive change in vehicle design related to crew safety and Practitioners ergonomic seating position was observed, which improves patient care task achievement.

Area(s) for Improvement

No specific observations 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 note that Practitioner induction and ongoing training ensures that Practitioners safely transport patients according to recognised industry health and safety standards, for instance; all Practitioners and patients are secured during transport. The Provider operates a comprehensive safety training programme through its Learning for Life Programme and the Operations Handbook, given to all Practitioners, contains specific directions related to safe transport of patients, safe driving, and driver attitudes. Regular risk assessments and ongoing monitoring of transport practices are documented and actioned. Patients must be secured on the stretcher with shoulder straps attached during transfer. Ambulances are equipped with cameras to monitor safety; this footage can be reviewed if issues arise. The Assessment Team confirmed that a Driver Training course is available through the Provider's specialist driver training Digital App. The Provider has a staff member who is an Emergency Services Driving Standard (ESDS) Instructor. The Provider conducts a driving assessment as part of the Induction programme. However, the Provider's Driving Policy states that the Provider is not currently an approved ESDS driver training provider.

Area(s) of Good Practice

The Provider takes patient safety very seriously and has some robust procedures in place to support safe transport.

Area(s) for Improvement

The Provider is advised to ensure that all drivers are trained to ESDS that is relevant to their deployment.

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

A formal policy on the use of emergency lights and sirens is in place, and the Provider has strict protocols to govern blue light activity. The Provider's Driving Policy outlines that subject to a driving assessment. Drivers who have completed emergency driver training with another service and hold ESDS Level 3 may be recognised as emergency drivers and may be authorised to use blue light and sirens when providing services for the Provider.
The Provider utilises an artificial intelligence (AI) assisted driving monitoring software that records blue light activities. If blue light has not been prearranged, this system alerts dispatchers and if there is no clear rationale the activity is escalated to the Operations Manager and the Education and Practice Development Manager who investigate the incident with the crew. The Provider actively audits blue light use. In discussion, Practitioners were knowledgeable regarding the Provider's Blue Light and Siren Policy.

Area(s) of Good Practice

A clear and restrictive policy regarding the unnecessary use of blue lights and sirens is in place, which provides protection to patients, members of the public, and Practitioners.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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 Provider has a comprehensive Fire Safety system in place for their premises. The Provider submitted a range of associated documents and inspection log sheets, which included a Fire Safety Policy, a Fire Alarm test log, Fire Awareness Certification for management members, Health and Safety Statement and associated log sheets. The Assessment Team evidenced safety training certificates for members of the Providers Management Team. Submitted documentation reviewed by the Assessment Team evidenced that regular tests and fire safety drills are carried out on the premises. The Fire Safety Policy outlines the building plans and procedure for evacuation. In discussion, Practitioners stated they were aware of the appropriate evacuation process and assembly points in the event of an emergency in the building. It was noted that fire safety precautions were in use and all extinguishers inspected had in-date service dates. A walk around of the premises confirmed that all exit routes observed were clear and afforded free passage to potential escapees.

Area(s) of Good Practice

The Provider's premises as inspected appears to be well protected from a fire safety point of view.

Area(s) for Improvement

No specific observations 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 reviewed the Provider's submission of a comprehensive Business Continuity Plan and a Disaster/ Serious Disruption Recovery Policy; both outline the strategies and activities necessary to ensure the continuous operation and delivery of patient care in the event of major disruptions. The Provider identifies items such as IT failure, facility loss, pandemic, or a mass disruption incident and cites the primary goal of minimising downtime, protecting staff and maintaining patient safety, and regulatory compliance as key goals.

The Provider's Business Continuity Plan and Disaster/ Serious Disruption Recovery preparations are as robust as they can be; given the nature, depth and breadth of unknown challenge. In attempting to quantify this area they have planned for, the Provider has insured against predictable circumstances. Through its governance structures, the Provider utilise external expertise from two other countries to improve its planning for the unknown and its delivery of services going forward.

Area(s) of Good Practice

The Provider's Disaster/ Serious Disruption Recovery Policy takes a risk assessment approach, categorises level of disruption, and specifies actions to be taken at each level, which provides a graduated and co-ordinated response to issues as they arise.

Area(s) for Improvement

No specific observations 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 has adequate planning in place to deal with the first few minutes of a major incident until Statutory services arrive. All ambulances have necessary equipment in place and carry major incident 'patient categorising tags'. The Assessment Team reviewed evidence of a major incident training day that the Provider hosted, which utilised subject matter expertise from Statutory services to facilitate the training. Practitioners were required to complete triage simulation exercises, and use 'patient categorising tags'. The expected actions by Practitioners were the focus of the training exercise. PHECC have recently approved the Provider to deliver a programme on major incidents through its associated Recognised Incident and Provider's staff will be able to maintain their competency in this respect.

Area(s) of Good Practice

The Provider has hosted practice exercises to simulate the requirements of dealing with a major incident.

Area(s) for Improvement

No specific observations 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

The Provider has a 3-year programme of audit in place, which is documented. This 3-year cycle aims to audit PCR under the following headings: pain management, hypoxia, TR band and completion rates. The Provider regularly audits PCR and hand hygiene.

Representatives explained that the governing focus related to audit is based upon what is achievable, appropriate, and clinically important. The Medical Director oversees the audit process and reviews audit results. Lessons are sought, improvements are identified and feedback for Practitioners is developed based on the improvement requirements either instantly e.g. hand hygiene or via notifications to staff. The Assessment Team reviewed an audit on PCR carried out in October 2025 and re audited in February 2026.

Area(s) of Good Practice

The Provider is building on existing audit activities and there is good evidence of results and improvement actions being communicated to Practitioners.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 2

Criterion

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

Rating

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

Assessment Findings

The Provider provided the Assessment Team with its latest CPG Service Provider Annual Report, which was submitted to PHECC for its CPG Service Provider licence renewal. All relevant areas of the guidelines were in order.

Area(s) of Good Practice

The content in the Provider's Annual Report fulfils PHECC requirements.

Area(s) for Improvement

No specific observations 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

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

Assessment Findings

The Provider made a significant submission related to infection protection and control (IPC), including Practitioner guides and audit material. The Provide maintains a formal Infection Prevention and Control Policy, which outlines safe practice for staff and provides a list of pathogens at the end of the document. It is noted that the Provider has developed an IPC module in their Learning for Life Programme.

The Provider provides all equipment required to maintain infection control precautions and to ensure cleaning and disinfection can be provided after each call is completed. The Provider completes intermittent swabbing of vehicles and conducts analysis of the results, which is regularly assessed to drive focused improvements in IPC strategy. Hand hygiene is regularly audited, and feedback is given to Practitioners in real-time. Practitioners completed training on handwashing and donning and doffing of Personal Protective Equipment (PPE). During PE, Practitioners utilised disposable linens to reduce infection risk, and following transportation of the patient, the disposable sheet on the stretcher was removed and the stretcher was cleaned down with wipes. Clean linen was replaced in preparation for the next patient. The crew also clean down the ambulance at the end of each shift.

When taking a call, detailed questions related to a patient's infectious risk / status are asked, and relevant information is communicated to the crew on the call log. If the crew wish to refresh themselves on process, they can access the Infection Prevention and Control Policy on the Provider's app. The control centre can be queried on any related issue and will liaise with infection control specialists in the hospital or arrange direct engagement with the crew.

The Assessment Team note that whilst Clostridium difficile (C-Diff) and Carbapenemase-Producing Enterobacterales (CPE) are both discussed in the Learning for Life IPC educational module, they have been omitted from the Infection Prevention and Control Policy document list of pathogens.

Area(s) of Good Practice

The Provider has a vehicle swabbing programme and swab results/levels for individual areas in the vehicle are available on a digital dashboard, which the Provider can then use to drive specific improvement or develop new internal standards.

Area(s) for Improvement

The Provider is advised to include C-Diff and CPE on the list of pathogens at the end of the Infection Prevention and Control Policy.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider has a robust waste management system and details of waste segregation are included in the IPC Policy, which forms part of Practitioners' Induction. The Provider has a signed Service Level Agreement (SLA) with a clinical waste management company, which the Assessment Team confirmed. The Provider details waste segregation in its IPC Policy and the Induction material submitted confirmed that waste management is included in the safety induction. The Assessment Team reviewed evidence that Practitioners are supported with information delivered during their induction process, in their Operations Handbook and the Learning for Life Programme and in the IPC Policy. During PE, Practitioner operating aspects of the clinical waste management system, including providing safety equipment related to sharps management, was observed, and the storage arrangements for clinical waste were inspected.

Area(s) of Good Practice

The Provider's arrangements for infection prevention and control are robust.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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

Following a review of the submitted material and on-site inspection the Assessment Team evidenced that the Provider ensures there are adequate medication supplies to support Practitioners to deliver PHECC CPG in accordance with their clinical registration level. During PE, it was confirmed that 100% of all medications administered are reviewed within the internal clinical audit processes by the Quality and Compliance Manager to ensure that medications have been administered safely and in accordance with the PHECC CPG advisements.
The Assessment Team conducted a review of the Provider's medication management systems and verified compliance with relevant medicinal product regulations.

Area(s) of Good Practice

The Provider has systems in place to ensure that medications are legally administered in accordance with PHECC CPG.

Area(s) for Improvement

No specific observations 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

The Provider has a robust medication control and management system in place. The Assessment Team considered the building to be secure, which ensures medical security. Access to the building requires swipe card and keypad access and there is closed circuit television (CCTV) monitoring in place throughout the facility. Access to the medication storage area is only possible via a swipe system and access to controlled drugs has a second key requirement. Operationally, medications are secured onboard and medication kits are signed out and back in via a defined system, which is overseen by the Resource Compliance Manager. There are robust control systems in place for regular and for controlled medications. All medication transactions are recorded at each stage of their journey.

The Provider provides Practitioners with guidance for processes related to medication management in the Operations Handbook, including administration expiration and disposal. Medication recalls and alerts, that staff must read and sign to ensure awareness, can be distributed to Practitioners on the Digital App that Practitioners use when operational.

A Vehicle inspected was equipped for both EMT/Paramedic skill sets, with appropriate medications available for crew members to deliver PHECC CPG. Practitioners' medication bags were also equipped with EMT and Paramedic medications and were sealed and tagged. A spot check on the bag confirmed that the random medications checked were in date. Controlled drugs were kept in the safe and ambulances have internal and external CCTV and footage was retained in the event of the need to review an incident.

The Resource Compliance Manager tightly controls medication use, and audits are regularly conducted.

Area(s) of Good Practice

The Provider has a robust system to ensure the safe management of medications in their operations.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 3

Criterion

3.5 The Provider must have current HPRA Licence and or Registration as appropriate for its PHECC approved clinical level - Paramedic and or Advanced Paramedic.

Rating

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

Assessment Findings

The Provider provided the Assessment Team with evidence of its current licence for Schedule 2 medications and its registration for Schedule 3 and 4 medications. Relevant medication licence and registration from the Health Products Regulatory Authority (HPRA) were confirmed to be in date. The Assessment Team also reviewed the Provider's most recent HPRA inspection report.

Area(s) of Good Practice

The Provider's medication management practices for controlled drugs are robust.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider has a SLA with its supplier and key stock minimum levels are specified.
The Operations Manager deals with stock / devices / consumables. The Assessment Team inspected the consumables stores and confirmed that the store was well stocked with both consumable and non-consumable equipment. The stores are available to Practitioners to replace equipment. Equipment replaced is recorded on the Digital App, which makes entries on an inventory list that is regularly reviewed and actioned upon by the Provider's Operations Team. Vehicles inspected had appropriate equipment for both EMT and Paramedic practice on board. A spot check confirmed that the equipment service tags were observed to be in date on Suction, Defibrillator, and Stretcher.

Area(s) of Good Practice

The Provider has a good system in place to manage equipment.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 3

Criterion

3.7 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 operates a comprehensive Practitioner Induction Training Programme, which is designed to establish a standard approach to the induction and onboarding of new operational PHECC Registered Practitioners into the Provider's service. The programme has defined objectives and specific skills, and identified equipment where competency of use must be achieved.

The process takes approximately 4 weeks to complete and involves 6 stages and a portfolio submission. Practitioners undergo in-person training and undertake further learning via a learning management system. The programme contains a recognition of prior learning element, which may be granted whereby an individual can show suitable evidence of competency in a particular skill or knowledge. There is an experiential block, the length of which depends upon the previous training and experience of the inductee.

All Practitioners are subject to the Learning for Life Programme, which ensures their competency in operations on an ongoing basis.

Area(s) of Good Practice

The Provider's new employees are inducted into a comprehensive good practise support system.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 3

Criterion

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

Rating

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

Assessment Findings

The Provider submitted a comprehensive Child Safeguarding Policy. A review of submitted evidence and discussion with Representatives identified that the Provider has safe practices that support children and adult safeguarding practices during its operations. The Assessment Team confirmed that dealing with children and vulnerable adults is included as part of the Provider's Induction programme. Children First and Adult Safeguarding certification via online learning are required to be achieved during the internship process.
The Provider ensures staff are up to date with their safeguarding children and safeguarding vulnerable adults certificates. Staff are unable to work if these certificates are incomplete or expired.
During PE, it was confirmed that Practitioners were aware that the Provider had a Safeguarding Policy in place and that they had completed mandatory children first training online.

Area(s) of Good Practice

The Provider ensures adult and child safeguarding are specifically covered during Practitioner induction training.

Area(s) for Improvement

The Provider is advised to integrate its provisions for vulnerable adults into the Child Safeguarding Policy to ensure that adult safeguarding is also enshrined at policy level.

Standard 3

Criterion

3.9 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 conducts regular audits in areas relevant to its operations e.g. PCR completion and Hand-hygiene. Evidence reviewed confirms that the audit cycle is completed with results being fed back to Practitioners via notices that are sent to staff via the Digital App and acknowledged to confirm increased compliance. The Assessment Team noted that one audit carried out in October 2025 resulted in feedback being given to Practitioners for improvement, and a re-audit was carried out in February 2026 closing the audit loop.

Area(s) of Good Practice

Typically, notifications are accompanied with offers for Practitioners to complete online modules related to areas of audit, thus aimed at improving future compliance scores.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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 Provider has a robust system of corporate governance over its operation via 7 nationwide locations.
The Provider submitted a clearly outlined Organisational Chart detailing the roles, responsibilities and reporting structures of staff, which were confirmed during discussion where each member of the Management Team exhibited effective control of their individual domains and collectively inputted to a cohesive Management Team approach. Management conduct weekly meetings that provide collective management engagement with specific topic that are covered by a set agenda. These meetings are minuted and produce an action list that ensures active corporate governance is present. The Provider also operates a Risk Register and a risk dashboard to monitor activities from a risk perspective.
Evidence was submitted regarding external SLA in place to support operations. The Provider has a Change Management Policy in relation to its internal governance and direction.

Area(s) of Good Practice

The Provider has adopted a collective management model following an internal change process that generates specific areas of focus for each manager, who then contribute collectively to determine the Provider's strategy on current direction and challenges.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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's Clinical Governance Team meet regularly to discuss clinical governance matters. The Assessment Team reviewed the Clinical Governance meeting minutes and Medical Director meeting minutes, which detail current issues and responses to matters discussed. The minutes contain defined actions determined to address issues noted on clinical audit, and subsequent minutes contain review of the effectiveness of actions that were taken, these minutes include Medical Director input and direction.

The Provider has developed a Learning for Life Programme, which includes 9 modules and has a requirement for annual assessment. This is an important element in clinical governance within the Provider's organisation. The programme has several levels of competency and there are in-built training, monitoring, and assessment elements for Practitioners. The Programme supports clinical governance of the Practitioner as it ensures effective monitoring of Practitioners during internship and beyond into clinical practise.

Area(s) of Good Practice

The Learning for Life Programme system provides systematic support for clinical governance improvement for the Practitioner's operations.

Area(s) for Improvement

No specific observations 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's registration with the Medical Council was submitted and verified by the Assessment Team. The Medical Director is an Emergency Medicine Consultant who possesses suitable experience to oversee and complete the role. Based on submissions made and discussion, the Assessment Team determined that the Medical Director has been supporting the Provider in this respect for a number of years and is embedded in their processes, supporting the Provider by attendance at various meetings, facilitating the supply of prescriptions for required medications including controlled medications. They also oversee the clinical audit process by liaising closely with the senior clinical staff on the Management Team to determine audit priorities, and action related to outcome findings. They provide support to the Clinical Governance system and is available to the Provider to answer clinical questions/issues as and where required and attends quarterly meetings to provide clinical support for discussion of management issues.
The Medical Director co-signs the privileging letter that all Practitioners are issued once qualified to provide services for the Provider.
During PE, Practitioners correctly described the Medical Director's role within the Provider's service and identified them by name.

Area(s) of Good Practice

The Medical Director is involved in determining the Provider's clinical audit topics.

Area(s) for Improvement

No specific observations 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

The Provider's Document Quality Management System is in place, and publications have suitable document control information within. Documents provided by the Provider for review by the Assessment Team were uniformly presented e.g. date, policy number, version number, and person responsible for updating the document were included.

Area(s) of Good Practice

The Provider properly manages information and controls the retention of update information, which is important in governance terms, should there be an important need to determine what policy was in place at an earlier specific date.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Provider receives alerts from the regulatory bodies that are relative to its services.
The Provider uses a Digital App that details Practitioners' workload for the shift. This Digital App can provide push notifications that must be read, understood and signed off by Practitioners. The Provider submitted evidence of the circulation of medication safety alerts to Practitioners. Safety alerts are sent through the operations Digital App, and, dependant on the gravity and potential impact of the notification, the Provider can attach specific criterion to specify that staff must read the safety alert, whereby failure to read the alert will result in the Practitioner being unable to start their shift. Evidence of the circulation is retained on the Provider's records for governance purposes.

Area(s) of Good Practice

The Provider leverages its online learning platforms to disseminate important clinical information and reinforce clinical notifications.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 4

Criterion

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

Rating

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

Assessment Findings

The Provider has a Health and Safety Policy in place, which includes a Safety Statement. The Assessment Team also reviewed evidence of monthly health and safety meetings and the operation of a Risk Management Policy and process. The Assessment Team reviewed the Provider's Risk Register and a risk related dashboard. The Provider aims to identify areas of potential harm and how they intend to mitigate or eliminate the identified risk.
Clinical incidents are initially managed to reduce subsequent risk and immediate impact wherever possible, and the Medical Director is contacted for advice and the Provider's corrective action is determined. The issue is subsequently discussed at the Clinical Governance meetings.

Area(s) of Good Practice

The Provider is clearly risk aware and maintains a Risk Register.

Area(s) for Improvement

No specific observations 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 Provider conducts regular management meetings with all relevant department stakeholders, meetings have a set agenda and discuss a cohesive range of business management and development topics, which include workforce planning, operational and dispatch operations. During these meetings staff deficits and any issues related to facilitating calls received are discussed, and resources are managed to maximise operational effectiveness.

Area(s) of Good Practice

The Provider conducts regular monitoring and management activity around workplace planning.

Area(s) for Improvement

No specific observations 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

All Practitioners are credentialed and privileged to deliver pre-hospital care on behalf of the Provider, to the Provider's clients. Practitioners have access to their co-signed letter of privilege from the Medical Director and the Provider and their valid CFR-A certificates through the Provider's Digital App.

Area(s) of Good Practice

The Provider has an effective system to ensure the legitimacy of Practitioner's credentials and support their retention.

Area(s) for Improvement

No specific observations 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 conducts initial screening of potential employee's English language competency at the interview stage through conversation related to general and clinical discussions, and by issuing simple Practitioner task related instructions. Written English language competency is also assessed by transcribing spoken clinical instructions. The potential employees may be deemed to be fluent, or they are advised to seek an external assessment to achieve certification in internationally recognised standards for English language competency.

Area(s) of Good Practice

Where there is any uncertainty of English language competence, the Provider relies upon recognised certification.

Area(s) for Improvement

No specific observations 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 Provider has developed the Learning for Life Programme to support its staff development
This programme starts on induction and sets out and builds competencies in the expected standards related to safety and quality of services. Staff are mentored and must achieve defined competencies and are required to submit a completed portfolio within 3 months of commencing employment.

Area(s) of Good Practice

The Learning for Life Programme is a comprehensive system of staff development that should ensure competency over a diverse topic range.

Area(s) for Improvement

No specific observations 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

Practitioners are well supported and mentored, and the Provider's Learning for Life Programme is the Provider's commitment and process to building a top-class and sustainable service. This is a tailor-made programme developed specifically to train staff to achieve competency in a variety of subject matters. The topics, processes and procedures dealt with during the Learning for Life Programme are focussed on enabling Practitioners to complete their duties in line with their scope of practice. Practitioners are supported by a suite of online learning short courses and mentor sign-off on skills for their portfolio as they are achieved throughout the process. Following induction, Practitioners must engage and achieve the required standards of operations and competency, which is a contractual matter, their achievement of a high level of service and task competency is required and is a non-negotiable condition of their employment.

The Learning for Life Programme features a graduated progression through levels that support the Practitioner throughout their career so that they may become Instructors Supervisors or Mentors in due course, should they wish to follow that pathway. As their career progresses each Practitioner must show evidence of CPD points yearly, which can be obtained via in-house training and education, external courses, and must include clinical skills. The Provider operates a PHECC Recognised Institution, which provides access for the Provider's Practitioner to access formal and PHECC certified training as required.

Area(s) of Good Practice

The Provider has developed a tailor-made programme specifically to train staff to achieve competency in a variety of subject matters.

Area(s) for Improvement

No specific observations 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

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

Assessment Findings

The Provider maintains a formal agreement for operational placements of EMT students with a PHECC Recognised voluntary organisation. The Provider provides training to students by facilitating placements where they are mentored and where clinical skills are developed. The Assessment Team learned that students do not have induction, they are spoken to before going out on a call as to what to expect, how it is run, and what is expected from them. All students must have mandatory training completed prior to being allowed on placement. The students are a third member of staff on the crew, and they do four ten-hour observational shifts.

Area(s) of Good Practice

All students must have mandatory training completed prior to being allowed on placement.

Area(s) for Improvement

No specific observations 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 Provider has a robust Health and Safety Policy and contractual arrangements in place to support the safety of its staff, which includes fire safety. They provide a Critical Incident Stress Management (CISM) that can be accessed either through one of the Management Team or by directly emailing a trained CISM Provider confidentially. The Provider currently has no Employee Assistance Programme (EAP) in place, however, Representatives stated that a new provider for EAP is being investigated currently.

The Provider conducts 'Town Hall' style online meetings where staff can directly raise a discussion on topics of their choosing, which can reasonably be considered a cultural initiative that supports employee wellbeing.

Area(s) of Good Practice

The Provider has a robust Health and Safety Policy.

Area(s) for Improvement

The Provider is advised to conclude its search for an EAP service provider and communicate the new EAP details to its staff at the earliest convenience.

Standard 5

Criterion

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

Rating

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

Assessment Findings

The Provider has effective processes for the performance management of employees and Practitioners and has recently introduced the Learning for Life Programme to support Practitioners through internship and beyond as their career develops, participation in this process is mandatory.
The Provider also introduced a system of CPD in 2026, which specifies a set number of CPD points be attained annually, 75% of which must be related to practical skills. Practitioners must submit proof of their CPD points to obtain re-registration and privileging letter. Those who do not obtain or submit their CPD points are asked to attend a clinical skills knowledge assessment for their practicing clinical level.

Area(s) of Good Practice

The Provider makes significant efforts to ensure the high-quality performance of their clinical staff.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

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

Staff can provide feedback to the Provider through the Provider's Digital App. During PE, it was confirmed that Practitioners are afforded a safe space to feedback ideas or comments to management as comments may be submitted under their own name, or submitted anonymously, if preferred.

There is a monthly staff feedback form available to Practitioners and the Provider hosts online 'Town Hall' style meetings, which they hold on consecutive days to maximise staff attendance. In discussion, the Management Team underlined efforts made to develop an open culture and identified their open-door policy. Staff can approach the Management Team directly if they have any concerns or queries. Depending on the nature of the feedback, it is sent on to the most relevant member of the Management Team, for instance, HR, Finance, Operations.

The Management Team meets weekly to discuss workforce planning, operational support, and within this meeting any issues arising from feedback are discussed and response strategies designed to improve situations, and an implementation decision is taken. The Provider has information on protected disclosure / whistleblowing in its Employee Handbook.

Area(s) of Good Practice

There are effective systems in place to afford Practitioners opportunities to submit feedback comments to management regarding subjects of their choice.

Area(s) for Improvement

No specific observations 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 Provider manages its PCR in accordance with PHECC guidance. Effective PCR completion during a call was observed and information documented was comprehensive. Completed PCR were stored in a locked box in the cab of the vehicle. On completion of shift PCR are moved to a locked box in the crew room. In discussion, it was confirmed that PCR are collected each day and filed away by the responsible manager.

The Assessment Team reviewed evidence of PCR being audited for completion and of resultant corrective action being communicated to Practitioner. Evidence of subsequent audit improvement for completion of PCR data was also observed.

Whilst the Provider is currently maintaining PHECC Standards with a paper-based PCR system, the Assessment Team were informed that the Provider os in the process of initiating implementation of an electronic PCR (ePCR) with the intention of improving call communication, and data collection during calls. Representatives also cited the system will increase their ability to perform clinical audit.

Area(s) of Good Practice

The Provider's systems are currently compliant with respect to this criterion.

Area(s) for Improvement

No specific observations 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

The confidentiality and security of data is protected. The Assessment Team observed evidence that PCR are effectively managed, and all patient data is controlled and protected throughout its journey from collection, through storage and onwards to audit and analysis. All completed PCR are placed into a locked box in the front of the ambulance and, on return to base, are removed and placed in a locked box in the crew room. The Compliance Manager retrieves them daily and transfers them to a permanent storage location. This process was observed in operation during the PE and during a closer inspection at the Provider's premises.

Area(s) of Good Practice

All patient data is controlled and protected throughout its journey from collection, through storage and onwards to audit and analysis.

Area(s) for Improvement

No specific observations noted by the Assessment Team.

Standard 6

Criterion

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

Rating

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

Assessment Findings

The Provider has a supportive culture related to ensuring improvement and accuracy of clinical data collection. The Provider utilises a specific form to complete the audit of PCR and to identify deficits or omissions. Individual Practitioners receive a completion score, and training, teaching and mentorship is provided to Practitioners to aid improvement of the quality of the Provider's healthcare records. The Assessment Team reviewed audits related to PCR completion rates and corrective actions that followed based on the outcome of the audit.

Area(s) of Good Practice

The Provider carried our audits on PCR to ensure good quality healthcare records are maintained.

Area(s) for Improvement

No specific observations 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
36	39	34	24	35	12	180
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 7 of this report.

No of criterion assessed	46
Maximum score available	184
63% of Max =	116
Assessment Results	
Total score achieved	180
Total score as percentage	98%
Assessment Outcome Rating	**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 Medicall Ambulance Limited in accordance with Council Policy for Recognition to Implement Clinical Practice Guidelines (POL003) is unaffected.

Medicall Ambulance Limited 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 Medicall Ambulance Limited in the upcoming licensing period.

Medicall Ambulance Ltd

Assessment Outcome Rating
Acceptable

Standard 1: Person-Centred Care and Support		
Statement – The intent here is to ensure the Provider has a patient-centred focus by providing services that protect the rights of patients, including empowering them to make informed decisions about the services they receive. The views of patients should be sought and analysed. Sources of this information include complaints, compliments, and patient feedback surveys. The feedback system needs to be transparent, and the information should be used to make improvements. Patients should be provided with instructions that are clear and relevant to their special needs and ethnicity.		
	Criteria	**Rating Score**
1.1	Patients have access to pre-hospital emergency care based on their identified needs and the Provider's scope of services.	4
1.2	Access to pre-hospital emergency care is not affected by discrimination.	4
1.3	The Provider ensures information from calls / activation is recorded accurately and dispatched according to priority.	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.	4
1.9	Patients' complaints and concerns are responded to within an agreed timeframe and openly with clear support provided throughout this process.	4

Standard 2: Effective Integrated Care and Safe Environment		
Statement – The intent here is to evaluate if the Provider's environment supports safe services. Fire safety, security, and planned preventative maintenance programmes are some of the topics covered. Safe clinical care is evaluated including identifying high risk patients. Pre-hospital emergency care Providers have a crucial part to play in major incident planning and testing.		
	Criteria	**Rating Score**
2.1	The Provider has systems in place to ensure Practitioners utilise the PHECC CPG (Clinical Practice Guidelines) appropriate to their scope of practice.	4
2.2	The Provider has a standardised handover process in place to ensure the safe, timely, and structured exchange of information during handover of patients.	4
2.3	The Provider has a system in place to ensure the safety of their vehicles in line with legislation.	4
2.4	Training is provided for staff to transport patients safely, including during emergency situations.	3
2.5	The Provider has a policy on the use of emergency lights and sirens.	4
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.	4
2.9	The Provider has a 3-year programme of clinical and environmental audits in line with the services provided.	4
2.10	The Provider submits a CPG Service Provider Annual Report,* which informs PHECC of clinical and other activities in their organisation. (*Calendar year).	4

Standard 3: Safe Care and Support		
Statement – The intent here is to evaluate risk management and reporting systems. Other safety issues are measured: Infection prevention and control (IPC), waste management, safeguarding, and medication management are patient safety issues that require specific attention in this standard. The sudden outbreak of transmissible diseases means practices have to rapidly adapt existing emergency plans to manage services and reduce the transmission of infection. Utilising PHECC CPGs provide important sources of best practice.		
Criteria		**Rating Score**
3.1	The Provider describes in a plan or policy the content of the infection prevention and control programme.	3
3.2	The Provider segregates and manages waste according to hazard level and disposes of same, according to best practice.	4
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.	4
3.5	The Provider must have current HPRA Licence and or Registration as appropriate for its PHECC approved clinical level – Paramedic and or Advanced Paramedic.	4
3.6	The Provider ensures that there are systems in place to ensure the availability of medical devices and consumables.	4
3.7	Employees, volunteers and/or contractors with the relevant competencies receive training on the safe use of the Provider's diagnostic and therapeutic equipment.	4
3.8	The Provider has a safeguarding policy to deal with children and vulnerable adults.	3
3.9	The Provider can demonstrate follow-up and actions taken as a result of audit and monitoring findings.	4
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.	4
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.	4
4.5	The Provider has a system for monitoring and circulating new recommendations issued by PHECC, other regulatory bodies, and public health alerts.	4
4.6	The Provider develops a risk management plan that includes a reporting system and a process for identifying potential risks.	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.	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.	4
5.6	The Provider has appropriate arrangements for the management and supervision of students (if applicable).	4
5.7	The Provider has systems in place to promote and protect the wellbeing, health, and safety of employees, volunteers and/or contractors.	3
5.8	The Provider has processes for the performance management of employees, volunteers, and/or contractors.	4
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.	4
6.2	The Provider ensures confidentiality and security of data is protected.	4
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